Academic Medicine and Quality of Medical Care

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Academic medicine comprises education, research, and medical care respectively provided by medical schools, research institutions, and teaching hospitals. Thus far, academic medicine has been unsuccessful in establishing, protecting, promoting, and improving the quality of care. Its role in that area should therefore be reconsidered. Quality improvement activities require constant planning and perseverance, explicit standards of good practice, quantitative measurement, and comparison with previous performance or the performance of others. Preparedness and willingness to change attitude, approach, and behavior are pivotal to the success of such activities. Early exposure of medical students to the principles and practices of quality of care improvement would be a starting point for a life long process of experience-based learning that allows physicians to change and improve practice through the application of relevant knowledge and skills. It is essential that changes in graduate and postgraduate education and training be introduced, to improve an understanding of the importance of focusing on the care process from the patient’s perspective as well as on the need for interdisciplinary cooperation and team performance as prerequisites for good medical care. Their education should also emphasize the measurement of the quality of delivered care, provide an understanding of the demand of society for accountability and how to meet it, as well as competence in using the principles and practice of quality improvement to provide, document, and improve the quality of care in institutions of academic medicine.

Key words: education, medical; quality indicators, health care; quality of health care
tration was unnecessary in 15% of cases (with hemo-
ysis and circulatory overload in 4%) and the use of
frozen plasma was not indicated in 67% of cases (12).

High-quality care – care that is effective, effi-
cient, up-to-date, and timely – has lagged behind the
advance of medicine. Approaches to quality improve-
ment have been clarified and generally agreed upon,
and their implementation has proved that they make
possible the detection of deficiencies, the determina-
tion of their causes, and their prevention through ap-
propriate corrective actions resulting in the improve-
ment of quality without having undesirable effects.
Thus quality improvement activities have already di-
rectly benefited patients, assisted physicians to pro-
vide better care, and have the potential to do so more
widely (13).

Paradoxically, although physicians working in
academic medicine want to deliver the best care pos-
sible, many are unaware or skeptical regarding the
need for quality improvement. In a Swiss university
hospital, heads of clinical departments lacked knowl-
edge in quality improvement and the incidence rates
of adverse events in their departments were not
known to them (14). Physicians often oppose quality
improvement initiatives or are not sufficiently in-
volved in their conduct. Some of the reasons are lack
of financial incentive, work overload, and a suspicion
that the activities are aimed at reducing costs rather
than improving quality (15). However, it may also
stem from the basic structure of the academic envi-
ronment, from faulty incentives for entering or main-
taining an academic career as well as from inade-
quate education and training of academic medicine
physicians.

In many countries, particularly in continental Eu-
rope, the style and organization of academic life date
back several centuries and preserve many relics of
that times. One of these is a strong belief in authority,
which sometimes overrides evidence (16). Chair of an
academic basic science or head of a clinical depart-
ment have life tenure and are very powerful. They are
unchallenged in their domains without external or in-
ternal quality or utilization review or cost effective-
ness analysis (17) and cost of care is not a consider-
ation (18). If additional resources for improving care
are not forthcoming then the customary, unsatisfac-
tory practice is continued without any attempt to im-
prove care with available resources (19). Within this
environment medical care assessment is based on
subjective and implicit criteria with the judgment ex-
pressed by the department head and unquestioningly
accepted without submission to assessment based on
objective explicit criteria and standards. Furthermore,
in most countries medical academic careers are built
on research publication rather than on the actual
quality of the care delivered, which is in any case nei-
ther measured nor rewarded. Consequently, the inter-
est of physicians leans essentially towards basic or
clinical research. From that academic vertex, the
quality of care delivered and the need for improve-
ments are condescendingly regarded trivial (20). Nat-
urally, physicians who consider quality improvement
insignificant will not initiate quality improvement ac-
tivities or participate in those conducted by others
and will not change their practice and so improve the
quality of care they deliver (21,22). Quality improve-
ment activities require constant planning and perse-
verance, explicit standards of good practice, quantita-
tive measurement, and comparison with previous
performance or the performance of others. Prepared-
ness and willingness to change attitude, approach,
and behavior are pivotal to the success of such activi-
ties. Early exposure of medical students to the princi-
pies and practices of quality of care improvement
would be a starting point for a life long process of ex-
perience-based learning that allows physicians to
change and improve practice through the application
of relevant knowledge and skills. However, despite
frequent recommendations for incorporation of the
concept of quality of care into medical education,
there are few reports of courses being taught in medi-
cal schools (23). Individuals interested in pursuing ac-
demic careers should also add an understanding of
the process of medical care delivery and the princi-
ples and practice of quality improvement to their ba-
sic knowledge and skills that make them versed phy-
icians.

Academic medicine would have to undergo a
transformation in order to fulfill its role in improving
the quality of medical care and thus translate its sci-
centific discoveries into benefit for patients.

An important change would have to occur in the
relationships between seniors and subordinates in ba-
sic science and clinical departments. Chiefs should
act as senior consultants rather than issue orders, and
subordinates should freely exchange and discuss
ideas with their seniors. Ideally, the relationship
should be one between colleagues rather than the au-
tocratic, as it has been traditionally in many academic
environments.

Commitment to the idea of subjecting quality of
care provided in teaching hospitals is an important
step to be adopted and implemented. Subsequently,
the monitoring of aspiring academic physicians, both
basic scientists and clinicians, must now take into
consideration their involvement in quality improve-
ment efforts in addition to their research output.

It is essential that changes in graduate and post-
graduate education and training be introduced, to im-
prove an understanding of the importance of focusing
on the care process from the patient’s perspective as
well as on the need for interdisciplinary cooperation
and team performance as prerequisites for good med-

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<th>Box 1 Goals of education on quality of care:</th>
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<td>1. View medical care delivery as a system of people, procedures, activities and technologies that interact and collaborate to address the needs of individuals and communities. To identify the person, persons or groups for whom medical care is provided.</td>
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<td>2. Understand their needs and preferences as well as the relationship of care to those needs and preferences.</td>
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<td>3. Acquire the knowledge, skill and attitude needed to work effectively in a group.</td>
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<td>4. Understand and value the perspectives and responsibilities of other disciplines and the implications of their work.</td>
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Impact on the rest of medicine and on health care

The lead of academic medicine and thus increase its

trend outside academic medicine will inevitably follow

that ought to be taught to medical students and physi-
cians at the beginning of their academic career.

Changes within the established health care system outside academic medicine will inevitably follow the lead of academic medicine and thus increase its impact on the rest of medicine and on health care (24).

References


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