INSTITUTIONAL AND PROFESSIONAL RESPONSIBILITIES IN QUALITY ASSURANCE

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The quality of care has three components: the goodness of technical care, judged by its effectiveness, the goodness of the interpersonal relationship, judged partly by its contribution to technical care, and the goodness of the amenities. Quality assurance protects and enhances quality through system design and performance monitoring. Monitoring may occur informally in the course of collaborative practice. Formal monitoring is conducted by: (1) systematically collecting information about the process and outcome of care, (2) identifying patterns of practice, (3) explaining these patterns, (4) acting to correct deficiencies, and (5) verifying the effects of remedial actions. Rather than being a policing activity, monitoring implements professional accountability and contributes to rational management by documenting the quality of the product. Its effectiveness depends in specified ways on (1) leadership, (2) organizational characteristics, (3) characteristics of health care professionals, (4) features of the method of monitoring, and (5) methods used to influence practitioner behavior.

INTRODUCTION

Every health care practitioner and every health care institution has two major objectives: (1) to provide care of the highest possible quality, and (2) to provide that care at the lowest possible cost. In theory these two objectives are separable, but in practice they are closely interrelated. This is because: (1) bad care that can harm patients is also wasteful, (2) wasteful care often has potential to harm patients, and (3) waste in any form depletes resources that could be used to treat more patients better. These three linkages do not describe all the interrelationships between cost

and quality [1]. But they suffice to show us that our two objectives have to be pursued with an appreciation of the relationship between them. Having said that, I want to focus on the pursuit of quality.

WHAT IS QUALITY?

Before we can do anything about quality, we need to clarify for ourselves and for the institutions we represent what quality means. We should do this, first, in general terms, and then in terms that are sufficiently concrete and specific to permit us to say to what extent we have attained our objectives. Unless this is done, and done well, we will continue to mouth meaningless platitudes. It is destructive to quality to take the name of quality in vain.

It is useful to think of quality as having three components, which are, however, closely interrelated [2].

The first component is the quality of technical care. In essence, the quality of technical care is proportionate to its effectiveness, which means its expected ability to achieve the greatest improvement in health that science, technology, and skill can now offer.

Some have said that greatest effectiveness should not be equated with greatest quality because some small improvements in health may not be worth the added cost of obtaining them. This reformulation of the meaning of technical quality is of fundamental importance to social policy, but I will arbitrarily rule that it is not relevant to our considerations here [3]. I shall assume that we are obligated to do the best we can for each patient.

The more relevant issue is who judges what is the best for each patient. I am going to take the position that what is best for the patient can only be judged by full and frank discussion with the patient or responsible family members. This is necessary for our own protection, but it is even more fundamental to achieving our primary objective, which is service to our patients.

The second component of quality is the goodness of the interpersonal relationship among all concerned with care, with special attention to the relationship between the patient and the health care practitioner. We all agree that we must treat patients with sensitivity and tact, that the patients' autonomy, privacy, and other interests should be protected, that the patients' trust should not be betrayed.

The third component of quality is the goodness of the amenities of care, by which I mean convenience, creature comforts, and even the esthetic attributes of the setting in which care is provided.

To recapitulate, the quality of care has three components: the goodness of technical care, the goodness of the interpersonal relationship, and the goodness of the amenities. But these three components are interrelated. In particular, if the interpersonal relationship is faulty, the patient may not be able to tell us what his problems are, or what he wants us to do for him. Similarly, we may be unable to make the patient understand what he needs to do to get better, or to motivate him to do it well. Success in the interpersonal relationship contributes to success in technical care, and the reverse is also true.

PRECONDITIONS TO QUALITY ASSURANCE

Assuming that we have agreed on what quality means, at least in general terms, I can now move on to discussing how we can protect and enhance it, an activity that we call "quality assurance". But, before this, there are two important preconditions to quality assurance that must be mentioned.

The first precondition is accessibility. It is obvious that health care institutions and practitioners cannot do their work, whether good or bad, unless there is, to begin with, access to care. Therefore, access to care at the community level is a necessary first step in assuring quality. Moreover, each institution and each practitioner can, through their own policies, requirements, attitudes and behaviors, facilitate or impede access, and in that way either to serve quality or do a disservice to it.

Some people believe that accessibility can be too great as well as too little, too much accessibility leading to unnecessary interventions that can be both wasteful and harmful. I am going to take the position that these abuses result not from too great accessibility but from the ignorance, injudiciousness, or the venality of the providers. It is true, however, that easier access to care offers greater opportunity to provide bad care as well as good care. Therefore, as access improves, the task of quality assurance becomes even more critical.

The second precondition necessary to quality assurance is money. It is true that we can maintain the level of quality we now have, or even improve it, by providing care more efficiently, and it is absolutely necessary that we do everything we can to accomplish this. Yet, no matter how efficient we become, quality will still require money. We must rid ourselves of the notion that, by some magic, we can obtain quality on the cheap. We must be careful, in particular, not to call "efficiency" cost reductions that have been obtained at the expense of quality.

If we, as a society, wish to settle for a lower level of quality in order to save money, we ought openly and honestly to say so. We owe at least that to the people who look to us for help and guidance.

QUALITY ASSURANCE

It is useful to think of quality assurance itself as having two components: system design and performance monitoring. Both are necessary. Neither can succeed without the other [4].

System Design

By system design I mean the way in which the system of health care, in general, and any health care institution, in particular, are set up. System design includes material elements, human elements, and organizational characteristics. Physical facilities, equipment, staffing, policies and procedures are all aspects of system design. So are the allocations of authority and responsibility and the mechanisms by which they are exercised. In particular, system design includes the policies and procedures that govern recruitment, credentialing, promotion, remuneration, continued education, retention, and discharge of health care personnel.

Do I mean by all this that quality can exist only in large, lavishly staffed institutions? The answer is, "No". The secret of quality is in a careful matching of the care required by patients with the capacities of its providers. If each institution and its staff limit their care to what they can best provide, referring all other patients to the most appropriate available provider, quality can be high everywhere. Under these circumstances, the smaller, local institutions would even have an advantage in convenience, intimacy, and friendliness. The presence of functional differentiation and referral such as I have described is, itself, a feature of system design.

Clearly, this and all other aspects of system design are matters that require collaborative decisions by holders of leadership positions, irrespective of whether these are on the board of trustees, in the administration, or on the clinical staff. It is also necessary and wise to include representatives of professional and community interests more broadly defined.

From the spirit of this collaboration, the values that guide it, and the expertise available to it will emerge those characteristics of a system or of an institution that make it more or less friendly to quality. In a sense, these characteristics will define the boundaries of the range within which quality is likely to vary. Beyond that, the fine tuning of quality so it is targeted to a particular desired level, is a goal to be achieved by yet another component of system design: namely the apparatus formally charged with performance monitoring.

Performance Monitoring

Before I go on to describe formal performance monitoring, I need to remind you that in a well-designed system or institution, much information about performance is obtained informally or incidentally by collaborative work, discussion, consultation, conferences, and the like. Whatever can be done to break down the compartmental-ization of care, so the work of colleagues can be made visible to each other, creates an incentive for each one to perform at a level that at least avoids embarrassment, and certainly censure. But there is also a need for a specific organizational unit whose primary function is to monitor clinical performance continuously, impartially, and consistently.

I would like to say something about the components of such a unit or activity, about its functions, and about its effectiveness.

Components or Steps in Performance Monitoring

The first component in a system of clinical performance monitoring is information about the process of care as implemented by health care practitioners and by patients, and about the outcomes of care, both immediate and delayed. We hear a lot of discussion about the relative merits of process and outcome measures in this context. Most of this is often misguided and almost always unnecessary. The choice of information depends on what questions we want answered, and on what infor-mation can give us the answers most precisely, at lowest cost. Rather than having to choose between process and outcome, we will find that almost always we will need information about both outcome and process, and that we will have to compare the two [5].

The second step in performance monitoring is analysis of the information so as to
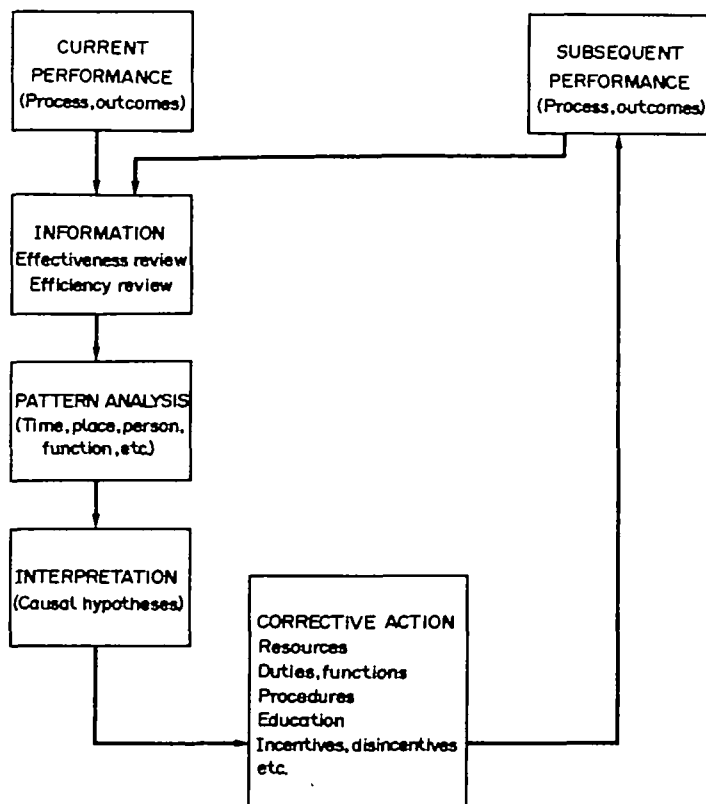
FIGURE 1.

discern patterns of performance that characterize and localize both good practice and questionable practice.

The third step is to arrive at an explanation for the patterns of practice observed. In particular, it is necessary to find out why substandard practice has occurred.

The fourth step is to take action to correct the deficiencies observed. The actions taken can vary considerably, depending on what the nature of the underlying problem is. Sometimes there is a failure in individuals who need to be educated and remotivated. Often there is failure in the system, so the system needs to be redesigned, re-equipped, or redirected.

The fifth step is to continue performance monitoring, with particular attention to problems identified and addressed, to make sure that these problems have been corrected, and that other problems do not go undetected.

Any serious imperfection or interruption in this succession of steps (Fig. 1) can cause the entire system to collapse. Even worse, it can go off course, causing considerable damage.

Not infrequently, the information obtained is faulty or incomplete. The information that is more easily available pertains mainly to technical care. Information about aspects of the interpersonal process that contribute to patient satisfaction is not sought. Even with regard to technical care, the information obtained can be

inaccurate or incomplete. Even when the information describes accurately and fully what happened during one episode of care in a given institution, there is no information about what happens after the patient is discharged. We often do not know how well the patient carried out the care prescribed or, if care is received at other sites, what took place there.

Even if all the information we wanted were available, we would still face successive pitfalls along the way to effective monitoring and modification of clinical performance. All too often, information painstakingly gathered at considerable cost is simply unused, or if used it is not interpreted properly, or if interpreted properly it is not acted upon, or is acted upon in ways that are either ineffective or disruptive rather than constructive.

Clearly, the design, operation, and effective use of a clinical performance monitoring system requires considerable resources and expertise, as well as committed collaboration among all levels of an organization. The larger institutions may have material and human resources equal to the task. Smaller institutions, if they have the will, can enter into collaborative arrangements to make the task possible.

Why We Need Performance Monitoring

Seeing how complex and costly a system of clinical performance monitoring is, "Why," we must ask, "do we need it?"

A rather superficial answer could be that, in one form or another, it is being imposed on us by external agencies, either voluntary or governmental. If that is the only reason, or the main reason, we are likely to implement it reluctantly or half-heartedly, failing to use it to best effect. Often we incur most of the costs of such a system but reap less than the full benefit. Rather than instituting clinical performance monitoring in the spirit of reluctant accommodation or fearful self-defense, the commitment to having it must emerge spontaneously, from within, out of a realization of how deficient we are without it. We need it if we take seriously our accountability to our communities. We also need it because it is an indispensable requirement for good management and good clinical practice.

Every organization recognizes the necessity of sound financial accounting and management to its solvency, survival, and growth. But how can an administrator and the trustees to whom the administrator is responsible, manage an institution rationally if they have no information about the quality of their product, which is health care? A clinical performance system, by providing that vital information, becomes a tool for rational management.

The clinical performance information system should also be recognized as a necessity by health care practitioners in the assessment of their own work. It is customary for each practitioner to keep track of his or her own activities and accomplishments in the treatment of each patient. Practitioners should learn to add to this case-by-case approach an epidemiological perspective which requires a view of how groups of patients are managed by each practitioner and by practitioners collectively. Without adopting this epidemiological perspective and the methods pertinent to it, practitioners are unable to get the kind of information about their performance that reveals overall patterns signifying failure or success in their mission.

It is essential not to regard clinical performance monitoring as primarily a policing

activity imposed by external agencies for their own purposes. It should be regarded, rather, as a requirement for the conduct and management of practice, so that trustees, administrators and clinicians can achieve their own legitimate, compelling objectives. If this total change in orientation does not take place, performance monitoring is in danger of becoming a repressive form of policing, something of a club to be used to beat health care providers and practitioners into submission.

Effectiveness of Performance Monitoring

Primarily to achieve our own objectives, and secondarily to defend ourselves against external impositions, we need to have our own systems of clinical performance monitoring and to make them function effectively. Consequently, I end with some thoughts on the attributes that may influence effectiveness. I shall draw for this on an excellent review by John Eisenberg, supplementing it with my own interpretations and speculations [6,7].

As you would expect, there is no one attribute that distinguishes effective from ineffective methods of monitoring. Rather, the secret lies in a careful balancing of several features, and in adapting the whole to the characteristics of each setting. I shall deal with the important features of an effective system in the following order: (1) leadership, (2) organizational characteristics, (3) characteristics of health care professionals, (4) features of the method of monitoring and review, and (5) nature of the interventions used to influence practitioner behavior.

Leadership is perhaps the single most important determinant of success. Practitioners with the highest professional standing and prestige, as well as administrators in the highest positions of authority, should be genuinely committed to the performance monitoring enterprise. The commitment should be expressed not merely in words but also in deeds, including actual participation in the activities of performance monitoring when possible and appropriate. The person in direct charge of the performance information system itself should be highly qualified, be of unquestioned integrity, occupy a high position in the organization, and move easily in the highest reaches of the administrative and clinical hierarchy.

As a second condition for success, the organization as a whole should provide moral and material support. In general, the organization should be oriented to recognizing and rewarding good performance, while it also identifies and discourages performance that is less than fully acceptable. In particular, there should be a clear link, known and understood by everyone, between the rewards that practitioners can expect, and the findings of the clinical monitoring system. These rewards could be privileges to practice, promotions, income, or other forms of recognition valued by health care professionals.

Certain characteristics of the health care professionals themselves are, most probably, a third ingredient in success. It is likely that personality as well as prior socialization will influence willingness to participate in performance monitoring and responsiveness to its findings. Therefore, careful recruitment and early review of subsequent conduct, are important safeguards. It is also possible that practitioners who are more closely linked to the organization, or more dependent on it, may be more amenable to performance review. Therefore, salaried staff, at least in key positions, could contribute to success.

A fourth condition for success is proper design of the clinical information and

review system itself. The system should, of course, meet basic technical requirements that I shall not discuss. Rather, I would like to emphasize that the methods of performance review should be seen, by the health care practitioners to whom they are to apply, as legitimate, reasonable, and fair. The methods should derive from, and clearly reflect, concepts of quality practitioners recognized as central and legitimate rather than peripheral or even foreign to quality. Consequently, it contributes to the success of the enterprise to have the practitioners whose performance is to be evaluated, participate in developing the methods to be used in the evaluation and continue to participate in their implementation. By this, and by any other means, one should make it impossible for anyone to claim that the bases for evaluating performance are obscure or unacceptable. Finally, the methods adopted should be applied consistently and persistently, without idiosyncratic variations and without favoritism.

The fifth condition for success is to adopt methods for influencing behavior predicated on the assumption that practitioners, though subject to all the frailties of humankind, are, as a whole, honorable persons who wish to do well, need the respect of their patients and colleagues, and are willing to learn. Accordingly, we can begin the list of our interventions with "feedback", which means simply reporting to practitioners, singly or in groups, information about their performance. According to Eisenberg, feedback is more effective if it is conveyed by a professionally respected person; if it is individualized; if it is face-to-face; and if the individual is compared to colleagues. Comparisons to abstract standards and use of less personal methods of communication, such as letters or computer printouts, are less effective.

If failures in practice have occurred only out of carelessness or inattention, feedback may be sufficient to bring about the desired effects. Otherwise, it will have to be coupled with education. Eisenberg contends that certain conditions should obtain if education is to be effective. The practitioners should be convinced, usually as a result of prior feedback, that there is, in fact, a problem that requires correction; education should be conducted by influentials whom the practitioners respect and trust; it should be directly pertinent to the behaviors that need to be modified; and it should occur in person-to-person discussions in preference to lectures or course work.

The option to impose penalties or sanctions is a necessary part of a clinical performance monitoring system, but punishment should be the last resort, to be used when other methods have failed. To make it the initial step, or the most prominent feature in a system of behavior modification is certain to produce resentment and antagonism. It is also important to have available a set of progressively harsher sanctions, so that the punitive response can be modulated to the seriousness of the misbehavior, and to the apparent recalcitrance of the offending practitioner [8]. It should be apparent to everyone that sanctions are used, that they are used fairly, and that whenever the situation calls for it they can be of the utmost severity.

All of these interventions, quite appropriately, are directed at the practitioners who hold the key to quality in health care. At the same time, we should be keenly aware of the fact that organizations can profoundly influence the conditions under which care is given, making the provision of good care more difficult or less so. Very often, the trail of investigation initiated at the discovery of failures in performance leads to the conclusion that the organization itself, or the larger system within which we all must function, have perhaps unknowingly set up obstacles to good perform-

ance that need to be removed. While the primary reliance in our quest for quality is on the knowledge, skill, motivation, integrity, and dedication of health care practitioners, we cannot expect them to be unflaggingly heroic or self-sacrificing in the service of quality. It is the responsibility of the organization, rather, to create the conditions under which good practice is as effortless and rewarding as it can possibly be.

CONCLUDING REMARKS

And now, let me conclude by recapitulating my major themes.

I have tried to show that the pursuit of quality must begin with a clarification of our own objectives and a rededication to their attainment.

I have argued that in order for us to succeed, system design and performance monitoring must go hand in hand.

I have hoped to persuade you that the impetus for performance monitoring must come, not from the outside, but from within, arising out of a deep conviction that without it we cannot tell what we do.or what we accomplish.

Finally, I have argued that performance monitoring, in order to succeed, must be animated by the desire to learn and to improve, rather than by the urge to restrain and punish.

If we are persuaded by the logic of these arguments, it becomes necessary for us to take the initiative to develop methods of performance monitoring more congenial and more effective than those being imposed upon us.

Then, rather than merely responding, often resentfully and reluctantly, we can, instead, joyously lead.

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