Beyond the Quality Illusion: The Learning Era

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Abstract

By highlighting the intangible, personal, contextual, and illusory nature of "quality," the authors reconceptualize quality improvement as a pluralistic and moral journey. They imagine a new era of quality improvement in which patients and health care providers work together to understand and achieve quality. The authors recommend, for the path forward, a "travel kit" of 10 crucial elements—compassion, deliberation, flexible goals, ownership, the engagement of patients, the inclusion of payers, the involvement of learners, feedback loops, the fostering of learning, and the application of different sources of knowledge—to reframe quality improvement in a new era of learning.

Nobody is against quality. We may safely assume that patients, providers, and payers all want the right thing done in the right way. But does this ideal mean the same thing to—and for—everybody?

Care should be safe, effective, efficient, timely, equitable, and patient-centered.[1] The idea is to measure the health care provided to patients along these lines and, in turn, to base improvement on those measurements. This plan sounds reasonable, and it has led to a mushrooming of quality activities and a mature industry with its own routines and language; however, cracks in the system have become visible. Firstly, more and more health care professionals feel they do not have ownership of their own work, which creates stress and decreases meaning.[2] Health care providers, including physicians, want their work to be meaningful. They truly want to help patients, but many feel some pressure from the system to complete additional protocols devised to safeguard quality. Secondly, some critics have questioned the foundation of the quality movement (i.e., evidence-based medicine), voicing qualms about methodology, validity, and usability.[3] They have asked, for example, how does the quality improvement movement deal with multimorbidity? How should physicians make group evidence relevant for individual patients? Thirdly, sustainability is a concern; despite all quality efforts, costs are still rising.

Even though some physicians and others have addressed these issues, we think few have even considered the actual core of the problem. In this Invited Commentary, we add a more personal and philosophical touch. We start with a visit to the "consultation room" of a philosopher; then, attempt to conceptualize quality differently; and, finally, end with a "travel kit" of 10 crucial elements to include on the road to a new era of better care.

The Consultation Room of a Philosopher

On a golden afternoon I meet a philosopher at the entrance of our hospital.

He asks, "Where do you want to go?"

I look up at the sky, where a few clouds drift by, and turn to my companion: "Show me your consultation room."

The philosopher smiles. "Should I have been an ancient Greek, I would have taken you to the market square, but let's go to the forest."

"Why the forest?"

"Because," he replies, "It's a good place to get lost."

Walking away from the hospital, I share my concerns: "I want to help patients, but get stuck because of a mismatch between quality tools and person-centered care. For example, really listening to patients is not possible if I am to complete all of the time-consuming patient registrations by the deadlines set forth. The mismatch is something of a paradox that I cannot get my head around. My colleagues and I try to keep in touch with the energy and dreams we once had as young doctors—making a difference for patients. We sense a lack of quality in our work and blame the system for it, the world of protocols and indicators. Yet, at the same time we defend a concept of quality that has created this system and that puts pressure on our work."

"What kind of concept are you referring to?" asks the philosopher.

"That is what I wanted to talk to you about. I feel that we physicians have gone in the wrong direction."

A Physician's Odyssey

"Since when have you had that feeling?" the philosopher asks.

"I don't know … it has grown over time. As a student, I dreamt about helping people with reproductive problems and decided to become a gynecologist. During my training I acquired skills and knowledge, but I missed something. I often joke that I entered my medical education as a human being and left it as a medical specialist. When I started working as the head of an academic in vitro fertilization center, I was puzzled that no protocols, guidelines, or indicators were in place. Why did doctors use different procedures for similar patients? Why did in vitro fertilization centers keep their outcomes secret?

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To address such questions, my team and I developed protocols, guidelines, and outcome registries.[4] However, these tools were not used sufficiently and only slightly improved outcomes."

"Did you talk about that?" the philosopher asks.

"Maybe not enough" I admit. "We focused on implementation. We studied barriers and facilitators to creating and using the protocols and registries, and we evaluated strategies for improving adherence.[5] We learned a lot, but the effect was limited."

As we leave the hospital far behind and enter the forest, I continue my story: "Our major lesson was that we forgot to involve patients. How did they see quality? What were their preferences, needs, and expectations? How could they partner with us? So we offered patients online access to medical records and built online communities.[6] We involved them in developing guidelines and in measuring quality."[7]

"Looking back, what do you think about that time now?" the philosopher asks.

"We generated a lot of energy, but realized that we did not find ways to improve quality sufficiently and, importantly, that quality does not mean the same thing for each patient. That's why we developed personal health records[8] and did a trial on personalized decision making, allowing parents to choose to have one or two embryos transferred.[9] We also personalized treatment by asking patients for their preferences and needs. These initiatives were promising, but also disruptive for current quality tools."

I stand still, as does my companion.

"So here I am," I tell him, somewhat confused. "Quality tools have not brought me where I wanted to be. I see colleagues struggling with the gap between their dreams of helping people and the daily reality of practicing in a quality improvement environment. Somehow this whole journey has left me feeling uncomfortable and disheartened. That's why I decided to consult you."

The philosopher laughs: "So I should come up with a diagnosis now?"

I nod.

"Alright, your case history makes me think of a doctor's odyssey. You are probably homesick for your initial dreams of working closely together with patients to improve their well-being."

Heart and Mind

"Could be," I continue, "but I also have some fundamental problems with the definition of quality."

"All definitions are problematic," says the philosopher. "What counts is how they influence what people do in practice. Moreover, definitions keep changing over time. Quality has to do with what people actually value in their daily lives. It is intrinsically personal, and therefore local, historical, and contingent. We can never address that in a single, static definition."

"I like what you say about the importance of what people do in practice. Of course, improving safety, effectiveness, and so on is important. I am not cynical. I believe in progress. But we are missing the point. We have a culture of measurement nowadays. If a thing cannot be measured, it does not exist. But I try to think about the intangibles and what is important to each individual patient. I will always remember the patient who said to me: 'Doctor, I'm not an average patient. I'm special!' And she was right, of course. Every patient is a unique person with a unique story."

"So is quality about personal context?" asks the philosopher.

"Yes, very much so. Person-centered care is on the rise, luckily. I am glad that it has long been recognized as a dimension of quality. However, person-centeredness is not enough. The very core of the system is under attack."

"And that core is?" asks the philosopher.

"I don't know. Perhaps it has to do with knowledge, with truth even."

By now we have entered the depths of the forest, and neither of us has a clue where we are. We wander into an open space revealing what once must have been a pretty arbor, but which is now overgrown with shrubs and moss.

"Shall we pause here?" the philosopher asks, while he cleans a bench, wiping off dried leaves. "What a lovely place, an unexpected surprise." For a while we just sit in silence and listen to the birds in the trees.

After a while I break the silence: "Perhaps the core of the problem is about truth indeed, about how people frame reality. Is there a philosophical theory that could help us?"

"Tons of theories, but we do not need them. Let's just rely on common sense." Spreading out his arms, the philosopher asks, "For example, what do you see now?"

"I see trees, birds, clouds … and I see you."

"Do you see quality?"

"No, not really."

"Where is quality?" the philosopher queries.

"I don't know, maybe it is in our hearts and minds."

The eyes of the philosopher start to twinkle. "You just made an important distinction. Apparently, some things have an existence in the world, like those trees and birds, but other things, concepts that we use to make sense of that world, reside in our brain, like models, systems, and … quality."

"Yes, I can see the difference, but how is that helpful?" I ask.

"Well, it is helpful when people actually make that distinction, but many people don't."

I nod. "You are right: Many people see quality as an objective truth that can be measured just as the height of that tree can be measured. They seem to believe their measures to be neutral mirrors reflecting true quality. I think they do not see quality as something that resides in our hearts and minds."

"Indeed," says the philosopher, "the problem starts when people see their models as true and turn their back on the complexity of the real world. That creates an illusion."

"A quality illusion?"

"Exactly!" the philosopher says.

"But," I continue, as we begin seeking a path out of the woods, "In an effort to avoid being nihilistic, let's imagine what a new era, that goes beyond 'the quality illusion,' would entail."

Beyond the Quality Illusion

A walk in the woods is more than a physical experience; it is also an exploration of unknown territory. The philosopher and I needed this time in the unfamiliar to distance ourselves from the hospital environment and to rethink the concept of quality and explore next steps.

The currently dominant concept of quality has reductionist tendencies and is at odds with the dynamic complexity of today's health care. Too often, quality tools have become disconnected from the real world of people. Walking in unknown territory made us realize the importance of both embracing uncertainty and working together to learn and improve.

Into the Learning Era

We favor a new concept of quality that is dynamic, pluralistic, and moral. *The* quality does not exist; rather, quality differs according to the context and perspectives of the people involved. The crucial concept to grasp is that quality has a *moral* nature. Even as physicians and other health care providers choose particular measures of quality, they have already begun to employ certain moral notions about what is good or bad. We believe, therefore, that what counts as "good" is not something that can be discussed on the basis of "facts." On the contrary, "facts" themselves reflect a moral position.

This line of reasoning is not an attack on empirical research. Scientific data remain important. Research should be deployed to effect practice improvement even more than it does now, by getting closer to or becoming part of quality initiatives. To get there, health care providers should fight the misconception that data are without values and context. Just read the story by Katy Butler,[10] who writes about her father's pacemaker in the *New York Times Magazine*. The pacemaker was given on the basis of evidence-based protocols, but ruined her family's life. Stories like hers offer a glimpse of the depth, complexity, and wealth of the world beyond measurements. Most doctors know in their hearts that there are too many stories like Butler's. The way to go is not to update the protocol or add more numbers but, rather, to embrace the new concept of quality—that is, to start learning. We—health care providers and patients—are all on the road together, and quality is not a final destination but a journey itself. Health care providers should not deny the dynamic, pluralistic, and moral nature of quality but, instead, see it as the starting point of a journey of discovery. The quest is to discover how individual patients define quality and to work with them to achieve it.

Travel Kit

We believe that our contemplations in the woods have yielded some ideas for what to bring along on the quality journey. A travel kit that addresses the dynamic, pluralistic, and moral nature of quality should comprise the following elements: compassion, deliberation, flexible goals, ownership, the engagement of patients, the inclusion of payers, the involvement of learners, feedback loops, the fostering of learning, and the application of different sources of knowledge.

1. Compass of compassion

Being more meaningful starts with really listening to people—not only because listening is the decent thing to do but also because quality is found in the hearts and minds of people. Health care providers should receive training in narrative medicine and learn to value patient stories as crucial sources of knowledge.

2. Continuous deliberation

On the road ahead, those of us working in quality improvement need to talk to one another constantly. We have to test our moral assumptions and honor different perspectives in open dialogue. We have to share experiences and discover whether we frame situations in the same way.

3. Fuzzy goals

The quality journey needs fuzzy, flexible goals, not preset destinations and ordained measures. Fuzzy goals create room for creativity and learning. Too rigidly defined objectives inhibit performance, especially when those working toward the goals feel that they will not be achieved.

4. Ownership for professionals

Allow practitioners sufficient space to exercise their professional judgment while still being clear about which situations call for more or less personal discernment. Guidelines and protocols should help professionals be reflective practitioners, not make them uncritical automatons.

5. Patients on board

Including patients in quality improvement initiatives is an effective way to start a transformation.[11] Patients are experts on having the disease. Joining forces with these patient–experts expedites change, creates pluralism, and places the raison d'être of health care at the health care improvement table.

6. Payers as partners

Quality improvement can benefit from the participation of payers. If providers stop seeing payers as enemies and appreciate their legitimate role in cost containment, then the two stakeholder groups can, together, make care better for patients and more affordable for society.

7. Involvement of young professionals

Young professionals, including students and other learners, are curious and creative. Involving them brings original perspectives. Those in practice should invest in students and provide trainees with opportunities to learn from patients.

8. Iterative feedback loops

Medical practice can learn a lot from human-centered design practices that are iterative and make progress through cycles of fast prototyping and continuous testing. Practitioners should focus more on the local context and develop tools with built-in feedback loops that provide actionable data quickly.

9. Learning culture

Cultivating a learning culture would bring quality improvement into a learning era. Encouraging people's questioning and honesty instead of disciplining those who critique or make an error stimulates a climate of curiosity, drive, and openness. Such a culture is necessary for confronting a conspiracy of silence, an unsafe environment where nobody learns from mistakes.

10. Different sources of knowledge

Quality improvement in an era of learning requires critical practitioners who use all kinds of knowledge sources, including patients' stories, local data, big

data, and, yes, scientific data gleaned from evidence-based medicine.

Health care is a large enterprise, and changing it is not easy, but it needs changing. When we start to see quality improvement as a shared journey, together we will initiate a new era of learning.

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