Editorial

From Chicago to Budapest, a tale of two cities

It is the best of times, it is the worst of times, it is the age of reason, it is the age of arbitrariness, it is the epoch of science, it is the epoch of intuition, it is the season of CQI, it is the season of QA, it is the spring of personal improvement, it is the winter of performance indicators. In short, our times are so complex that most of its noisiest experts insist on its being described, for good or for evil, in the superlative degree of comparison only [1].

In 1997 the annual ISQua conference was held in Chicago, stressing performance measurement and improvement. In 1998 the annual ISQua conference will be held in Budapest under the slogan ‘Motivated for improvement’. The shift in emphasis from measurement to motivation illustrates the existence of different but complementary ways of thinking in today's world of quality in health care. A quick look at the map of Chicago reveals the American passion for straight lines, an impression that is only strengthened in the vertical sense when looking at the downtown skyline from Lake Michigan. A 1-hour stroll through Budapest in 1988 and 1998 respectively, reveals why this is a city of change. The banks of the Danube and the castles and churches of Buda and Pest are symbols of continuity, but the change from communism towards a market economy has resulted in a face-lift of the city. Both the charms and negative side-effects of capitalism can be noticed; however, the existence of a strong motivation to improve cannot be denied.

Measurement and motivation are both necessary ingredients for quality in health care. Although very few people will disagree with this statement, it is surprising how many quality initiatives fail, because this simple truth is not taken into account. The bandwagon with indicator developers, database handlers, quality system designers, and business process re-engineers seems to be moving in a direction independent from that of the cruise ship with its management gurus speaking about leadership style, personal development, corporate image and cultural change. This is creating confusion among health care professionals and patients. Physicians have to find a balance between evidence-based practice and empathic behaviour and are entrusted with clinical leadership on the one hand while being forced to function within a framework of performance indicators on the other. Patients are supposed to act as rational well-informed consumers and have to balance this behaviour with their often less rational need for attention and comfort. Let's have a closer look at the two cities.

The city of measurement

In the city of measurement, medicine is characterized by two mutually enforcing trends of rationalization: the 'scientization' of medical decision making (evidence-based medicine) and the 'engineering' of care delivery. The scientization trend finds its origins in the scientific foundation of medical practice but has, over the past 25 years, expanded towards the scientization of medical thinking (medical decision-making in the 1980s) and the scientization of medical actions (expert systems, practice guidelines, monitoring systems in the 1990s) [2]. The engineering trend finds its biggest proponents among managers but is considered also by health professionals as a helpful way to re-design the working processes in hospitals and other health care organizations [3]. Although the two trends seem complementary and its propagandists find each other in their common belief in an outcome and a data-driven world, there are very few industry-based quality models and systems that really incorporate the evidence-based medical decision-making models. Generic industrial models such as ISO (focusing on process control) and the Baldrige or EFQM model (focusing on management development) hardly reach the level of quality of the medical decision-making processes, although they can be a tremendous help in improving the organization and performance of medical work processes. On the other hand, practice guidelines and clinical indicators are often weak in prescribing and monitoring organizational issues. Even local algorithms and audit studies are weak in linking the problems related to the clinical content of work with organizational issues such as assignment of responsibilities, systematic record-keeping, monitoring of care processes, and communication between care providers [4].

The art of quality management of medical care, executed by health professionals, based on evidence-based medicine, and combined with process engineering, is still in its infancy. The challenge will be to initiate projects and programmes that combine the two approaches and in which the health care professionals are the real project owners. Measurement systems designed and operated by health care managers, financiers and policy makers are bound to fail when they are not consistent with the quality systems health care workers themselves use to continuously evaluate and improve the patient care they deliver. The measurement technology should not be isolated from the knowledge owners. Measurement instruments that become merely part of the power play between managers and doctors will cost a lot of money, will
produce questionable data and, more importantly, will not succeed in nurturing motivation and learning. At their best they will be an instrument for quality control in an era that asks for quality improvement.

**Dead-end streets**

The city of measurement is also faced with several methodological hurdles. Measurement always implies a limitation to things that can be measured and thus reduces the complexity of reality. Measurement becomes less valuable as a quality improvement tool when the distance in time and place towards the subject of measurement becomes larger. For feedback to be effective as an incentive for learning, it must come at a moment when the experience is still fresh in the mind of the physician, and it must reflect data that are as close as possible to the individual's own activities. Performance indicators, providing feedback based on aggregated data over a long period of time, may be scientifically valid, but they are often less effective in terms of achieving behavioural change. They can even be dangerous, because the collection of data for all types of monitoring devices may result in a shift from involvement and commitment of individual doctors towards 'the system'. The fact that data are collected and indicators are produced may lead to the perception that care processes are under control and that physicians and nurses can afford to pay less attention. For the time being this is an erroneous perception and a potential threat to quality.

What is needed are quality systems, owned and used by the professionals and constructed on the basis of both evidence-based medicine and industrial engineering in a context where the goals of health care are clear and the mutual roles and responsibilities are assigned. Ideally, local quality systems are attuned to the local situation and focus on local health needs, but contain clinical indicators that are also based on national practice guidelines. These quality systems are a support tool for health care professionals on the one hand and an instrument for accountability on the other. But again, this asks for mutual trust and the respect of professionals, patients, managers and policy makers. It takes real leaders in health care to use the measurement mandate wisely.

**The city of motivation**

In the city of motivation psychology and sociology play a dominant role. Theories on organizational sciences, professionalization and management of professionals [5—11], stress the role of health professionals as knowledge workers who ask for a realm of professional autonomy and the specific leadership styles of health care managers. Motivation of health care professionals is linked to status, self-fulfilment, and emotional as well as financial reward. We need to acknowledge that the processes of motivation and change are not only regulated through the rational thoughts of the neo-cortex but also through emotions induced by the limbic system and the deeper motives released by the paleo-cortex. To understand why and how quality management of physicians is shaped in a given context, a look from the perspective of professionalization theories can be enlightening [4]. When developing a hospital into a learning organization, it is essential to recognize how the scientific method itself may inhibit the finding of daily truth and actionable knowledge [7].

Quality systems and performance indicators only result in quality improvement when they facilitate learning. For doing this they need a soul, consisting of the motivation of the subjects of change and improvement. In this respect many industry-based texts on Total Quality Management and Continuous Quality Improvement seem of limited use, as they deal only with the engineering aspects of quality improvement. Some of these texts have more in common with the Scientific Management School of Taylor of the beginning of the century than with recent management theories on change in professional practices. Also, many managers and policy-makers in the health care field still feel more comfortable with traditional control-based management styles. The growing interest all over the world in indicators, accreditation and certification has little to do with enlightened policy-makers but everything to do with a search for new control mechanisms to contain the cost and quality of health care. This may, in the long run, discredit many of the good things in CQI theory. Notions of responsive regulation [12] are still rare amongst governments, and although quality systems are becoming more common in health care institutions, the health care system itself is often far from being a quality system. A comparison of national policies in this respect can be helpful and may demonstrate how, on the surface, every country integrates similar phenomena such as audit, guidelines, accreditation and quality systems in their specific national context, and under what circumstances these instruments prove to be effective [13].

**The future of improvement**

Both in theory and in practice, linkages between measurement and motivation for improvement of quality in health care are still weak. The implementation of practice guidelines, quality systems and accreditation programmes needs a lot of additional effort and research. Effective strategies for change are not generic and will not be found solely through randomized controlled trials. There is, however, a substantial amount of empirical evidence and experience worldwide that can be used as a means of narrowing down the gap between measurement and motivation. During the ISQua conference in Budapest, October 7—10, the scientific programme will focus on this very issue. The first sentence of this editorial is a paraphrase of the opening sentence of Dickens’ ‘A Tale of Two Cities’. It was Dickens’ conviction that reason is useless, even dangerous, and that human happiness depends on the good will, sympathy and kindness we show towards each other. This attitude did not stop him from being actively
involved in the social consequences of the industrial revolution. As with reason in medicine, management and policy-making in health care are far from useless. But it would also be foolish to think that quality can exist without good will, sympathy and kindness, in Chicago as well as Budapest.

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References