By Jay Crosson, MD

Patient Safety and the Group Practice Advantage

The Institute of Medicine's 1999 report on medical errors and patient safety, *To Err Is Human,*[1] has had—and will continue to have—many salutary impacts on the quality of American health care, including the care provided by Kaiser Permanente (KP). Our organization has responded with impressive speed, enthusiasm, and resources to strengthen our existing patient safety systems and to develop new procedures and protocols where needed—many of which are discussed in this special issue of *The Permanente Journal.* But to my mind, one of the most welcome outcomes of the report is the recognition it has brought to the quality and safety advantages inherent in highly organized, integrated systems of care, such as KP, Group Health Cooperative, and a few other health care providers.

In fact, the report states that the key cause of medical error is the "decentralized and fragmented nature of the health care delivery system"[1:3]—a pointing finger that may partly explain the defensive posture with which some physician organizations greeted the report. In effect, the report suggested that the way three quarters of American physicians are organized—in solo or small group practices connected to other parts of the delivery system only loosely, if at all—causes thousands of preventable medical errors.

Benefits of Our Integrated Health Care Delivery System

In contrast to the defensiveness of some physician organizations, however, Permanente physicians responded positively to the Institute of Medicine report because it urged us to do what we at KP have been doing for more than half a century: work together to improve the quality and safety of the care we provide to patients.

The systemic approach to care delivery called for by the Institute of Medicine already exists in an integrated system like Kaiser Permanente, where the most fundamental building block supporting patient safety and quality is each KP Region's Permanente Medical Group itself. The inherent advantages of prepaid, multispecialty group practice may sometimes be invisible to those who have never practiced in the more traditional, "cottage industry" health care environment. The Institute of Medicine report therefore came as a welcome reminder of a few elementary truths. Among the most important of these truths are three facts of modern health care:

- The increasing complexity and specialization of medicine has dramatically undermined the ability of any individual provider to keep abreast of all vital information, skills, and technology. Who, for instance, can read more than a few of the estimated 1500 medical articles per day currently appearing in some 4000 health-related journals?[2] The answer is that no one needs to if everyone is practicing in a physician-led, team-based environment of close, proactive cooperation and consultation with hundreds of colleagues representing dozens of specialties and subspecialties, each supported where appropriate by evidence-based, best practice guidelines developed by their own colleagues. Such an environment and style of practice may be rare in much of the world, but it is the norm among the Permanente Medical Groups.
- Patient safety also depends on the ability of clinicians to hold themselves accountable to high standards of quality (and improvement in quality), clinician competency, continuity of care, and adherence to an explicit strategy for ensuring patient safety. But such accountability presupposes a group practice ethic that promotes shared responsibility for care of individual patients as well as of entire patient populations. Such an ethic comes naturally to self-managed, prepaid medical groups; but where can the incentives or structures for effective peer review and accountability be found outside such an environment? In the KP system, group accountability for quality and safety exists at both the medical group level and at the Permanente Federation level, where it takes the form of a rigorous quality review process conducted by the interregional Medical Directors Quality Committee.
- Many of the greatest possible gains in patient safety and quality depend on the ability to invest in, deploy, and effectively use care management protocols and sophisticated new clini-

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cal information technologies, such as the electronic medical record. The Institute of Medicine's March 2001 report, "Crossing the Quality Chasm,"[3] emphasizes this point by devoting an entire chapter to the urgent need for bringing American medicine into the Digital Age.

But the Institute of Medicine's report fails to address the question of how the vast majority of America's physicians, working as they are in isolation or in loose aggregations, can be expected to finance such long-term quality improvements. Nor does the report ask the tougher question of how a disaggregated collection of clinicians and organizations, many with competing incentives, is supposed to utilize a single information system that depends on aligned incentives, sharing, and cooperation? Our own experience with care management and with clinical information systems demonstrates the great difficulties—and cost—of effectively deploying such sophisticated and important tools, even among the most integrated group practices in the country. I can only imagine the obstacles outside the group practice environment!

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Accountability: An Ethic of Group Practice

In fact, it is daunting to imagine how almost any of the patient-related programs that Kaiser Permanente routinely depends upon can be effectively used outside an integrated health care delivery system based on group practice medicine. Programs such as KP Northern California's ADEP (Adverse Drug Events Prevention) or KP Southern California's patient identification and surgical site marking techniques (and so many others) all require extensive cooperation and sharing of information, and they all benefit from the ethic of group accountability that is at the heart of group practice.

Conclusion

Permanente physicians can and should take great pride in the accomplishments we have already achieved in the area of patient safety throughout our program. Certainly much remains to be done, and the work remains a top priority at every level of the organization—from departments and facilities up to each KP Region's Permanente Medical Group and on to the Permanente Federation itself. Some of the more important changes will depend on legal or regulatory actions, including establishment of an effective, confidential, voluntary reporting system, as well as sensible tort reform.

But as we go about the work, let us occasionally remind ourselves that we already have the most potent tool in the patient safety medical bag: the prepaid group practice ethic of accountability for both quality of care and patient safety. ❖

References

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2. Lawrence DM. Patient safety and the American health care system [news release]. Available on the World Wide Web (accessed April 19, 2001): http://www.kaiserpermanente.org/newsroom/releases/052200.html.
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Built-in Quality Control

In group practice, there is built-in quality control in the careful choice of doctors, and in the sharing of patients and knowledge. In addition, in our group, each service has a chief of service and a nucleus of senior doctors who work with other clinicians and share their patients' medical problems.

Raymond M Kay, MD, in a speech entitled, "The Kaiser Medical Care Program," 1985. This "Moment in History" quote collected by Steve Gilford, KP Historian