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Meeting Report

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Effectiveness, efficiency and excellence: can they coexist? This was the provocative question that drew 260 registrants from across Canada to the CMA's Fourth Annual Leadership Conference in Ottawa in late February. A strong lineup of speakers and workshops ensured that all sides of the issue were discussed, including some that physicians aren't anxious to hear about.

In a CMA-sponsored survey conducted last year, 72% of physician respondents said patient satisfaction is the key consideration when quality of care is being measured. But conference speakers suggested that relying too strongly on patients' perceptions might actually misdirect efforts to improve care.

The remarks of Pranlal Manga, PhD, a health economist with the health administration program at the University of Ottawa, may have left some members of the audience a little dazed – the language economists use often does that to physicians. However, his may have been the pivotal presentation at the Conference. First, his comments brought isolated clinical and administrative issues into context in the cruel, hard world of budget constraint. He also told doctors that, although their efforts to improve quality have considerable merit, they are attempting to bring about these improvements in entirely the wrong fashion.

“Too many (institutional quality programs) focus on administration or managerial issues,” he said. “I think they are approaching quality of care in a circuitous way.” He added that there are probably good reasons for this roundabout route, “one of them being physician resistance”. Manga suggested that in most cases caregivers fall into the trap of believing that offering the maximum number of services or the maximum quality of service to the patient is the way to improve the quality of care.

¹ This report by Judith David of the Canadian Medical Association's Department of Publications appears simultaneously in this Journal and in the CMA Journal, by kind permission of the Editor of the latter.

In a workshop session that same day a speaker with arthritis and one with AIDS argued that patients speak authoritatively when they discuss the quality of care they receive. But patients' opinions may actually be misdirecting current efforts to improve the quality of care, especially in institutional settings. Allan Gregg, president of the polling firm Decima Research, presented survey results that revealed the public has strong opinions about quality.

However, the opinions were not, in fact, about the quality of care but about how the care was delivered. Unless something goes grossly wrong during treatment, the public will have insufficient reason to be concerned about, or have opinions on, the care itself. The only measure, then, can be the way in which the care was delivered.

Likewise, Manga suggested, current quality-related programs address the processes of care almost exclusively rather than confronting quality of care head on.

Improved quality of clinical care can result from improved processes, though. Dr. Donald Berwick, the keynote speaker, is principal investigator for the United States National Demonstration Project on Quality Improvement in Health Care. He cited the case of Melissa, a 9-year-old patient admitted to hospital with a kidney infection. In the emergency department the attending physician followed procedure by ordering a regimen of powerful nonspecific antibiotics, which would be employed until the infection could be identified. However, the girl's urine sample was either misplaced, mislabelled, lost or broken. Or perhaps the analysis was never done, he added, because the sample never made it to the laboratory.

Whatever the cause, the result of these lapses in process was a child trapped in a 10-day regimen of powerful nonspecific antibiotics whose benefit could not be determined. In addition, the emergency room report on her record was entirely illegible: it contained the fourth page of a carbonless form. Improvements in management processes would have led to improvements in the care Melissa received, Berwick argued.

Dr. Ron Wensel, chairman of the CMA's Committee on the Quality of Care, went further. "Hospitals are processes," he said. "The admitting process, the transportation process, the collection of blood, the delivery of lab results, the booking of operating rooms – all of that is process. The advantage of total quality management is that you look at each of those processes, flow-chart them, break them down into their components, and look for the opportunities to fix the things that could be improved."

To what end are these improvements made? Wensel pointed to research done by Berwick that showed inefficiency or wastage account for 20% to 40% of hospital expenditures. The waste is found in cancelled tests, in needless tests, in late bookings for X-rays and lab work, in inefficiency. "Savings achieved by reducing inefficiency represent resources that can be otherwise used to provide necessary care", said Wensel. He has proved it at the University of Alberta Hospitals in Edmonton, where he is vice-president for medical affairs.

But Manga had difficulty with Wensel's assertion. Without demeaning the efforts doctors are making, he said their attempts to improve quality are "bound to be very limited if you look at the issue of quality of care from the system perspective. I want to distinguish between the notions of optimality and maximiza-

tion. Far too often we talk about maximizing quality of care. Whether we talk about health, education or other things, our job should be the optimization of quality, not the maximization.

“Maximization is using the necessary resources to continuously improve the health of a single patient or of patients of one physician or hospital. It’s a very micro, or partial, view of what we’re trying to do. Optimization takes a much more holistic view toward making the best use of health resources for the benefit of the entire patient population. That would lead to a better overall result than would maximization.”

And, says Manga, because many of the organizational, structural and infrastructural issues that would optimize the quality of care are the responsibility of government, it has the most important role to play in improving the quality of care within the health care system. Physicians have an important place, too, he said, but their principal responsibilities lie at the micro level – at the bedside.

Regardless of their place, though, Manga said physicians have to change the way they think about care. Without minimizing the responsibility they have to individual patients, he said physicians also have to think about the responsibility owed to the system and to the patients of other physicians and patients in other hospitals.

Another speaker, Senator Michael Kirby, said governments have already begun to take managerial responsibilities seriously. He argued that policy options that were unpalatable a decade ago are now acceptable.

Another program highlight was the speech by Ovide Mercredi, national chief of the Assembly of First Nations. He stole a few minutes from ongoing constitutional negotiations with the Federal Government to address a plenary session on the health needs of Canada’s Indian population. He invited doctors to be partners in restoring Indian culture.

Mercredi’s comments focused on the relationship between health of a culture and health of an individual. “The reason we place so much emphasis on the inherent right to self-government,” he said, “is that it’s good for the mental health of our people . . . One of the reasons we have health problems in our communities is that our culture has been destroyed. Now we have to rebuild it, and that’s a long process . . . Self-government has to do with mental health – giving our people a chance to restore their communities, their culture, so that we can recover, begin to heal, begin to deal with the social and economic needs of our communities, the health and education needs, the justice needs. Our quest is to end exclusion, to try to be included in a fundamental way as part of the future of Canada.”

Dr. Carole Guzman, the CMA president, closed the conference with comments on issues raised by all speakers. She also outlined the CMA’s activities. “At the macro level, we are cosponsoring a utilization management congress in September. At the institutional and community-based levels we are developing regional educational workshops on quality and programs geared toward physicians in community practice.

“We are involved in facilitating the development and implementation of national practice guidelines. We need uniform methodologies, implementation strate-

gies and new applications. For this, we need a partnership with other key stakeholders. The CMA has already begun this process and will be developing quality criteria for guidelines at a workshop scheduled for the fall of 1992.”

Future issues of this *Journal* will focus on presentations made at workshop sessions during the conference.