The Challenges of Physicians' Participation in Hospital Accreditation Programs: A Qualitative Study in Iran

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Abstract

Background. Due to the increasing pressure on hospitals to improve the quality of patient care, the need for physicians to participate in quality improvement Programs, especially hospital accreditation, has become more important. The present study was conducted to describe challenges of physicians' participation in accreditation programs in Iran using a qualitative approach.

Methods. We conducted interviews with 11 managers, 9 physicians, 8 officials and experts in the field of quality management selected through purposive snowball sampling. The initial in-depth unstructured interviews were reviewed and transformed into semi-structured ones. The data obtained were analyzed in ATLAS.ti using the conceptual framework method.

Results. 3 main concepts (cultural, organizational, behavioral) and 12 sub-concepts (Motivation, patient demand, mutual trust and evaluation system, high workload, understanding the role of quality management unit, unrealistic accreditation, nature of accreditation, empowerment of physicians in the field of quality, effective communication, resource constraint, ambiguity in the role of uncertainty about participation), And 57 items emerged from the analysis of the data.

Conclusion. The implementation of this program can be improved through Culture building, proper accreditation training and quality improvement activities in the medical community helped to implements.

Introduction

All the organizations to compete for their survival in the environment and are looking for quality services. Health organizations are also excluded from this provision. In the field of health services, the issue of quality has a special place, Because the serious duty and mission of maintaining health and caring for the life of society is the responsibility of this sector. The special nature of medical services and the lack of expertise of the client in evaluating these services, which causes even an error in the treatment of patients, imposes very serious consequences on them and costs a lot of money (1). Due to the increasing pressure in hospitals to improve the quality of patient care the need for physicians to participate in hospital quality improvement projects is very important. Physicians are a key element in key decisions regarding the care of hospitalized patients and seriously in quality improvement projects are hospitals, including improving hand washing hygiene to reduce ventilation-related pneumonia. Nevertheless, Hospitals' efforts to involve physicians in improving patient care are essential as physicians face increasing reimbursement costs and time constraints (2). Physicians play a key role in the clinical management of patients within the health care system. They also regularly cause many problems in the systems that work and affects their own work as well as that of other health care professionals. Therefore, they are an excellent resource for identifying solutions to these problems and leading the way in implementing them. However, physician training programs focus almost entirely on knowledge and skills for managing clinical problems. And there is almost no training in health service management skills

or effective quality improvement (3). Physician participation in clinical leadership and organizational strategies to improve quality, an essential prerequisite for providing safe and high-quality care. As a result, many hospitals have accepted physician interaction as a top strategic priority. It is obtained in order to better understand the key factors of engagement with the physician. Physicians should be involved in quality improvement activities to make systems work more securely and reliably. Previous evidence suggests that safety and quality improvement are higher when physicians are engaged and committed to the system (4).In Ferdowsi's study, it was stated that many problems of physicians' non-participation can be solved by properly training them, creating appropriate motivation and facilitating their future participation. Of course, each of these solutions requires taking into account the specific conditions of the region and the hospital (5). in the study by Baltang et al., The professional responsibility of physicians to perform both the direct role of clinical care and to help improve the quality of services is clearly described. There are several projects that have targeted young physicians in interaction and training to improve quality and have been successful(6). The article by Mainz et al. Describes the challenges, roles, and concerns of physicians about how to implement clinical governance. Physicians' resistance to quality assurance and quality improvement efforts is common in all countries and public health systems. It may seem that if managers ask physicians to provide the best possible care for their patients, they all say they do. Because, this is the apparent cognitive difference between the desire to provide high quality services and resistance to organized efforts to ensure quality and improvement (7). While many organizations believe that physician involvement is important in quality and safety, they have not properly defined, measured, and improved it. It is therefore not surprising that several health systems have developed a sustainable plan to attract physicians in quality and safety. This hurdle represents an important challenge for health care leaders seeking to achieve effective improvement in patient care. While physicians' interaction is not widespread across health care systems, there are well-functioning organizations that engage with physicians in quality and safety (8). Therefore, since it is very important to improve the quality of health care services and increase the participation of physicians in this matter, this study aimed to assess the challenges physicians' participation in quality improvement programs in hospitals in East Iran.

Method

In this qualitative study, semi-structured interviews were conducted with 11 managers, 9 physicians, 8 managers and experts in the field of quality management (Table 1) who were selected based on the inclusion criteria. The inclusion criteria included the following: Having effective experience in the field of accreditation (more than one year), which means work experience in a hospital. Having relevant scientific background and participating in accreditation committees (more than 6 months). We tried to encourage open reflection through a free approach to interviewing, and interviewed a wide range of people from every organization to gain a broad perspective. The first two interviews were in-depth and unstructured. Subsequent interviews tended toward semi-structured interviews. The interviews lasted 40–70 minutes and were conducted in people's offices to make respondents feel more comfortable. A total of 28 interviews were conducted prior to data saturation. The author began the data collection with a general

question (such as "What are the challenges of physicians' involvement in hospital accreditation activities?"), Incorporating the ideas and perspectives of all participants. He then shifted the discussion from broad concepts to more specific topics. The data obtained in ATLAS.ti version 5 were analyzed by the responsible author using the content analysis method. Interviews were orally transcribed and reviewed several times to give a general feel to their content. Identify meaningful units or primary codes, classify codes based on similarities and differences, and set themes as indicators of the organization's core content. The text identified a total of 57 items and 12 sub-concepts and was classified into 3 main topics. The codes were compared by two researchers and decisions on disputes were made by consensus. The present study has been considered to ensure the validity and accuracy of the data from four criteria (validity or acceptability, reliability or compatibility, transferability, verifiability) Proposed by GABA and Lincoln and the researcher has tried to make the findings reflect the real experiences of the participants. In-depth interviews, meetings with experts were held to ensure the correctness of the codes and the researcher's interpretations of them, and correction of codes that do not reflect the opinions of the respondents. The process of subject encryption, classification and extraction was reviewed by supervisors, consultants and experts to ensure that the classes were consistent with the participants' statements. In order to increase the transferability of the findings and help others in tracking the researchers' thoughts and examining the characteristics of the study population, the researcher used a clear, accurate and purposeful explanation of the study process. All interviewees verbally agreed to participate. This research has been approved by the Medical Ethics Committee of Mashhad University of Medical Sciences (No. IR.MUMS.REC.1398.263).

Results

Most of the participants in this study were men (78%), with a doctorate degree and higher (67%) with 11 to 20 years of work experience.

Generally, 57 challenges to physicians' participation in accreditation activities in hospitals in eastern Iran were identified in 12 sub-concepts. (Motivation, patient demand, mutual trust and evaluation system, high workload, understanding the role of quality management unit, unrealistic accreditation, nature of accreditation, empowerment of physicians in the field of quality, effective communication, resource constraint, ambiguity in the role of uncertainty about participation) And 3 main concepts (cultural, organizational, behavioral) are categorized. The categories and concepts obtained in this research are shown in Table 2.

1. Cultural challenges

1-1). Motivation

One of the challenges in this area is the lack of connection between accreditation and physician performance. In fact, between the fate and income of the physician should be connected to the type of his performance in accreditation and the legal aspects of accreditation should be seen for physicians and other medical staff.

"That we, on behalf of the governance and leadership of a medical center, have not been able to approve processes that involve physicians in accreditation. That is, the doctor knows that he is doing what he is doing, if it does not comply with the accreditation criteria the right thing will not work, or here is a headache for the doctor "And it does not achieve the desired result." (E13)

Another common obstacle is the lack of a financial incentive mechanism. Many participants cited non-use of work as an incentive and stated that this issue has greatly reduced the participation.

"If you see that the doctor is involved in the accreditation process, the percentage of his work goes up, the participation will definitely increase but when he sees it, he works so hard but gets nothing and it takes time, says why I should cooperate That's why we have to work on finances, for example, put a percentage in the work to cooperate in accreditation "To encourage more cooperation." (E22)

Differences in evaluation results with actual hospital performance are one of the barriers to physicians' cooperation in hospital accreditation.

"In the big hospitals that always and in any situation gave the first-class hospital This mentality may have arisen in physicians That is, doctors think that they can work with any condition Because there is a government hospital, with that level of income if first class "Come down, it will be very bad for both sides." (E28)

Another challenge in this area is the lack of distinction between positive practices in the field of accreditation; in fact, physicians cannot have the motivation to introduce continuous quality improvement initiatives or actively seek new opportunities in this field.

"Yeah, a lot of our staff say that we were first class now and we were fixed or we were second class and we became one, you did not give us any encouragement, what about money? We do not have financial resources, it is the same for the doctor, he says I am so "I got involved, it didn't affect me at all." (E24)

When hospitals do not reward and punish for taking the initiative in accreditation, the motivation of physicians to participate decreases.

"Another thing is that there is no feedback from this and no incentives for doctors. For example, I came to the hospital's deputy for treatment and helped in accreditation. What feedback does I get from it, financially or spiritually or in a position?" (E26)

1-2) Patient demand

One of the barriers to participating in accreditation is that unfortunately patients do not distinguish a good doctor from a bad doctor in terms of service quality.

"Sometimes you see because of the patient's company or, for example, the special circumstances that exist Sometimes some things may go away "Sometimes, due to external factors, such as the sex of the

patient or the typology that accompanies the patient, it may interfere with the performance of the activity ...". (E10)

Respondents believed that patients' lack of a sense of demand played a role in their participation in accreditation.

“Definitely effective If the patient demands a lot the doctor also has to participate more And so he has to strengthen his information ... ". (E16)

1-3) Mutual trust and evaluation system

Obstacles to the accreditation process include lack of leadership and proper management of physicians, lack of managerial support for them, and inability to work with other medical professionals Also, not requiring hospital physicians by the management team to perform quality and accreditation indicators can reduce the level of participation in quality and accreditation standards

"Distrust can also play a big role, when one set works together, when they know that it benefits everyone, everyone participates together, but if they know they are bothering and the management team does not give feedback on their activities or he spends their money somewhere else as a result, it does not matter to them." (E8)

Lack of an accepted evaluation and monitoring framework for physicians for quality and accreditation indicators can lead to a decrease in the level of interest in quality and accreditation standards

"When you do effective monitoring, Not monitoring that is wrist mode, Surveillance that is arresting and helpful and educational Well, if we make monitoring like this Naturally, people tend to participate." (E5)

2. Organizational challenges

2-1) High workload

One of the biggest challenges in accreditation and quality improvement processes in a public hospital is finding the balance between quantity and quality.

"I do not think hospitals care much about quality and more quantity matters to them and because their income increases "He likes the service he offers to be more and I don't think he pursues quality much" (E15)

Concerns about the lack of time and heavy workload for physicians to perform any quality improvement activities, often cited as a major obstacle in trying to introduce a systematic approach to quality improvement in primary health care Also, sometimes general hospitals, despite admitting many patients Cause doctors not to participate enough in accreditation

"On the other hand, the problem that doctors have is that they do not have time. Finally, in teaching hospitals, faculty members are so involved in treatment education and research issues that they no longer cooperate in these areas" (E12)

2-2) Understand the role of quality management unit

There is a high degree of indifference among physicians about the need for hospital accreditation. Also, the lack of knowledge about the implementation of quality improvement activities is a major obstacle for doctors to start new quality improvement initiatives in the hospital.

"The most important part is that the doctors did not understand the harm, they do not feel the need." (E28)

"Many doctors are not involved in this process and they do not know what to do many doctors are not aware of the accreditation process at all " (E9)

2-3) Unrealistic accreditation

It has sometimes been observed that physicians are discouraged and interrogated by the evaluator in performing the accreditation work, which reduces their participation. Also, sometimes the lack of transparency about the collection of accreditation data and the requirements for the use of clinical data, and especially the dissemination of its findings, can discourage physicians from accreditation projects.

"One of the problems with accreditation may be that sometimes those standards or criteria or steps of accreditation are not very clear to the owners of the process and those who work in the hospital" (E1)

Increased interventions by the Ministry of Health in relation to quality improvement initiatives are often seen as a direct obstacle by physicians.

"The government hospital also tells the Ministry of Health that the flower is on its own If you give us a bad grade, "You are hurting yourself." (E23)

2-4) The nature of accreditation

Sometimes the multiplicity of methods, tools and approaches related to accreditation processes and quality improvement in practice in general leads to different types of obstacles to the active participation of physicians. Young physicians feel that these accreditation projects are more paperwork and less involved.

In some cases, the periodic and seasonal or discontinuous process of accreditation leads to the fatigue of physicians and their less participation in accreditation projects.

"It means that, unfortunately, the staff understood that quality work means making a document That is, only we are documenting " (E5)

"The accreditation itself, when it came and went, was done for two or three days and stopped, until a year later, two years later, when the accreditation was done again." (E1)

2-5) Empowering physicians in the field of quality

Many young doctors do not feel ready to take quality improvement programs, and this affects the level of participation of young physicians in quality improvement activities, On-the-job training (provided there) by physicians is considered inadequate in terms of quality improvement, which in turn reduces their participation in activities. In some cases, a gap in knowledge during study about what clinical activities related to accreditation require of physicians may cause physicians to perform less than their academic competence and potential for accreditation.

"During school You are told that your job is just to cure Well, when they tell me that I have no motivation to do quality work "And then there is no clear job description for the doctors." (E 28)

2-6) Effective communication

One of the obstacles perceived by physicians at the level of the accreditation system is the lack of a reliable information system and some complex databases that allow the comparison of criteria.

"Now we do not have a single information system, we now have about twenty models of hospital software, each with its own set of problems." (E2)

2-7) Limitation of resources

At the institutional and organizational level, lack of financial and technical resources, limited staff, lack of necessary physical infrastructure of the hospital prevents the active participation of physicians in the quality improvement initiative.

"Nurses, medical equipment and facilities, the hospital environment, the ratio of patients to doctors, all of these are effective." (E16)

3. Behavioral challenges

3-1) Ambiguity in the role

Despite efforts to improve quality in health care and in general, some GPs still have a vague view of the concept of quality improvement.

"Many doctors do not know what their role is in accreditation at all and which ones are related to them." (E12)

3-2) Uncertainty about how to participate

Physicians resist change and lack the skills to contribute to quality and accreditation activities. Many doctors also say that these quality improvement programs are new to us and very difficult to do, because we only see patients, we do it even if we are not satisfied with it.

"This is the view. We know that this accreditation that has been done this year will not change anything here in the future, so there may be an apparent effort, but there is no hope of change." (E8)

Physicians' involvement in quality improvement activities can be challenging. In fact, this culture of accreditation is less common among physicians.

"It is cultured in the nursing system, but not in the medical system, and groups should be involved, for example, it may be necessary to involve group managers and department heads in accreditation work, "When they get involved, they know more about the challenges, and they feel they need to cooperate more." (E12)

Discussion

The purpose of this study was to identify the challenges of physicians' participation in accreditation programs in hospitals in eastern Iran. Implementing accreditation requires many changes in the behavior, culture and organizational structure of the hospital to improve the performance of physicians in performing hospital accreditation activities (9). One of these models, which expresses the challenges of physicians in accreditation activities in the form of three domains of individual GP level, performance and system level at the individual GP level - his or her attitudes, beliefs, values, knowledge and skills determine the processes of implementing quality programs. Obstacles at the performance level include organizational culture and available resources (human, financial, infrastructure). Obstacles to quality improvement in public actions at the system level are related to inadequacy and support from the government or health authorities (9). This research has divided the challenges in the form of 3 main cultural, organizational and behavioral domains.

Participants in the present study emphasized that the lack of distinction between positive practices in the field of accreditation may be due to lack of planning and provision for proper implementation of accreditation for physicians, which leads to many other challenges and overshadows the strengths of the plan. This point was also emphasized in Wolfson's study (10).

As in our study by Coyley et al. (11) physicians feel that accreditation is a formality and that they are reluctant to implement the accreditation program. It is suggested that by appropriate modeling of successful countries in the field of hospital accreditation around the world that have outsourced accreditation to the private sector, this is possible to minimize some kind of conflict of interest.

Existence of the challenge of not ranking hospitals based on the accreditation score in Hudelson's studies (12) It was also emphasized that, it has led to a decrease in motivation and indifference among physicians and treatment staff so that no difference is seen between higher and lower grade hospitals

and even the same grade in private and public hospitals.. It seems that it is possible to help by linking the licenses of the doctors working in the hospital to the rank of that hospital and to involve the interests of the doctors in the rank of the hospital or to create more coordination between the evaluations by the ministry. Another challenge in this area is the lack of a link between accreditation and physician performance, which was also emphasized in Becker and Richard's study (9). This study states that even in countries with a long tradition and countless successes in quality improvement (eg the United Kingdom) General practitioners may not have an incentive to introduce ongoing quality improvement initiatives, such as accreditation or actively seeking new opportunities in this field. In fact, the fate and income of the physician should be linked to the type of performance in accreditation, and the legal aspects of accreditation should be seen for physicians and other medical staff. In fact, accreditation should be given a more legal and mandatory aspect in areas related to physicians.

In the study by Gosfield et al. (13), one of the most compelling findings is the extent to which physicians make the difference between their brilliant performance in accreditation and the gains and losses. In the continuation of this study, they have shown a relationship between physicians' dissatisfaction and loss of independence, increased responsibility, changed reimbursement conditions and increased expectations of patients, payers, insurers and regulators with quality improvement activities. It is suggested to give a special point to it by linking the performance of hospital wards with quality improvement and accreditation activities, in fact, if the department works within the framework of accreditation rules and regulations, and physicians also work well to improve quality, to score higher points than their homogeneous parts for example, in all rows of surgery, the part of the surgery that works best should be given a higher score. Marshall also confirms the patient's perception in his study that doctors sometimes have a negative complaint that unfortunately patients do not know a good doctor from a bad doctor and are not able to diagnose it. Or the criteria and mental format of patients about the quality of the physician's work are different (14). It seems that by properly educating patients and their companions through a series of communication channels can help solve this issue.

One of the challenges is the low focus of the management team on physicians, which was also emphasized in Baker's study (9) .The results of this study showed that some of the barriers that may hinder quality improvement and accreditation processes are: Lack of leadership of general practitioners, lack of managerial support and ability to work with other specialists. Given that the role of physicians in accreditation is very important, there is a need for the management team to activate more serious levers to involve physicians in accreditation. Another important challenge in this area is management distrust, which was also emphasized in the Calderon study (15). As expressed in this study, physicians' suspicions and suspicions about their managerial motivations and hidden plans have prevented him from making the necessary efforts in quality improvement processes., It is suggested that action be taken in the hospital to resolve the conflict of interest regarding accreditation and try to get closer the relationship between the hospital accreditation management team and doctors. The inefficiency of the Quality Improvement Office in attracting the participation of physicians was also expressed by the interviewees, Dixon et al. In their study showed that young physicians may not be able to access technical advice and support for clinical audits or quality improvement projects if they need help(16) Given the importance of

physicians' involvement and involvement in accreditation, it is recommended that staff be added to the hospital's quality improvement unit to focus more on physicians to improve activities. Lack of knowledge about the nature of accreditation was also expressed by the participants, Zarkali and Donaghi stated in their study that some of the respondents (physicians) were completely unaware of the available resources (accreditation and quality improvement activities) and one of the respondents stated that “I perform my clinical activities as "I was informed later that our hospital had been evaluated and I was unaware"(17). In our study, a number of doctors said that if you know the description of his duties, most are not familiar, because they do not inform in fact, participation can be increased by informing the lesson and engaging with the interests and needs of physicians. Lack of transparency and tangibility of the measures are among the challenges mentioned. In the Pato and Kapovich study, it was stated that there was a lack of transparency in the collection of confidential patient data and the requirements for the use of clinical data in research, in particular the dissemination of findings from accreditation. It can deter physicians from pursuing quality improvement and accreditation projects (18) Sometimes physicians are not informed of accreditation information and other quality improvement activities and are not given the necessary feedback. Another challenge in this area is the recognition of accreditation by physicians. In their study, Boyle et al. Showed that some physicians believe that accreditation creates extra paper, in other words, many physicians say that they make extra paper for us, they take our time, they take our time., That we sit and write (19). One of the serious challenges in this area is the compulsory, mandatory and stressful challenge of the accreditation process, which was long between accreditations at that time. Studies by Ledima, Kitty, and Nabir suggest(20–22) that fear of bullying and coercion by evaluators and management teams in accreditation, anxiety, and stress lead to withdrawal from engagement or lack of reflection on quality improvement activities by physicians. Sometimes, GPs' negative attitudes toward accreditation can lead to the belief that they see accreditation as a test of their clinical competence and poor performance.

Lack of training in the process of quality improvement and accreditation during the education of physicians is another challenge. Hooper and Beton and Bagnal showed in their studies (23–25) In some cases, a gap in knowledge during study about what clinical activities related to accreditation require of physicians may cause physicians to perform less than their academic competence and potential for accreditation. Another important challenge is the lack of training in the process of quality improvement and accreditation in retraining courses, which was also emphasized in the Salberg study (26). In this study, it was stated that on-the-job training in relation to quality improvement was considered insufficient by physicians in fact, training physicians specializing in new skills, including accreditation for measurement, planning, and quality improvement, requires significant investment, which most physicians have little capacity for. In this regard, it is better to entrust the trainings to a series of non-governmental companies and the Vice Chancellor of the University should supervise them and evaluate the effectiveness of the courses periodically.

Another challenge in this area is the lack of institutionalization of accreditation in culture. In their study, Hoffman et al. Showed cultural issues (e.g., a "culture of blame" that hinders learning and irresponsible physicians., In fact, at a time when cultures are refraining from reporting concerns about patient

accreditation and quality improvement, Physicians' participation in quality improvement activities can be challenging (27) To increase the culture of participation among physicians, it is recommended that the necessary training be reported from the medical student period on the importance of quality improvement for the patient and the physician himself, and that the hospital's medical elders try to use culture and role modeling.

Limitations

Our study has some limitations. Inclusion criteria for interviewees were used, and a snowball system was employed to find interviewees so some experts may have been missed. Our findings may have been different if the participants or researchers were changed. Furthermore, this study addressed only the challenges of physicians' participation in accreditation programs and future studies are recommended to focus on the strengths of the program, as well.

Conclusion

It should be noted that accreditation and quality improvement activities, even in developed countries, have problems and challenges relatively similar to the identified challenges. In this study, this indicates the relative generality of some challenges among different countries. Given that all the challenges identified in this study are large and significant, people, physicians and managers are dissatisfied with the plan and the type of participation.

It is suggested that policymakers be determined to address the challenges in order to properly implement national accreditation activities that are consistent with the goals of the plan and its internationally recognized definition and the countries that have implemented the plan.

The results of this research can be used by policy makers and managers in the field of health and quality promotion in the province and the country and while eliminating possible shortcomings and increasing the level of physicians' participation in accreditation activities, improve the quality and quantity of accreditation provided. As a result, it will lead to greater satisfaction of service recipients and hospital service providers.

Declarations

Ethics approval and consent to participate:

This research has been approved by the Medical Ethics Committee of Mashhad University of Medical Sciences (No. IR.MUMS.REC.1398.263). All participants provided written informed consent form for the various aspects of data collection. It was also implemented in accordance with the principles and regulations of confidentiality and privacy. All research methods were carried out in accordance with relevant guidelines and regulations.

Consent for publication:

Not applicable.

Availability of data and materials:

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Competing interests:

The authors declare that they have no competing interests.

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Authors' contributions:

All authors contributed to the design the study, data collection and data analysis, wrote the main manuscript and approved the final version for publication.

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Tables

Table 1. Demographic characteristics of participants

Demographic characteristics		Health managers (%)	physicians (%)	Quality management experts (%)	Total (%)
Gender	Female	1 (9)	2 (22.3)	3 (37.5)	6 (21.4)
	Male	10 (91)	7 (77.7)	5 (62.5)	22 (78.6)
education	MSc	3 (27.2)	0 (0)	6 (75)	9 (32.1)
	PhD and above	8 (72.7)	9 (100)	2 (25)	19 (67.9)
work experience	1-10 years	1 (9)	4 (44.4)	3 (37.5)	8 (28.6)
	11-20 years	4 (36.3)	4 (44.4)	4 (50)	12 (42.8)
	21-30 years	6 (54.5)	1 (11.2)	1 (12.5)	8 (28.6)

Due to technical limitations, table 2 is only available as a download in the Supplemental Files section.

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- Table2.docx