Health Care Quality: A Tale of Multiple Cultures

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There are two premises in this paper. The first premise is that in spite of multiple, extensive efforts over the past several decades, healthcare quality[1] (HQ) in the United States (US) appears to be increasingly elusive. The second premise is that the HQ issues and processes on which we have been focusing will not result in substantial improvement in HQ. Fixing these HQ issues will require changes in the multiple, often conflicting, cultures[2] embedded in healthcare.

In support of the first premise one finds that "on average, Americans receive about half of recommended medical care processes. . . . [The] gap between what we know works and what is actually done is substantial enough to warrant attention. These deficits, which pose serious threats to the health and well-being of the U.S. public, persist despite initiatives by both the federal government and private health care delivery systems to improve care."[3]

Although "quality" has become a global obsession,[4] healthcare quality in the US has been particularly elusive. The level of resources (money, people, information and technology) committed to the effort is almost incomprehensible. We know that HQ issues are real because during the past decade we have overwhelming evidence from such sources as: [5] Institute of Medicine (IOM) studies; General Accounting Office studies; Congressional Research Services reports; congressional and legislative hearings, findings, and public policy; revised standards from the Joint Commission [JCAHO], National Committee on Quality Assurance [NCQA], and other organizations,

as they have repeatedly reconfigured their processes; federal agency research, reports, and reorganizations (AHRQ, CMS, CPSC, FDA, HRSA et al.);[6] prodigious jurisprudence; foundations and independent bodies; numerous articles in the professional literature; and numerous investigative reports in reputable newspapers and magazines.

One way we have decided to assess quality is by identifying deaths due to iatrogenic causes.[7] A recent article in JAMA has suggested that mishaps in the healthcare milieu could represent the third leading cause of death in the US.[8] Another approach has been to focus on injuries and accidents, although no death ensues. Others assess quality by economic costs; how much is spent or lost due to some measure of quality.[9] Clinicians may view high quality outcomes as those procedures which fall within a statistical norm. To a patient, quality may be as diverse as not having a reaction to a medication, cleanliness, having a call light answered promptly, perceived attitude of providers, the cost of care or pharmaceuticals, or level of difficulty in obtaining an appointment. Consumers are increasingly sensitive to frequent use of diagnostic and treatment technologies, especially when explanations or rational is deemed inadequate. Consumers might (and frequently do) accept less than six sigma for their housing, transportation, or clothing. Most consumers are not, however, prepared to accept anything less than six sigma for their healthcare outcomes.[10]

Although we are certainly becoming smarter about all aspects of HQ, we seem no closer in controlling the angst, costs, or exposé of new issues. By way of review, some of the efforts to get control of the voracious HQ appetite have involved: study the phenomenon into oblivion; involve the consumer; accreditation mandates (CMS,

JCAHO); litigate everybody and everything; deny we have a problem; encourage the courts, media and politicos to feed at the HQ publicity trough as often as possible; develop “data banks” to document providers with a history of bad outcomes; publish lists of providers who have known negative outcomes; peer evaluation; credentialing and privileging processes; reinvent, reengineer, and rename the quality processes; establish state and national clearinghouses and institutes; develop a cadre of well-trained and educated quality managers; insist upon evidence-based medical practice; establish standards of care criteria; require protocol enhanced medical practice; encourage technology (automated pharmacy systems; unit dose; electronic order entry; PADs; smart cards; digital records; digital signatures, et al.); abdication to the non-healthcare corporate community;[11] create new professional healthcare associations ostensibly to address HQ issues because existing associations have not provided adequate leadership in this area;[12] establish programs to sensitize providers to consumer’s concerns; educate consumers on ways to protect their own health and welfare; and numerous other efforts. While it would be incorrect say that these things have had no constructive impact on HQ, it would be equally wrong to insist that they have had any overall, significant track record in reducing the magnitude of HQ issues across the system.

The second premise in this paper is that the nature and the extent of HQ issues are a factor of culture. A corollary to this second premise is that we may not be able to effectively mitigate HQ issues because the different stakeholders involved have profoundly different perspectives on the nature, cause, and appropriate solutions

involved. If this premise is correct then what we have been doing up to this point to address HQ probably may not work any better in the future than it has in the past. The multiple cultures in HQ are represented by principal constituencies (stakeholders) in the US healthcare community. These include the medical care provider groups (physicians, nurses and other clinicians), managerial groups (boards; senior managers), consumer groups and their advocates, the insurance industry group, the legal community (plaintiff and defendant attorneys) and government. All have different opinions (sometimes among themselves) as to who is responsible for HQ outcomes, and why. Within the medical provider group, few physicians accept the argument that they are responsible, one way or another, for large numbers of medical errors, most of which are probably not malpractice. Further, they seldom acknowledge that their collective attitude and pervasive cultural characteristics are a major impediment to meaningful change. However, nurses and other healthcare clinicians, attorneys, and consumers frequently differ with physicians on these matters. The medical insurance interests frequently suggest that clinicians, and physicians in particular, need to improve their outcomes. Unfortunately, the insurance community exaggerate the extent of adverse HQ by settling “malpractice” cases that have little or no merit simply because it is efficient to do so. The insurance groups also cite institutional leadership as culprits, including both senior managers and board members, some of whom still do not seem to understand that in healthcare *Darling*[13] is not necessarily a term of endearment. Consumers and consumer advocates often assign HQ culpability to physicians and institutions. There is some consumer sympathy for capping malpractice awards, but nearly as many people (not just plaintiff attorneys) have doubts about the

wisdom of this approach. Neither are consumer groups particularly fond of government's apparent inability to improve HQ outcomes. A continuously growing bureaucratic quagmire, system complexity, managed care, excessive drug prices, significant increases in the costs of sickness insurance,[14] and access issues have not improved the consumer's mood much of late. A case in point is the growing nationwide consumer unrest over pharmaceutical industry practices, including the apparent lack of interest by the medical community in coming to the consumer's aid, or worse, being part of the conspiracy. Consumer dissatisfaction, although sometimes having little to do with the technical facets of healthcare, generate large numbers of complaints, which often have a role in developing lawsuits.

The author's experience and studies suggest additional, poignant observations regarding cultural-based HQ issues, and why it may be difficult to overcome them. Denial plays a part.[15] Some governance principals simply do not acknowledge (or wish to acknowledge) that the numbers are as significant as the IOM and other reports suggest. It may be speculated that to admit such might invite criticism from one's superiors, a clinical constituency, the press, or encourage more aggressive legal attention. Thus, fear of malpractice plays a part because it is a part of the medical community's professional culture that any expression of doubt will invite lawsuits and/or loss of confidence in the system, despite evidence to the contrary. Some argue that attorneys on both sides of the equation have little interest in trying to correct this perspective because it is not in their interest to do so. A related issue to both fear of malpractice and waste and abuse (see below) is the excessive exposure to technology generated by the practice of defensive medicine. Please note this is not the same as

actual malpractice wherein harm ensues through carelessness or incompetence. Fraud, waste and abuse plays a part through deliberate overuse and inappropriate use of technology, the chemicalization of medicine,[16] conflict of interest, and deliberate fabrication of inputs or outcomes for personal gain or cover-up. Given corporate negligence and malfeasance in today's market, one might suggest that insurance entities should be included within this area of concern. Greed plays a part. In the healthcare enterprise, as with other enterprises, maximizing the "bottom line" has long been recognized as a powerful blindfold to reality, and has allowed many a corporate leader to stumble onto the slippery sloop of allowing whatever it takes to succeed. Overwork and understaffing[17] plays a part. Recent studies have confirmed what medical care workers have insisted upon for years; that there is too much pressure to do more with less, to perform without adequate rest, or working too many consecutive hours. We, as a society, would never accept the level of sleep deprivation and work hours in transportation and other safety sensitive industries that is a part of our corporate and professional culture in healthcare. Professional arrogance includes not only a refusal to admit mistakes, but actually blaming other persons and things for problems. A related factor is the long held, yet antiquated, tenant of medicine that the "doctor" – and only the "doctor" – is responsible for the quality of healthcare. Clinicians, the courts and other HQ constituencies have held differently. [18] Corporate negligence plays a part through unwillingness and/or inability to provide the leadership (motivation; accountability), resources (money; people; information) and support (education and training; empowering employees and the institution to act without fear). Nurses, for example, have long asserted that lack of respect for their knowledge, skills

and abilities, especially by the physician community, has contributed to their disillusionment and burnout. Further, the argument goes, a concomitant lack of management support against such abuse, along with a lack of empowerment, has helped contribute to a nurse “shortage” and thus foster negative HQ. Lack of applied technology plays a part. In order to monitor and use the latest technology all persons in the healthcare marketplace need to be “wired.” In some communities the consumer has become proficient at virtual self-care while some clinicians still do not use E-mail in their practice. Another factor is that technology has been shown to be effective in reducing medication and procedural errors.

So what, if anything, can we do about HQ? Can we get past the idea that more training, more intensive monitoring, more intrusive documentation, more criticism of one’s personal work versus the system, or more money will make things better? What makes us think that reinventing peer review will work? It has rarely had a positive impact on HQ. What makes us think six sigma will do anything that TQM or CQI was unable to do? After all, they involve substantially the same processes. Why should we believe the solution to cap malpractice insurance claims will have a salutary effect?

There is just as much evidence this will have a negative impact, as well as unleash a number of additional social and economic evils. The author contends that we keep reinventing the same processes and pouring money down a black hole of uncertainty because it is in the self-interest of some core constituency. Even if we did hit upon a HQ panacea we might not be able to implement it because doing so could run counter to one or more of the multiple cultures of relevant stakeholders. If we do not find a way to deal with the cultural issues associated with HQ we may have to be

content with an optimal level of HQ, as opposed to perfection, with all of the expense and frustration that entails.

Suggestions for improvement. Since we have not been able to bring HQ within acceptable boundaries through the efforts noted above, does this mean we should stop trying? Probably not. Here, then, are some suggestions for improving HQ. First, we have to admit that what we have been doing is not sufficient to fix the HQ problem. Rather, what we have been doing is spinning our wheels in place. Any form of continued denial is not going to help. Perhaps we should consider the idea that the culture of core constituencies plays an overriding part in the process. Second, consumers must be incorporated into the healthcare family as full partners, although this clearly goes against the predominate culture of the collective healthcare establishment. They must, however, be provided the education and training to understand their options, and be held accountably where appropriate. Third, we need to get over the “they’re out get me syndrome.” The evidence supports that the vast majority of lawsuits, complaints, and other expressions of concern about HQ are deeply felt perceptions. Fourth, we need to demystify medicine. The closed medical culture has been one of secrecy and exclusion for too long. Fifth, we should recognize that the WEB is creating a new paradigm of medicine. Organized medicine and healthcare institutions can lead this paradigm revolution or become tossed in its wake. Sixth, healthcare managers must become more responsible and accountable. Boards must begin to accept not only their fiduciary responsibilities to the organization, but also their special and unique responsibilities to the healthcare consumer and society. This includes controlling misuse of technology and inappropriate behaviors of

providers. Further, those responsible for healthcare governance should stop using the legal community as a screen to cover their own unwillingness to take the hard decisions to address HQ issues. Seventh, we need to automate, automate, and automate. Healthcare is too complex, growing too fast, and has long since surpassed the ability of any person, place, or thing to keep track of all that is going on. Standardized smart cards, fully automated records and other electronic technology should be incorporated into a mandated, nationally integrated system as soon as possible. In summary, the author contends the core problem is that relevant stakeholders have a set of opposing cultures, and are not ready, willing, or even able to cooperate or change. This is going to remain true regardless of how much effort or money we invest in other HQ areas. Unfortunately, there is evidence that the players either do not want to change, or cannot change. The fear of loss of control, or influence, or income, or power is a significant motivator for keeping things the way they are, regardless of any consequences. In short, we may need to find a way to act upon the multiple cultures that influence the outcomes of healthcare in order to improve healthcare quality.

The author invites commentary on this paper.

References and notes

1. Any definition of "healthcare quality" (HQ) varies with the advocate and/or audience at any given moment. Most writers on quality feel compelled to contribute their own understanding of the concept. To this end, I contribute that healthcare quality is "healthcare wherein the outcome of service provided is what was intended by the provider and expected by the consumer, based on meaningful, useful, and understandable information for all parties, has value to the intended parties, and does not harm the person it is intended to help." (emphasis intended) Also germane is the notion that quality is in the "eye of the beholder. " For example, a physician may honestly believe s/he is providing a high quality of health care given the vicissitudes of science and people coming together under conditions of stress and uncertainty. To a grieved parent or spouse, however, or their attorney, it may look like a different situation entirely.

2. Culture as used in this paper includes the learned and socialized values inherent in a person's belief system. These values have social, psychological, and economic components that influence and govern an individual's behavior as well as the immediate social group of which they are a part. For professionals, culture includes values that are part of their professional worldview and to which they have a strong affinity. Like all greater social values, these embody rituals, taboos, and "tribal"

requirements, admonitions, and sanctions, and cannot easily be thrown off or ignored. “Corporate culture” is a part of the equation as well. The author acknowledges that he is not the only one to suggest a link between culture and quality. The link has been long established from the works of Peter Drucker to W. Edwards Deming et al., as a principle of TQM/CQI and in many other facets of the management process. Culture has also been implicated in IOM studies referenced below. The author does contend, however, that he has broached the issue from an unusual perspective.

3. McGlynn, E.A., Ph.D., Asch, S.M., M.D., et al. (2003). “The Quality of Health Care Delivered to Adults in the United States.” *New England Journal of Medicine*. N Engl J Med 2003;348:2635-45 (June 26, 2003).

4. Total Quality Management-like concepts are now a part of all primary economies. Quality is considered a competitive strategic requirement. If one desires to do business in today’s global market, whether involving pharmaceuticals, durable medical equipment, transportation vehicles, or other products, they will need to meet rigorous standards imposed by international bodies, such as the International Standards Organization (ISO).

5. The author assumes that these organizations are familiar to readers of this journal. Space allowed for this article does not permit detailed documentation for each item. If any reader wishes verification or details the author will be pleased to discuss this. The HQ aspects of these organizations may also be explored on the WEB under their respective names.

6. Respectively: Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Consumer Product Safety Commission

(CPSC), Food and Drug Administration (FDA), and Health Resources and Services Administration (HRSA).

7. Institute of Medicine. (1999). “To Error is Human: Building a Safer Health System.” http://www4.nas.edu/news.nsf/isbn/0309068371?OpenDocument

8. Starfield, B. M.D., M.P.H. (2000). “Is US Health Really the Best in the World?” *Journal of the American Medical Association*. JAMA 2000; 284:483-485 (July 26, 2000).

9. *Kaisernetwork.org*. Daily Health Policy Report. “Medical errors, unnecessary treatments, misused drugs costs U.S. employers $390B a year.” Discussion of a report sponsored by the Midwest Business Group on Health. June 11, 2002.

10. Six sigma is a quality control process that Motorola developed in the 1980s. It seeks to reduce error rates to below 3.4 defects per million by designing quality processes into the production cycle. It has a lot of characteristics similar in concept and function to total quality management.

11. Managers for large corporations, because of concerns with healthcare costs, complaints by workers, their families, and union representatives, already under pressure because of using managed care in their benefit structure, formed quality-based groups such as Business Roundtables and Leapfrog. For example see: “Quality Health Care is Good for Business” @ http://www.brtable.org/document.cfm/73. Also, “Consumer Protection and Quality in the Health Care Industry.” On line at: http://www.brtable.org/document.cfm/72. For Leapfrog, see “Leapfrog business group wants to jump-start patient safety issues.”

Prager, L. *AMNews* (Dec. 4, 2000) On line at: http://www.ama-assn.org/amednews/2000/12/04/prsb1204.htm.

12. National Council for Healthcare Leadership (NCHL) On line at: http://www.nchl.org/ns/about/aboutnchl.asp. NCHL is a recently formed "not-for-profit organization that works to assure that high-quality, relevant and accountable leadership is available for all healthcare management disciplines including nursing and medicine to meet the challenges of delivering quality patient health care in the 21st century." (emphasis added) There is speculation among some healthcare managers that NCHL's founding principals and supporters believe that other healthcare leadership organizations, such as ACHE and AAMA, have not been adequately responsive to leadership-related HQ issues.

13. *Darling v. Charleston Community Memorial Hospital*. 211N.E.2nd 253 (Ill 1965), *cert. denied*, 383 U.S. 946 (1966). This landmark case held that the Board and nursing staff, as well as the physician, could be held accountable for negligence.

14. The author subscribes to the notion that the primary purpose of "healthcare" insurance in the US is to respond to "sickness"; and has little to do with providing, maintaining, or encouraging health. He further contends this is a deeply ingrained cultural attribute in the US. Therefore, evidence that it is an inappropriate, wasteful, costly, and morally questionable practice is moot

15. Personal communications with a number senior executives of medical facilities and providers over the years. Also supported in the literature.

16. Chemicalization of medicine is the authors description of a process of providing drugs (chemicals) as a dominate, and often first line, of medical treatment modality.

There is an increasing body of information wherein visits to clinicians result in prescriptions for antibiotics, antidepressants, and a number of other chemicals. All too often this occurs without adequate (or any) history, examination, or attempt to explore alternatives, thus exposing patients to expensive and potentially harmful chemicals. It is contended that pharmaceutical firms and patients contribute to this because of marketing and business strategies.

17. *ACHe-news* (May 31, 2001) "HRSA Study Finds Strong Link between Patient Outcomes and Nurse Staffing". See Also: *Joint Commission*. "Nursing Shortage Poses Serious Health Care Risk: Joint Commission Expert Panel Offers Solutions To National Health Care Crisis" (August 7, 2002) Online at: http://www.jcaho.org/news+room/news+release+archives/nursing+shortage.htm

19. Berwick, D.M., Godfrey, A.B., and Roessner, J. (1990). Curing health care: New strategies for quality improvement. Jossey-Bass Publishers: San Francisco. (p.16). See also *Darling* at note 13 above.