Editorial

Hospital quality management: a shape-shifting cornerstone in the foundation for high-quality health care

A century ago, hospital quality management was almost non-existent. Quality committees were primarily chroniclers. One excerpt from a hospital quality committee report at an American academic center might represent the best of hospital quality management practice then: ‘Autoclave did not rise >212°. Interns had to carry patients to and from the operating rooms owing to lack of orderlies. Rubber gloves were scarce on wards. Fly screens were removed without authorization. Physicians were often not notified of admissions or deaths’ [1]. While quality problems were documented (and some will seem surprisingly familiar to readers today), rarely did the notes specify action plans to improve quality. Of course, hospitals were relatively small, simple organizations. Accreditation (at least in the USA) was still a decade or more in the future.

Fast forward to today’s modern hospitals. Globally, the change could not be more striking. The complexity of operating a modern hospital is staggering. Although financing, regulation, oversight, the technologies available and the populations served vary across countries, the available services and the quality management challenges of delivering those services reliably are surprisingly similar. During recent decades, quality management sciences have advanced dramatically in many industries, operational standards are defined, and the information technology revolution has opened new possibilities for highly reliable service. Nevertheless, experience suggests that the application of these sciences, standards and information technologies in health care seems to advance slowly and unevenly both within and across countries.

Given the need for progress in quality management, the project, ‘Deepening our Understanding of Quality in Europe (DUQuE)’, arrives at a critical time. This special supplement describes an ambitious and timely multiyear, multinational study of hospital quality management in a carefully selected sample of hospitals. Reflecting the rich complexity of hospital management, the DUQuE project required diligent collaboration of a broad cross section of researchers, professionals, policy-makers and patients to collect and analyze the data needed to describe the structure, process and outcomes of hospital quality management. The investigators built on a solid foundation of decades of previous work on quality management principles, accreditation programs, measurement sciences, clinical indicator development, health services research methods and quality improvement science. In doing so, the DUQuE investigators have capitalized on the standardized instruments available from this past research, but also developed new instruments to measure the complex mix of governance, practice and actions of hospital quality managers, professionals and patients.

These preliminary results are intriguing. They support the important roles of leadership and governance, the use of protocols and hospital culture as drivers of quality and safety improvement activities. The associations with clinical outcomes are not yet clear. Some critics may point to null findings here and there and question whether the methods were up to the task. However, the prior literature tempers expectations—process and outcome links are frequently weak in observational, cross-sectional studies of quality. Even large, randomized, clinical trials tend to find modest effects of deliberately introduced management practices on clinical outcomes. In such studies, unmeasured effects of context and non-random influences may mitigate (or more rarely erroneously strengthen) observed associations.

Key takeaways from DUQuE are the rich conceptual map of the logic of quality management practice, the definition of a standard set of expectations for hospital quality management, the measurement instruments to determine adherence to that standard and the demonstration of the feasibility of a comprehensive, multinational research on quality management.

The DUQuE results will be relevant outside of Europe. The tools from the project will be applicable in other high-income countries of the world and should also be adapted readily to measure hospital management systems and their impact in low- and middle-income countries. That these projects are large and complex should not surprise us. We no longer live in a world where autoclaves, fly screens and rubber gloves are the complex technologies of health care. Instead, we live in a world where information technology will enable increasingly efficient studies of the impact of quality management on health outcomes in every part of the globe.

Reference


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International Journal for Quality in Health Care vol. 26 no. S1
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