President's Page

A Discussion of Quality: What Is It and How Can You Find It?

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In the December 2006 *ASA Newsletter,* Dr. Alex Hannenberg, the ASA Vice President for Professional Affairs, was quoted regarding ASA's development of quality indicators for anesthesiologists:

> In a remarkably short period of time, a robust set of anesthesia-relevant quality measures has taken shape. They will position us well as Congress, health plans and employers differentiate among specialties on the basis of their engagement in quality improvement.

He was talking about Pay-for-Performance in Medicare, a highly controversial and unverified attempt by those who directly pay physicians for their services to encourage physicians to single-handedly, as The Institute of Medicine says, "Close the chasm between what we know to be good quality care and what actually exists in practice."[1]

The IOM began in 1996 to assess how closely U.S. health systems met the IOM's definition of quality: "The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." The IOM asked RAND to gather data on the overuse, misuse, and underuse of U.S. health care services.

Phase two, from 1999-2001, publicized the IOM vision of transformation in U.S. health care to achieve improved quality. You may remember the 1999 report, *To Err is Human: Building a Safer Health System,* where our medical specialty was held up as a benchmark for other physician specialties when the IOM said:

> Anesthesia is an area in which very impressive improvements in safety have been made. As more and more attention has been focused on understanding the factors that contribute to error and on the design of safer systems, preventable mishaps have declined. Studies … indicate that today, anesthesia mortality rates are about one death

[1] "Crossing the Quality Chasm: The IOM Health Care Quality Initiative." **http://www.iom.edu/?id=21805** p. 1, August 2007.

> per 200,000 to 300,000 anesthetics administered, compared with two deaths per 10,000 anesthetics in the early 1980s. The gains in anesthesia are very impressive and were accomplished through a variety of mechanisms, including improved monitoring techniques, the development and widespread adoption of practice guidelines, and other systematic approaches to reducing errors.[2]

Phase three of the IOM's Quality Initiative is underway with efforts by many individuals and organizations to "reform three different overlapping levels of the system: the environmental level, the level of the health care organization, and the interface between clinicians and patients."[3]

My concern with this national experiment, initiated by the IOM and seeing widespread implementation in an uncoordinated fashion by Medicare, Medi-Cal, and numerous health plans, comes from my fear that when Quality is defined rigidly by bureaucracies, the inherent inertia of any bureaucracy makes that Quality definition as out-of-date as last year's state-of-the-art computer. I don't think Quality has a fixed position, but rather Quality must remain defined only in the moment in that place where we seek to know Quality.

In that American literary classic, *Zen and the Art of Motorcycle Maintenance,*[4] the central figure carries on an internal discussion on Quality, something he initially feels cannot be defined. The main character asks at one point,

> Does this undefined 'quality' of yours exist in the things we observe? Or is it subjective, existing only in the observer? … Because if Quality exists in the object, then you must explain just why scientific instruments are unable to detect it. … On the other hand, if Quality is subjective, existing only in the observer, then this Quality … is just a fancy name for whatever you like.
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> If everyone knows what quality is, why is there such a disagreement about it?

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[2] *To Err Is Human: Building a Safer Health System.* http://books.nap.edu/openbook.php?isbn=0309068371 p. 32, 2000. The National Academy of Sciences.

[3] "Crossing the Quality Chasm: The IOM Health Care Quality Initiative." http://www.iom.edu/?id=21805 p. 1, August 2007.

[4] Pirsig, Robert M. *Zen and the Art of Motorcycle Maintenance.* Quill William Morrow: New York; 1979.

Could it be that "although pure Quality is the same for everyone, the *objects* that people said Quality *inhered* in varied from person to person?" Yet this somehow seems false and doesn't really answer the question.

> Now there (is) an alternative explanation: people disagreed about Quality because some just used their immediate emotions whereas others applied their overall knowledge.

This develops two qualities: one is subjective; one is objective.

> Actually this whole dilemma of subjectivity-objectivity, of mind-matter, with relationship to Quality is unfair. That mind-matter relationship has been an intellectual hang-up for centuries. … Quality is not objective. … It doesn't reside in the material world. … Quality is not subjective. … It doesn't reside merely in the mind.

Quality is neither a part of mind, nor is it a part of matter. It is a *third* entity which is independent of the *two*.

So "the world is composed of three things: mind, matter, and Quality."

> Quality (can't) be independently related with either the subject or the object but could be found *only in the relationship of the two with each other.* … Quality is not a *thing*. It is an *event*. … Quality is the event at which awareness of both subjects and objects is made possible.
>
> Why does everybody see Quality differently? … Quality is shapeless, formless, indescribable. To see shapes and forms is to intellectualize. Quality is independent of any such shapes and forms. The names, the shapes and forms we give Quality depend only partly on the Quality. They also depend partly on the *a priori* images we have accumulated in our memory. We constantly seek to find, in the Quality event, analogues to our previous experiences. If we didn't, we'd be unable to act. We build up our language in terms of these analogues. We build up our whole culture in terms of these analogues.
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> The reason people see Quality differently … is because they come to it with different sets of analogues. … People differ about Quality, not because Quality is different, but because people are different in terms of experience.

Presumably, "if two people had identical *a priori* analogues they would see Quality identically every time."

Quality thus becomes a philosophical issue.

> The easiest intellectual analogue of pure Quality that people in our environment can understand is that "Quality is the response of an organism to its environment." … Quality is the continuing stimulus which our environment puts upon us to create the world in which we live. All of it. Every last bit of it.

We need to gather honest feedback to refine our personal Quality definition. Scott Adams, the creator of "Dilbert," said:

> Ignorance definitely is bliss. If everybody told me the things that I'm doing that are bugging them, that I should change to make the world better, I would feel really bad today. But they don't.[5]

Here, Adams seems to imply that our collective personal quality definitions can define a broader Quality. Adams continues:

> Small-business owners whose feedback loops are broken aren't just as happy to have it that way, they're much happier. … (But) small companies just don't have the luxury of being stupid.

And if they are? "They go out of business."[6] And aren't we all really just small business owners, like Adams in many ways, in our personal relationships?

Are there any ways to know when a small business is in trouble? Of course!

"The first clear signal is when you find yourself reacting to the market," says Robert G. Cooper, professor of marketing and technology management. "A real sign of danger is if (new types of products) are coming out that change the way things are done in your industry and you're not involved in the change," Cooper says. Or said another way, quality is always state-of-the-art.

Other signs of product-related problems include declining market share and customer dissatisfaction. "There's another indicator that many companies don't even measure," Cooper says.

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[5] Barrier, Michael. "Free-Spirited Enterprise," *Nation's Business*. October, 1997. 85:10 p. 63.

[6] Ibid.

> A drop in the percentage of sales that come from new versus older products is a sign of too much reliance on existing products and not enough focus on tomorrow's.[7] … New studies show that to have a good rate of success, you still have to have a good product and do things right."

State-of-the-art quality thus remains in touch with the broadest number of personal quality definitions.

> In the past, it's been very easy to do "ready, fire, and aim" without dire consequences. … Companies can (not) afford to do that today. And a mistake by a small company can be a knockout issue.[8]

At least in terms of business, Quality translates into state-of-the-art products built to retain the essence of Quality for more than six months. Quality also is transitory. It evolves; it is always changing, improving.

The Joint Commission on Accreditation of Healthcare Organizations, an organization defining continually changing quality standards in the medical field, provides on their Web site a "Quality Check" search engine[8] where one can look at the performance reports for organizations that have been evaluated (surveyed) by the JCAHO to see how well the organization meets current JCAHO standards. The Quality Check area also provides a context of comparable organizations' performance reports one can use to compare with any single performance report.

In regard to performance measurement the JCAHO said,

> In the quality oversight world, the forces which had earlier in the decade (the 1990s) driven performance measurement, quality improvement, and public accountability up onto the marquee are still there. Those driving forces are first the anxiety of a public that is increasingly insecure about all of the changes in the delivery system and what this implies about the quality of care that they will personally receive.[9]

In medicine as in business, the product—healthcare delivery—is under scrutiny for a definition of Quality.

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[7] Maynard, Roberta. "The Heat is One," *Nation's Business*. October 1997. 85:10, p. 18.

[8] **http://www.qualitycheck.org/consumer/searchQCR.aspx** August 2007.

[9] Performance Measurement, **http://www.jcaho.org/perfmeas/pm.html** March 2002.

And as in business, the expectations of performance in medicine are continually redefining Quality. The JCAHO explains,

> Whatever we may believe about this complex environment, it is driven by concepts of value. … The public knows that (the U.S. spends a lot of money on health care) and they want to know what they're getting for their money.[10]

In this the JCAHO sounds very much like Robert Cooper telling us that our customers are dissatisfied and we in medicine are out-of-step with that Quality assessment.

> A number of disparate environmental forces further supported the decision to transition the Joint Commission's unitary approach to performance measurement to one that embraced collaboration. For example, the growing impetus for health care reform ultimately led to the creation, in 1999, of the National Quality Forum. The Forum has now come to be acknowledged as the final common pathway for review and approval of performance measures. In addition, the Peer Review Organizations—renamed as Quality Improvement Organizations—assumed expanded performance measurement responsibilities, and the IOM's *Crossing the Quality Chasm* report laid out national measurement and improvement objectives. Stimulated in part by these initiatives, additional players progressively entered the health care quality measurement arena. Adoption of an inclusive approach has enabled the Joint Commission to be well positioned to work with a variety of measure developers to adapt and adopt measures, and to participate in national initiatives such as the Hospital Quality Alliance.[11]

The push to externally define Quality in Medicine is pervasive today. We see it in the untested P4P programs under development in the Medicare program and commercial health plans. We saw it in the "total quality improvement" programs undertaken in many hospitals in the 1990s.

The risk in developing bureaucratic definitions of quality becomes the retention of those quality definitions past the time when they remain state-of-the-art and in the perverse incentives created when those who provide the

[10] Ibid.

[11] "Evolution of Performance Measurement at the Joint Commission 1986 – 2010: A Visioning Document," **http://www.jointcommission.org/NR/rdonlyres/333A4688-7E50-41CF-B63D-EE0278D0C653/0/SIWGProloguewebversion.pdf.** August 2007.

Quality product are paid not just for delivering a Quality product, but are paid for achieving a static and rigid definition of Quality.

Those individuals who exude Quality give everyone around them a sense of security. I'm sure your patients look to you for the reassurance each of us finds in knowing we've associated ourselves with a physician of Quality. Please keep up your good, Quality work, doc! Our profession and organized medicine needs people just like you.

But in today's world, you and I also need to participate in the development and continual refinement of the bureaucratic definitions of Quality in medical care as much as we need to point out to anyone who will listen the inherent limitations of developing static benchmarks of medical "Quality" that remain in place long after real "Quality" has moved past those archaic definitions. State-of-the-art medical care from 10 years ago is no longer state-of-the-art and no longer represents Quality medical care as it once did!

"The reason people see Quality differently … is because they come to it with different sets of analogues. … People differ about Quality, not because Quality is different, but because people are different in terms of experience." Presumably, "if two people had identical *a priori* analogues they would see Quality identically every time."[12] And those analogues are constantly changing in medicine as physicians learn more about diseases and develop better techniques and tools to control diseases.

Consequently, we physicians need to point out loudly to everyone who will listen that bureaucracies that develop static definitions of medical quality **cannot** maintain Quality within their organizations because Quality is inherently in a constant state of flux—Quality continually evolves, thereby eluding unchanging definitions!

[12] Pirsig, Robert M. *Zen and the Art of Motorcycle Maintenance.* Quill William Morrow: New York; 1979.

The Perks of Getting Older

People call at noon and ask "Did I wake you?"

Your joints are more accurate meteorologists than the national weather service.

Your secrets are safe with your friends because they cannot remember them either.