QUALITY IN HEALTH CARE

Editorials

Patient care: what drives us to change?

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The past 10 years have seen the introduction of clinical audit, guidelines on clinical and organisational delivery of care, and more recently an emphasis on evidence based medicine. An intelligent member of the public, particularly if a trained manager, may believe that such an array of managerial tools would be related to an easily measured improved outcome, particularly in a common adult disease such as asthma. The British Thoracic Society (BTS) in conjunction with many allied respiratory healthcare workers produced guidelines for asthma some years ago. A review in 1996 found little evidence to suggest standards of care had improved since the publication of the BTS guidelines,¹ and in the same review the authors concluded that there was little good published research evaluating different ways of organising the delivery of asthma care. Are the guidelines flawed and the asthma clinics run by trained asthma nurses with high levels of educational material and social communication a passing “whim”, or are there more fundamental reasons why we are not able to translate either consensus and/or evidence based improvements into the organisation of clinical care?

In this issue of *Quality in Health Care*, Dawson *et al.*,² using case study methodology³ attempted to unravel the understanding of factors for changes in the organisation of asthma care and treatments. The authors interviewed hospital and primary care physicians of most grades in teaching and non-teaching hospitals and multiple partner and single handed practices using a semistructured interview technique to obtain subjective accounts of the nature and reasons for change as perceived by these physicians.

Two striking features of this paper are that within the four hospitals and many of the practices there was a lack of prescribing data, referral rates, emergency admission numbers, and systematic clinical audit, and that the authors accepted that they were unlikely to secure data on patient outcomes. These are surely areas which need urgent consideration.

Organisation of care

In this case study by Dawson *et al.* (page 253), clinical management and the organisation of care showed marked variations in the level of resources, the division of labour, and, in particular, the role of medical specialist firms versus the generalists. Most of the hospital clinicians' views related to the “beliefs” that specialist care was likely to be associated with an improved outcome. Some hospital doctors had strong views on the role of such organisational structures, but with only anecdotal evidence to support

arguments for and against, generalist or specialist firm structures were mainly based on “reality” (generalist) and “excellent” (specialist).

The role of nurses in the organisation of care in hospital was variable, but in primary care was heralded by most primary care physicians as a significant change in the care of people with asthma. Again, however, no comparative data exist on how such changes may affect outcome.

How clinical practice evolves

In an attempt to understand the process of change in clinical practice the authors asked what, why, and how changes in asthma care occurred. What had changed in clinical care over the years did appear to be a move towards the consensus approach in the BTS guidelines. However, when asked why their practices has changed, less than a third mentioned written evidence such as the guidelines, educational literature, and research. The individual statements show confusion among clinicians about the validity of randomised controlled trials, meta-analysis, and systematic reviews. The concepts of clinical efficacy (does it work) and clinical effectiveness (does it work in the real world) become blurred to such an extent (it is impossible to ascertain an estimate from those interviewed who would fit in this category) that the concept of evidence based medicine is incompatible with the day to day pressures of clinical practice. Doctors practising outside evidence based medicine or BTS consensus based guidelines for asthma were therefore tolerated or just considered old fashioned.

The major influence on why change had occurred could have been knowledge based but, when asked how change occurs, 85% of the respondents rated their own clinical experience as being of high importance in influencing their practice. Clinicians in this study appear to shape their practice to a great extent as a result of direct experience from seniors, peers, patients, and, to a lesser extent, members of multidisciplinary teams, with little evidence of change of behaviour attributed to evidence. Clinical experience as a major driver of change towards good clinical practice in asthma care could be considered acceptable if there was a uniform and quality standard to deliver that clinical experience. The organisational structures in primary and secondary care as outlined in the case study would suggest that such experience would be heterogeneous overall, but each clinician may have only been exposed to a single type of clinical experience. A major component of the clinical experience which affected change was

reported to be the hierarchical structure within hospital teams. The following of guidelines has been considered a form of “obedience based medicine”, but the effect of this hierarchical decision making process on clinical experience may make this more of a “truism” than when applied to following guidelines.

The clinicians’ failure to feel that organisational factors or managerial involvement are helpful in changing practice and improving patient care supports the notion that healthcare professionals, doctors, nurses, and managers live in different worlds.

The apparent failure of clinical and organisational guidelines to improve professional practice is not limited to asthma models,⁴ but does suggest the delivery of postgraduate education to be inappropriate, and perhaps we need to look at what the educational needs of the healthcare team are. Such “needs assessment” for continuing medical education have been reviewed,⁵ with some lessons learnt, which suggest that “needs” can be identified and potentially taught together. Multidisciplinary education is not just about learning the “same” item of

information or skill with different professionals, but should be understood as a way we can look into each others “worlds” to understand together not only what needs to change but also what motivates change in behaviour and clinical practice so that we can make real improvements in patient care.

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- 1 Eastwood A, Sheldon T. Organisation of asthma care, what difference does it make? A systematic review of the literature. *Quality in Healthcare* 1996;5:134–43.
- 2 Dawson S, Sutherland K, Dopson S, *et al.* Changing clinical practice: views about the management of adult asthma. *Quality in Health Care* 1999;8:253–61.
- 3 Fitzgerald L. Case studies as a research tool (editorial). *Quality in Health Care* 1999;8:75.
- 4 Oxman AD, Thomson MA, Davis DA, *et al.* No magic bullets. A systematic review of 102 trials of interventions to improve professional practice. *Can Med Ass J* 1995;153:1423–31.
- 5 Lockyer J. Needs assessment, lessons learned. *Journal of Continuing Education and Health Professionals* 1998;18:190–2.

Nuffield Trust: Policy Futures for UK Health

www.nuffieldtrust.org.uk (then follow the arrows on Policy Futures for UK Health)

The UK Nuffield Trust and Judge Institute of Management Studies, University of Cambridge launched in September 1999 a major website public consultation on their report, *Policy Futures for UK Health—Pathfinders*.

The purpose of the report is to help to inform UK health policy and health policy makers in determining the future direction of health-care policy and delivery. The report makes 150 recommendations for change, to be accomplished by 2015, and is based on 10 specially commissioned technical papers from leading authorities looking at major policy areas likely to impact on the future UK NHS, including:

- Leadership
- Financial sustainability
- Use of information technology
- Scientific advance
- New ethical challenges

The Nuffield Trust and Judge Institute of Management Studies are interested in the public’s views on this document, and are **especially keen to receive comments and feedback from the readers of *Quality in Health Care*. Please send any feedback to policyfutures@jims.cam.ac.uk or by post to Dr Charlotte Dargie, Nuffield Fellow in Health Policy, the Judge Institute of Management Studies, Cambridge University, Cambridge CB2 1AG. All comments need to be received by 5 January 2000.**

Feedback from the public, health professionals, and academics will be incorporated into the final version of the report due to be presented to the UK prime minister in May 2000. Anyone wishing to receive a copy of the final version of the report should include their name and postal address in their email.

The learning organisation: a necessary setting for improving care?

Clinicians in management, even those familiar with quality improvement theory, may not be familiar with the term learning organisation. From the position of a management advisor working across the clinical/managerial interface, of all the management and organisational theories the idea of the "learning organisation" probably offers more to quality improvement than any other.

So, what is a "learning organisation"? Learning organisations have a strong sense of direction (a vision), and crucially pay attention to the role and development of each individual within them. They are led and managed in such a way that the learning of these individuals is harnessed towards improved ways of working. The organisation itself as a "system" is able to change in a proactive way as it constantly uses new information to improve its performance.

Many consider that all quality improvement requires change, however change is a learning process and learning is a change process.¹ In terms of the leading thinkers in this field, Argyris and Schön have said that organisational learning involves the detection and connection of errors.² Schein thinks that for change to occur, the organisation must unlearn previous beliefs, be open to new ideas, and relearn new assumptions and behaviours.³ Senge, probably the best known proponent of the learning organisation, suggests that understanding of the "system" can only be reached by contemplating the whole, but that people within the system tend to focus on snapshots of isolated parts of it, and so rarely solve their deepest problems.⁴ These are powerful ideas, but in a system or organisation largely dominated by highly structured, hierarchical, historically determined professional demarcations—that is, a hospital or health organisation—how often do we challenge norms and assumptions, "unlearn", relearn, and focus on the whole system? The answer is probably "infrequently", and few of our healthcare institutions can be described as learning organisations.

Could an entire national health system or sector develop the characteristics of a learning organisation? A natural tension exists between the necessary regulatory and professional surveillance culture for health care and the equally necessary developmental elements. This is not confined to the UK NHS, but is seen in large healthcare organisations and systems throughout the world. This tension is demonstrated in systems of performance management—pressure from the top of a system (central or regional government)—for performance and quality improvement. Such pressure stresses overworked, pressurised, and demoralised "operating units" in the system. If an organisation is to move from a learning mode to one where innovation and even risk are rewarded, and where problems are approached in an integrated way, then a culture of learning, supported by communication and training, needs to be developed.⁵ The tension between regulation/surveillance and learning/development is unlikely to disappear, but these elements can coexist.

We need a system capable of learning at both the central and operating levels. If the tops or centres of systems were to adopt the maxims of the learning organisation in the way that they operate performance management, focusing on positive incentives for change rather than punitive, and considering the system as a whole rather than fragmented components, then we may see progress. Equally, if healthcare organisations become more proactive and dynamic

and thus able to react in an evolved way to externally imposed directives, then the response may be more positive—we must perhaps rearrange the way that we react. The quality initiatives being introduced in the NHS in England and Wales are attempting to follow these maxims.⁶ Davies and Nutley believe that if the government is to make progress towards real service-wide quality improvement, then a cultural transformation is necessary in the NHS involving considerable attention to organisational learning.⁷ The NHS *Learning Network* is a welcome development sponsored by the NHS Executive in England, promoting learning and sharing of good practice in service delivery.⁸

Unlearning is as important as learning. Multiple examples exist of reorganising processes of care for quality improvement at the individual disease, specialty, and cross organisational levels.⁹ Clinical guidelines and protocols effectively restructure care processes, as do the organisation-wide re-engineering or patient focused care projects. As part of this, processes are both unlearned and learnt, and norms and conventional wisdom are challenged. All of these features describe the learning organisation in action. Leadership is needed for an entity to develop the characteristics of a learning organisation. The difficulty experienced by many senior health managers—both clinical and non-clinical—is "letting loose" while keeping an appropriate level of accountability, giving the room and space for individuals to do what their values dictate that they should. This is where real innovation and improvement happen.

To become a learning organisation takes time, perhaps especially in an organisation such as an acute hospital with long established traditions and practice. New forms of organisation, for example primary care trusts in the English NHS, have the opportunity to embed the necessary characteristics. With the right design and leadership, the right things will be encouraged to happen to improve the quality of care offered to patients.

The application of the concept of a learning organisation could be described as the collision of theory and common sense. The activities listed here as components of a learning organisation are happening in high performance organisations under other names and labels. It is an extension of reflective practice, has enormous potential to leverage quality, and is definitely not just another management theory.

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- 1 Beckhard D, Pritchard W. *Changing the essence: the art of creating and reading fundamental change in organisations*. San Francisco: Jossey-Bass, 1992.
- 2 Argyris C, Schön DA. *Organisational learning: a theory of action perspective*. Reading, MA: Addison Wesley, 1978.
- 3 Schein EH. *Organisational psychology*. Englewood Cliffs, NJ: Prentice-Hall, 1985.
- 4 Senge P. *The fifth discipline*. New York: Doubleday, 1990.
- 5 Garside P. Organisational context for quality: lessons from the fields of organisational development and change management. *Quality in Health Care* 1998(suppl);7:S8-16.
- 6 Department of Health. *A First Class Service*, London: The Stationery Office 1998.
- 7 Davies HTO, Nutley SM. Developing learning organisations in the new NHS. *BMJ* 1999; in press.
- 8 Langlands A. Learning: the steps. *NHS Magazine* July 1999. <http://www.learningzone.nhsweb.nhs.uk>
- 9 Garside P. *Patient focused care. A review of seven sites in England*. London: NHS Management Executive, 1993.

The increasing importance of patient surveys

This editorial was first published in the *British Medical Journal* (BMJ 1999;319:720-1). It is reproduced here with kind permission of the author.

Now that sound methods exist, patient surveys can facilitate improvement people often think of "exit" and "voice" as the main ways patients can influence healthcare quality¹—that is, patients can leave providers they are not happy with or they can voice their opinions in an attempt to change care. A common strategy for eliciting patients' "voices" is to conduct surveys. Clinicians have long been sceptical about such surveys, partly because they communicate regularly with their patients and saw no need for another method of hearing their concerns and partly because satisfaction surveys used to be flawed measures of healthcare quality. Now, however, that is beginning to change as rigorous methods have been applied to developing and evaluating patient surveys.

Despite numerous studies of patient satisfaction,² they have not resulted in the quality improvement that many expected. Previous satisfaction surveys had little impact because they often did not meet minimal standards of conceptual or methodological rigour and were not designed to facilitate quality improvement efforts. Responses to such surveys are subjective and difficult to interpret since they are a complex function of expectations that may vary greatly among patients with comparable care. Moreover, the questionnaires assessed things, such as quality of the food, that have little bearing on the quality of clinical care, and thus the results provided little direction to those responsible for improving care processes.³⁻⁴

It is now widely recognised that there is a need for rigorous methods, other than clinical conversations, to elicit patients' views on such matters as treatment decisions and the quality of care received.⁵⁻⁶ Much effort has therefore been devoted to developing and evaluating survey measures that elicit reports about specific care experiences that reflect quality of care, not amenities.⁷⁻⁸ Such questions are less subjective and less influenced by patient characteristics, are more interpretable, and thus may be acted on for quality improvement purposes.⁹

The Picker Institute has developed and used such instruments to evaluate the quality of hospital care in the United States⁷ and more recently, in Europe. The Consumer Assessment of Health Plans (CAHPS) project has adopted a similar approach for ambulatory care in the United States.¹⁰ These newer instruments provide qualitatively better data than many earlier surveys, and the response of patients, clinicians, and others responsible for the quality of health care has been striking. One indication of the value of such surveys is the increasing public dissemination of the resulting data. CAHPS data were available to about 90 million Americans in 1999, including 39 million Medicare beneficiaries (<http://www.medicare.gov/comparison/default.asp>), 9 million federal employees, 40 million people covered by plans reporting to the National Committee for Quality Assurance, and people in plans surveyed by other sponsors.¹¹

Regional coalitions are also increasingly coordinating data collection and dissemination. A partnership of Massachusetts healthcare, business, and government leaders recognised the need for credible, publicly available data on the quality of hospital care in the state and launched a voluntary effort to collect information using the Picker survey from

24 200 patients discharged from over 50 Massachusetts hospitals.¹² Those data were used to create a report that was distributed to the hospitals and made publicly available after an initial cycle of internal reporting (<http://www.mhqp.org/statewidesurvey.html>). A testament to the quality and focus of the project is the fact that participants agreed at the outset to use the data not to judge "winners and losers" but to educate and inform hospitals and consumers and to focus and facilitate quality improvement efforts. The news media generally recognised that the important story was not that some hospitals were better than others, but that all hospitals were working collaboratively to respond to patients' concerns. Clinicians and administrators embraced the new measures as valid and important and devoted new energy to making the care of patients better, rather than criticising the message. The report stimulated numerous quality improvement activities. A similar project is under way in California with a substantially larger group of hospitals.

What are the most important lessons for clinicians from these activities? Firstly, put aside preconceptions about the value of patient surveys: there now are valid and reliable instruments that ask patients objective questions about aspects of care that both clinicians and patients think represent quality. Secondly, newer surveys and reports can provide results that are interpretable and suggest specific areas for quality improvement efforts. Thirdly, we should not worry about whether or not to release information on quality to the public and whether that impedes quality improvement. Public reporting is an inexorable trend, so our efforts should be directed to making sure that these reports contain reliable and valid indicators of quality and that their focus is not on identifying "bad apples" but on stimulating and guiding quality improvement efforts. Patients would much rather their voices be heard than exit out of frustration. Now that we have the right tools we should all work together to hear patients' voices clearly and meet their needs better.

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- 1 Hirshman A. *Exit, voice, and loyalty*. Cambridge: Harvard University Press, 1970.
- 2 Cleary PD, McNeil BJ. Patient satisfaction as an indicator of quality care. *Inquiry* 1988;25:25-36.
- 3 Williams B. Patient satisfaction: a valid concept? *Soc Sci Med* 1994;38:509-16.
- 4 Cleary PD. Satisfaction may not suffice: a commentary on "a patient's perspective." *Int J Technol Assess Health Care* 1998;14:35-7.
- 5 Fitzpatrick R. Surveys of patient satisfaction: I—Important general considerations. *BMJ* 1991;302:887-9.
- 6 Cleary PD, Edgman-Levitan S. Health care quality. Incorporating consumer perspectives. *JAMA* 1997;278:1608-12.
- 7 Cleary PD, Edgman-Levitan S, Roberts M, Moloney TW, McMullen W, Walker JD, et al. Patients evaluate their hospital care: a national survey. *Health Affairs* 1991;10:254-67.
- 8 Edgman-Levitan S, Cleary PD. What information do consumers want and need? *Health Affairs* 1996;15:42-56.
- 9 Cleary PD, Edgman-Levitan S, Walker JD, Gerteis M, Delbanco TL. Using patient reports to improve medical care: a preliminary report from 10 hospitals. *Quality Management in Health Care* 1993;2:31-8.
- 10 Hays RD, Shaul JA, Williams VSL, Lubalin JS, Harris-Kojetin LD, Sweeny SF, et al. Psychometric properties of the CAHPS 1.0 survey measures. *Med Care* 1999;37(suppl):MS22-31.
- 11 Veroff DR, Gallagher PM, Wilson V, Uyeda M, Merselis J, Guadagnoli E, et al. Effective reports for health care quality data: lessons from a CAHPS demonstration in Washington State. *Int J Qual Hlth Care* (in press).
- 12 Rogers G, Smith D. Reporting comparative results from hospital patient surveys. *Int J Qual Health Care* 1999;11:251-9.