The moderate success of quality of care improvement efforts: three observations on the situation

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Abstract

Why is the health care system still unable to achieve a breakthrough in its quality performance? This commentary offers three observations on the problem of the moderate success of quality of care improvement efforts. We based our discussion on theoretical models from management theory and research. We conclude that health care organizations invest efforts in quality improvement initiatives; however, there is a potential in improving the fit between these efforts and the specific problems these organizations face.

Keywords: health care quality improvement, health policy and management, patient safety

Physicians are not pilots

There is a trend among policy makers and researchers to compare health care organizations with other high-reliability industries, specifically, the aviation industry and nuclear power plants [7–9]. The conclusion has generally been that health care systems have not done as much as is required by a high-reliability industry to secure quality and safety. As a result, the health care industry has started to imitate management practices that have been successfully implemented in these other high-reliability industries to achieve high quality and safe performance.

However, it has been widely accepted in the management literature that any replication of one management practice in another organization is condemned to failure unless adjusted to the specific conditions of the adopting organization [10]. Various elements of the institutional environment are often industry and even organization specific and, consequently, comprise barriers to replication.

Institutional theory suggests that some organizations implement management practices because these symbolize legitimacy rather than because they contribute to operational objectives. Organizations that are the first to adopt new practices (i.e. first movers) are driven by a desire to improve performance. They are mainly interested in technical efficiency, which results from the operating benefits of the practice and its effect on eliminating problems [11]. On the contrary, organizations that adopt these practices later (i.e. second movers) are mainly interested in enhancing their image [12]. Second movers typically conform to institutional pressures, such as the demands of customers and the desire to

In this article, we drew on the common definition of quality used by ‘To err is human’ (2, p. 16) that includes three domains: safety or freedom from accidental injuries, provision of service in a manner that is consistent with current medical knowledge and best practices, and the ability to meet consumers’ values and expectations.
appear as if they are keeping up with competitors, for the sake of legitimacy. In other words, second movers implement new managerial practices because they experience external pressure. The ultimate performance improvement, according to institutional theory, belongs to the first movers because they implement a practice that fits their needs.

Specifically, the health care system, as a second mover, has increased the use of procedures, clinical guidelines, and evidence-based medicine [13,14] after the extensive use of the managerial practices of control and procedures by other high-reliability industries. However, although these practices have helped to improve the latter industries’ quality, their success in improving quality in health care is limited; the health care industry has unique characteristics that differentiate it from other high-reliability industries. First, the aviation industry is characterized by relatively low uncertainty because most situations are similar, and hence tasks are repetitive. Thus, an automatic pilot can perform the task. In contrast, although some aspects of patient care are quite routine, for example, treating a heart attack or performing a hernia repair is straightforward and routine, the health care environment is still highly uncertain as each patient is unique. Thus, strict adherence to policies and procedures can only partially ensure good performance because formal policies and procedures that should control employee behavior cannot encompass all possible daily-work situations [15]. Moreover, the patient–physician interface is a unique setup, which requires a very high degree of discretion, on-the-spot decision making, and versatility.

A second unique feature of the health care industry is the high complexity and the large variety of potential medical situations. Hence, to guide staff members’ behaviors in all these diverse potential situations, health care organizations are implementing more and more standard operating procedures. However, too many or excessively detailed procedures may interfere with the daily flow of work, create bureaucracy that complicates the job, and be a burden that demands investment of time and excessive human resources [16,17]. Particularly, in uncertain environments, very detailed or many procedures may inhibit employee discretion in situations that require immediate adaptation to changing conditions [18].

Third, in the health care system, the medical profession controls physicians’ behavior. Professions define social reality by creating principles and guidelines for action [19]. In addition, clinical autonomy, which is exercised by physicians in the treatment of their patients, supports a difficult-to-monitor practice environment [20]. Hence, organizational efforts to control physicians’ behavior by procedures and rules may fail—particularly at the nexus where they contradict professional norms.

‘Expecting A while rewarding B’ [25]

Organizational climate is an informal aspect of the work environment that also affects personnel behavior and performance in hospitals [16,17]. Climate refers to the shared perceptions of employees concerning which practices, procedures, and behaviors get rewarded and supported, and which are expected within their organization [21]. Employees rely on cues from their surrounding work environments to help them interpret events, develop attitudes, and understand expectations concerning their behavior and its consequences [22].

The official rhetoric in health care organizations is that high quality is always a number one priority. However, maintaining high quality and safety often entails working at a slower pace, exerting extra effort, or working under less convenient conditions. Consequently, whenever work pressures increase, staff should set the relative priorities between, on the one side, the work pace and pressures for productivity and economic efficiency, and on the other side, maintaining high quality and ensuring patient safety [23].

Health care staff members develop shared perceptions concerning the relative priority of quality and safety within their organization based on the way they perceive the probable consequences of their behaviors. To decide what the organization’s priorities are, staff members first seek information concerning the type of activities the organization rewards [24]. This may be obtained directly from the organization’s evaluation and reward systems and by determining whether quality and safety are part of the goal-setting and feedback systems. Once the required behavior is clarified, staff members aim to adjust their behavior so as to be rewarded. However, many reward systems mistakenly reward the behaviors that they try to discourage [25]. Although many health care organizations intend to officially emphasize quality and safety, they may reward employees only for productivity and economic efficiency [26,27]. For example, in primary care, insurance companies remunerate the providers per quantity and not for quality of visit, and remunerate hospitals per number of surgical procedures and do not consider appropriateness of use.

In addition, the medical profession sets priorities and, hence, guides behaviors. Physicians’ safety priorities are determined less by their organization and more by their professional expertise and autonomy, by their belief that the profession is regulated by its members, and by their belief in the importance of the service the profession provides [19].

The silent organization

Learning from mistakes is a critical factor for improving any organizational performance [28]. Learning is based on data that enable identification of the sources of failures and that facilitate implementation of corrective actions. Hence, health care organizations invest efforts in the development and implementation of new information technologies to collect data [29] and try to prevail on physicians to report their treatment errors to the system. Despite the declared goal of increasing learning by collecting reports of treatment errors, and the fact that physicians and nurses are urged to be honest about treatment errors, there is still a serious problem of underreporting of adverse events [1].

Most errors are generally not reported mainly because staff members are apprehensive of the punitive, individualistic, and adversarial approaches taken by their employers as well as the
fear of malpractice lawsuits [16,29,30]. To try to resolve the latter dilemma, for example, the US president recently signed into law the Patient Safety and Quality Improvement Act of 2005 (S.544), which has clarified legislative aspects of liability by providing legal protection to health care professionals who report their errors. However, as we explain below, without a profound managerial change that creates open and communicative organizations, we doubt the extent to which legislation can discourage ‘silence’ [31].

According to the management literature, employees decide whether to raise issues with management by ‘reading the context’ for clues concerning context favorability. A favorable context is when physicians perceive management (either top management or ward managers) to be willing to listen and be supportive, and that error reporting has relatively little negative consequences [32]. In general, underreporting of adverse events indicates that physicians perceive their organizations’ context as unfavorable. An unfavorable context is characterized by the shared beliefs that speaking up about problems in the organization is not worth the effort and that voicing one’s opinions and concerns is dangerous to their jobs.

Why do physicians perceive the health care context as unfavorable? We suggest an answer based on the concept of psychological contracts [33]. Psychological contracts within organizations refer to the employees’ shared beliefs, based upon promises expressed or implied, about the terms of an exchange agreement between them and the organization [33]. In general, the shared implicit psychological contract in health care organizations is a contract of blame in which an error is believed to be the responsibility of the employee who commits the error(s). Indeed, a recent trend in the health care industry is to use ‘cards’ that publicly report physicians’ success and error rates [34]. By publicly reporting error rates, physicians may compromise their employability and may also expose themselves to malpractice lawsuits. Consequently, silence prevails.

A different possible psychological contract between physicians and their organization is a ‘no-blame’ contract in which both sides agree that errors are because of systemic flaws, which must be detected and corrected. This removes the fear of personal liability and eliminates incentives to hide errors. Hence, one would voice an error to avoid potential hazards and to improve the system [2].

It is our observation that a ‘no-blame’ psychological contract exists within groups, for example within a team, a ward, or a profession. Ambiguous professional work is executed within the ingroup [35]; hence, the professionals and the profession perceive an error as an opportunity to learn and develop. However, although the profession supports internal learning and change, it blocks externally oriented sources of change and learning [36]. This occurs because a psychological contract of ‘blame’ tends to exist between groups, for example between management or regulators and those who are managed or supervised. As a result, reports will not cross the profession’s borders. For example, physicians tend to be suspicious about external monitoring because ‘they don’t understand our work’ whereas are ready to conduct fierce internal reviews of failures and to publish failures in a different learning format such as Morbidity and Mortality Meetings and Clinical Pathological Conferences.

In sum, we elaborated on three basic assumptions of quality improvement efforts in health care, which are applicable to most Western countries. Other factors that may affect quality improvement efforts were not mentioned here, although they deserve future research. Because the health care industry has unique characteristics, to amend its problems of quality, there is a need to first identify the origins of these problems. Health care organizations invest efforts in quality-improvement initiatives; however, there is a potential in improving the fit between these efforts and the specific problems these organizations face. We suggest that an interdisciplinary approach that combines management and health care quality theories can be used as a springboard for action.

References


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