

the quality of care that we provide — and to find new ways to improve it.

*Editor’s note:* Dr. Brennan reports that he did in fact pass the recertification examination in May.

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2. Lukes S. *Emile Durkheim: his life and work: a historical critical study*. London: Allen Lane, 1973.

## Personal Metrics for Practice — How’m I Doing?

Richard J. Baron, M.D.

Part of the challenge of being happy in medical practice arises from the difficulty of ascertaining whether we are truly succeeding as doctors. In primary care, we take on complex problems and often feel as if we’re failing. So we take whatever encouragement we can get. I was flattered recently when the husband of a dying patient thanked me for my care and said, “You’re one of those people who really *should* be a doctor.” The good feeling didn’t last, however — I soon ran into a man who had changed doctors after I had counseled caution on screening with prostate-specific antigen, and then the laboratory panel required by his insurance company revealed an abnormal result that led to a diagnosis of prostate cancer. He glared at me angrily as we passed on the street.

Doctors in academic and corporate settings have ranks, promotions, publications, titles, and corner offices. How do we practicing physicians know where we stand — according to meaningful measures of quality, independent of random instances of praise and blame?

One might say that the most readily available metrics for practitioners are financial. To assess

the financial performance of our four-physician practice, I use aggregated measures that are tracked and trended over time. With a standardized accounting framework and resources from national organizations, I can determine that the practice has done 8 percent better than last year, for instance, or that my income is 10 percent lower than the incomes of my colleagues. I can reorganize our office’s staffing and scheduling patterns or switch to a cheaper supplier of paper towels and see whether the bottom line improves. Yet financial success has almost no connection to my reasons for going into medicine. Gaining a sense of success that is congruent with my core medical goals requires a different set of measures altogether.

This past spring, in an effort to get a more stable, aggregated view of the quality of care I provide, I completed a diabetes practice-improvement module, part of the maintenance of certification process of the American Board of Internal Medicine (ABIM). Although my certification is not time-limited, I went through voluntary recertification in 1998 and have remained in the program to assure myself and my

patients that I still know what I am doing — and, more recently, to assess whether I am actually doing it. To complete the new module, I mailed a structured patient survey to a random sample of 21 of our patients with diabetes and audited their charts. The board compiled the results and sent them to me. There was some good news and some bad news, some expected findings and some surprises.

In our practice, we have worried a lot about having reliable office procedures to respond promptly and safely to patients’ telephone calls and requests for prescription refills or referrals. So it was gratifying to learn that 100 percent of the surveyed patients said it wasn’t a problem to reach us with a question or concern or to get a referral, and 90 percent said it wasn’t a problem to get prescriptions refilled. Current LDL cholesterol test results were available for 19 of the 21 patients; of these levels, 12 were less than 100 mg per deciliter and 3 were more than 130 mg per deciliter. All 21 patients had current glycosylated hemoglobin measurements, but only 15 of 21 had urinary microalbumin results available. It was painful to learn that only 60 percent of these pa-

tients “definitely” knew what to do to alleviate symptoms of low blood sugar, and only 50 percent said I was “good” or “very good” at “showing understanding of what it is like to live with diabetes.” Most wounding: only 50 percent of the patients rated their diabetes care overall as “excellent” or “very good.”

Time-limited certification is now a reality for all boards recognized by the American Board of Medical Specialties,<sup>1</sup> and since all boards will be requiring some measurement of performance in practice, more of us are going to get the kind of population-based picture of our practices that I got with my diabetes exercise. Many have greeted the requirement of recertification with skepticism and hostility, offering a variety of arguments against it: it's not relevant to my practice; it takes too much time and costs too much money; I'm a mature professional and don't need anybody looking over my shoulder; doctors who are older and perhaps less capable<sup>2</sup> than I are grandfathered in and don't have to do it, so why should I have to?

But perhaps these criticisms miss an important point. Seen as something imposed on the profession from outside, the process can feel like one more irritation. But what if we embraced a commitment to practice-based improvement as our own professional goal? What if I used this process to benchmark and improve the quality of the care I give?

A recent survey conducted by

the American College of Physicians and the ABIM<sup>3</sup> revealed a number of interesting things about how internists think about maintenance of certification. Of the physicians surveyed — a representative sample of internists who have been in practice for 10 years — half are practicing in groups of five or fewer physicians, and 17 percent are practicing solo. These small practices are likely to be more isolated than larger practices, with fewer tools for assessing clinical performance. Most general internists who are still in practice are being recertified (87 percent), and most of these are doing so to improve their “professional image” (59 percent) or to “update [their] knowledge” (51 percent); only 10 percent are doing so for “monetary benefits.” The surveyed internists report that health care organizations are inconsistent about requiring maintenance of certification: 31 percent said that it was required by an insurance plan, 30 percent by a hospital, and 22 percent by a medical group. Overall, 42 percent of the physicians reported that they participated because it was “required for employment.” So it looks as if more doctors are undergoing recertification for purposes of professional development than because they are being forced to or because they believe that it will help them to generate a higher income.

Now I have a lot to think about. How can I do a better job of educating patients about the

management of hypoglycemia? What systems can I put in place to increase the proportion of our patients with diabetes who undergo annual urinary microalbumin testing? And perhaps most challenging: What would it take to get more than half our patients to feel that they were getting “excellent” diabetes care? Somehow, worrying about these issues and trying to improve the care my office team and I provide seem more professionally rewarding than finding a new vendor of paper towels. Maybe next year, instead of riding the daily roller-coaster of praise and blame, I'll be able to say that I improved by 50 percent the rate of urinary microalbumin screening among patients with diabetes and increased to 80 percent the proportion of patients who say they've received excellent care. And maybe then, in the emerging world of “pay for performance,” my income will improve as well.

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Dr. Baron is a practicing internist and the president of Greenhouse Internists, Philadelphia. He has been a director of the American Board of Internal Medicine since 2001.

1. American Board of Medical Specialties. Maintenance of certification. (Accessed October 20, 2005, at <http://www.abms.org/MOC.asp>.)

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3. Lipner RS, Bylsma WH, Arnold GK, Fortna GS, Tooker J, Cassel CK. Who is maintaining certification in internal medicine — and why? A national survey of general internists and subspecialists ten years after initial certification. *Ann Intern Med* (in press).