Believe it or not, there was a time when data and measurement were not at the center of the healthcare debate. For example, when a patient went to see a doctor back in the 1960s, 1970s, and 1980s, he or she usually said, “Thank you very much, doctor. Do I need to schedule a follow-up appointment?” Today it is more likely that the patient will ask questions such as: “Where did you get your medical degree? How many times have you done this procedure? What is your complication rate for this procedure? Do you have data to show that this procedure will improve my health? Have you had a malpractice claim filed against you in the past 5 years?” Then, if the patient is really actively involved in his or her own healthcare delivery, he or she will probably pull out a piece of paper and inform the doctor, “This is what I found on the Internet last night and here is what I think is wrong with me….”

Over the past two decades the healthcare industry has moved away from being an industry based on high levels of trust and partnership between physicians and their patients to one of gentle (and at times not so gentle) tension between those who provide care, those who receive it, and those who pay for it. Whenever society begins to lose confidence in an institution, however, there is typically a demand for greater oversight of the institution and a related push for more data on the products or services it provides. This is precisely what has happened and is happening within the healthcare industry. As consumers, political leaders, the media, and the public in general have increasingly asked questions about the efficiency, effectiveness, and reliability of healthcare services, there has been a concomitant growth in the demand for more data on healthcare providers and results.

For decades, providers have been collecting what is classically referred to as administrative data (e.g., in a hospital these data included the number of admissions and discharges, percentage of patients who die in the hospital, percentage of patients discharged to home or nursing homes, number of lab tests performed, visits to the emergency department, number of setup and staffed beds, resource usage, average length of stay, and selected infection rates). These data have routinely been used internally to make
management decisions and then submitted externally to various oversight or regulatory bodies at the state, regional, or national levels at designated points in time for aggregation. Typically, these data are lagged anywhere from a few months to a year or more. Analysis of administrative data is usually performed using summary statistics (e.g., the mean, median, mode, minimum, maximum, range, and standard deviation) and comparisons by quarter or year are often the preferred approach to determine whether time period 1 is different from time period 2.

Healthcare administrative data are still collected on a regular basis around the world. Yet over the past 15 years, three key developments within the healthcare industry have had a profound impact on moving healthcare measurement and data collection in new directions: (1) the growing demand for greater transparency, (2) the growing focus on patient-centered care and concerns over poor service, and (3) the growing role of quality improvement (QI) concepts, tools, and methods.

### The Growing Demand for Transparency

Even though the discussions on transparency in healthcare have increased significantly over the past few years many people fail to realize that this is not a new topic within the healthcare profession. Three individuals specifically played key roles in the earlier debates on data disclosure in healthcare settings: Florence Nightingale, Ernest Codman, and Francis Peabody. Florence Nightingale (1820–1910) is probably the best known of this threesome. She was one of the first advocates for data collection and release. Her work in the Crimean War is legendary. She wrote *Notes on Matters Affecting Health, Efficiency and Hospital Administration of the British Army* (1858), which detailed not only her experiences in caring for the war's wounded but also provided detailed recommendations for reforming the organization and delivery of care within the British military hospitals. She developed statistical graphs to summarize the causes of mortality, known as Polar Area Diagrams (Figure 1-1) and then used these data to criticize the unsanitary conditions that prevailed in military hospitals and decried the incidence of preventable deaths. Although she did have her critics, she was not vilified nearly as much as the most ardent proponent of transparency, Dr. Ernest A. Codman.

Dr. Ernest Codman (1869–1940) is best known for his controversial “end results” system. “The end result idea is simply that doctors should follow up with all patients to assess the results of their treatment and that the outcomes actively be made public” (Swensen and Cortese, 2008, p. 233). As a prominent surgeon in Boston, Codman was a firm believer in making data not only more available to those who deliver care but also that it should be provided openly and freely to the public so they could make informed decisions on which doctors and hospitals they would use. His colleagues at Massachusetts General Hospital and Harvard Medical School (he graduated in 1895) favored many of his suggestions and recommendations for improving treatment procedures and outcomes as long as the information and data stayed within the medical profession. It was Codman’s insistence that the public have access to these results that created the major controversy. Codman held fast in his beliefs but it was at a price. He received stern criticism from his colleagues at Massachusetts General Hospital when he proposed the outlandish notion that data on physician and hospital performance should be released to the public:

> I am called eccentric for saying this in public; that hospitals, if they wish to be sure of improvement, must find out what their results are, must analyze their results, to find out their strong
and weak points, must compare their results with those of other hospitals and must care for what cases they can care for well. Such opinions will not be eccentric a few years hence. (Codman, 1917, p. 183)

In 1914, his hospital refused his plan to evaluate the skill and outcomes of surgeons. Eventually, he was denied privileges at Massachusetts General Hospital, which led Codman to resign and establish his own hospital (interestingly enough called the Codman Hospital and also the End Results Hospital) where he could further his practices of transparency and disclosure of patient results. In 1916, he privately published a compendium of his hospital’s results from 1911 through 1916 including the “clinical misadventures” that he and others had made (Codman, 1916, 1924; Donabedian, 1989; Neuhauser, 1990). Dr. Codman was clearly a man ahead of his time. He saw the medical profession as a caring and compassionate discipline but one in which there was an obligation on the part of the providers of care to be open and forthright with the results of their work. Unfortunately, this was a message that was not appreciated in the early 1900s by his
colleagues. In 1914, Dr. Edward Martin wrote to Codman the following:

Dear Codman:

God bless you! I suppose I should hate you if I lived in the same town, but my feeling, being remote, is quite other. Indeed the very enemies who lurk in second story windows with muffled rifles are waiting your passing, are the ones who take off their hats in deepest respect as your cold, but beautiful, corpse is carried away. (Mallon, 2000, 63)

Codman remained steadfast in his beliefs and practices. In the end, however, the profession’s dissatisfaction with him and his insistence on the end results system continued to grow. Although no one actually took shots at him, he did spend the last years of his life with few patients, no referrals from his medical colleagues, and little money. During his final year of life, he wrote that in the future he hoped that he would receive more favorable reviews than he did while he was alive (Mallon, 2000). Berwick in a Milbank Quarterly article (1989, p. 266) offered a postscript on Codman’s life and work, “Codman looked ahead. He looked, indeed, beyond us. Seventy-eight years ago he began his life’s work; forty-eight years ago he died. Are we ready for him yet?”

The third individual who helped to set the stage for a dialogue on transparency is Francis Peabody (1881–1927). Although less well known than Florence Nightingale and certainly less controversial than Ernest Codman, Dr. Peabody made major contributions to the healthcare field as a clinician, teacher, and researcher. He is best known for stressing transparency with individual patients and involvement of the patient in making care decisions. His basic philosophy was captured in a series of lectures to students at Harvard Medical School in 1926 and subsequently published under the straightforward title, “The Care of the Patient” (Peabody, 1927). Several key quotations from Dr. Peabody’s classic 1927 article provide not only guidance but also a challenge for today’s medical professionals:

The treatment of a disease must be completely impersonal; the treatment of a patient must be completely personal (1927, p. 878).

The good physician knows his patient through and through, and his knowledge is bought dearly. Time, sympathy and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient (emphasis added by author) (1927. p. 887).

The fact that Dr. Peabody stressed the need for transparency between the physician and the patient is probably one of the key reasons that he was highly regarded by his colleagues and Dr. Codman was not. Codman’s insistence on the public disclosure of all hospital and individual practitioner data challenged the existing status quo. Peabody on the other hand was seen as a compassionate and caring physician who was devoted to the individual patient’s needs and expectations. This was something that could be addressed quietly in the privacy of the doctor’s office and in one-to-one conversations with the patient. Such behaviors did not threaten the status quo of the medical profession as did public postings and disclosure of results proposed by Codman. Furthermore, Peabody did not stress that the individual physicians who did not engage in these open exchanges with patients should be publicly identified. It was, in his view, all a matter of personal taste and preference, and the results should be discussed only between the physician and the patient. For additional detail on the life and practice of Dr. Peabody, see Oglesby (1991) and Hurst (2011).
The Growing Demand for Transparency

If we fast forward from the transparency pioneers of the early 1900s, we realize that many of the barriers they campaigned against are still with us today. Despite the growing push for greater transparency in healthcare data, there is still considerable confusion and lack of consensus surrounding this topic. The classic definition of transparency (Webster's Dictionary, 1984) is that it is something that is easily detected; obvious; readily understandable; clear; without guile or cover; candid; clearly perceived; lucid. This seems to provide a reasonably straightforward set of definitions and criteria. But in a healthcare setting, the question of transparency has not been quite so straightforward. A colleague of mine, for example, told me he thought that transparency is “A frequently used term in healthcare settings that has no apparent consistent definition or meaning.”

Transparency has been and will continue to be a challenge conceptually, operationally, and politically. A few examples of recent transparency challenges are worth reviewing.

- An article in the Chicago Tribune (March 28, 2013) had the following headline, “Do Hospital Ratings Bring Clarity or Confusion?” The story led with the following conclusion: “Patients left to judge credibility of rankings groups and an array of data.” The article focused on St. Mary Mercy Hospital in Livonia, Michigan. The hospital received rankings in terms of quality and safety by four different organizations. The results showed that the Leapfrog Group gave the hospital an A rating. Healthgrades named the hospital as one of the top 50 hospitals in the United States. At the other end of the spectrum, however, the Joint Commission (JC) and U.S. News & World Report excluded St. Mary Mercy hospital from their lists of “best hospitals.” Finally Consumer Reports gave the hospital an average rating of 47 out of a possible 100 points. The article also describes how the Medicare program will be reducing the hospital’s payments owing to poor performance related to Medicare quality measures. If you were a patient living in the Livonia, Michigan area and trying to decide which hospital to select for your knee replacement surgery, how would you use these results? The data are made public, so this is not so much an issue about reporting data to the public but rather a lack of consistency in developing public reporting methods and systems, which is one of the serious issues related to transparency in the United States.

- The April/May 2013 issue of AARP: The Magazine made its first foray into the transparency arena when it published an exclusive report titled “America’s Safest Hospitals: Is Yours on the List?” When you read the article, however, you discover that AARP (formerly American Association of Retired Persons) did not do the assessments but partnered with the Leapfrog Group to prepare the report using the Leapfrog Group’s methodology and their 26 measures. A total of 66 “safety superstar” hospitals are listed in the AARP report. Although singling out 66 of the 5,724 hospitals in the United States may bring comfort to those who live near these facilities and recognition to the hospitals, it makes you wonder how well these 66 institutions would fare if they were assessed by the other organizations that rated St. Mary Mercy Hospital (i.e., Healthgrades, the JC, U.S. News & World Report, and Consumer Reports).

- Even though AARP The Magazine published the safest hospital list in their April/May 2013 edition, the July/August edition of another AARP publication, AARP Bulletin, included an article titled “Lifting the Veil on Hospital Rates.” This piece lauded the recent releases by the government showing what U.S. hospitals charge for various inpatient procedures, noting that this “may be ushering in a new era of transparency in healthcare costs, which have long been closely guarded by hospitals” (AARP Bulletin, July/August, 2013, p. 4). Although the release of such data is a step in the right direction, the challenge
A more dramatic response to the release of hospital ratings comes from Dr. Ezekiel Emanuel, the University of Pennsylvania bioethicist and oncologist who helped the White House draft the healthcare reform law. In the July 25, 2014 edition of The Wall Street Journal Dr. Emanuel’s sharp criticism of the U.S. News & World Report’s “Best Hospitals” rankings starts with the claim that they are “flawed to the point of being useless.” He continues his critique by pointing out that the rankings are based on an overreliance on reputation and a failure to take into account quality indicators, such as hospital-acquired infections and the incidence of preventable falls and pressure ulcers. His conclusion is that hospital rankings are good only for “media hoopla and a few chest-thumping press releases from hospitals at the top of the list.” Reading this story caused me to reflect on when I worked for the Hospital Association of Pennsylvania during the mid-1980s. The first hospital rankings report issued by the Pennsylvania Health Care Cost Containment Council (PHC4) was received with mixed reactions. Yet, a few of the hospitals that were ranked in the top decile of about 300 hospitals took it upon themselves to place ads in local newspapers extolling their good outcomes and high quality. Interestingly enough the next report released by the PHC4 was not so kind to some of these top-ranking hospitals. In turn, there were a few ads in local newspapers placed by competing hospitals pointing out that those who were previously ranked in the top decile had now fallen from grace. The ranking sword can cut both ways! The Healthcare Business Blog from Modern Healthcare documents this story at http://www.modernhealthcare.com/article/20130725/BLOG/307259986.

If we move from hospital transparency to physician transparency the challenges become even more pronounced. If Dr. Codman was alive today he would probably feel that not much progress has been made since he advocated for his end results.
A recent issue for transparency in the physician arena is the manner in which physician payments are determined. The American Medical Association (AMA), the chief lobbying group for physicians in the United States, meets confidentially each year to determine what values (time and intensity of a procedure) should be assigned to the services and procedures performed by physicians. These value assessments are then turned over to the Centers for Medicare and Medicaid (CMS) to establish the actual payments being made to physicians for treatment of eligible Medicare patients. A recent investigation into this practice (Chicago Tribune, July 26, 2013, section 2,10) revealed that the values and subsequently the payments to doctors are “so exaggerated that many doctors ‘averaged’ more than 24 hours of work per day.” In a study of 340 doctors at outpatient surgical clinics in Florida, it was discovered that the doctors performed at least 16 hours of procedures each day, even though most of the clinics were open for about 10 hours each day. The study also discovered that 78 of the 340 doctors actually fit 24 or more hours of work into a day. Twenty-one of the doctors actually filed reports (and claims for payment) that showed they fit over 30 hours of procedures into a 24-hour day. As a result of this new transparency in the way physician payments are derived a bipartisan group of legislators has drafted a bill that would require the reshaping of the way Medicare pays doctors.

The issue of transparency as I mentioned earlier, is not restricted just to the United States. In England, for example, The Daily Telegraph (June 13, 2013, no. 49, 157) had the following headline on the front page: “How Bad Doctors Can Hide Failings.” The story details how the National Health Service (NHS) developed “league tables” that would show doctor-specific results for selected surgeries and treatments. All this seemed like a good idea designed to assist patients in selecting “top performing doctors.” But the newspaper’s reporters discovered that the NHS has been contacting doctors and asking whether “their” data can be released. Those who refuse to have their results released will not have data relating to their performance published and they will not be identified for refusing to participate in the release. A high-ranking government official told the newspaper that this was a “farcical situation.” Jeremy Hunt, the Health Secretary for the English NHS, stated that “The medical profession has closed ranks to stop patients finding the truth.” He concluded that “transparency and participation must be the operating principles of the NHS. They can lead to more effective health care, better outcomes, greater accountability and efficiency.” In response the Royal College of Surgeons said that doctors are covered by data protection laws and that therefore they must give their consent before their data can be released to the public. Yet Mr. Hunt indicated that the NHS is proceeding to release individual surgeon data within several months on 10 different surgical specialties. They then expect to release data on all doctors, including general practitioners, over the next year and a half. Referencing how the release of similar data on individual surgeons in New York State put pressure on poor performing doctors and led to improved...
treatment and outcomes, the NHS Department of Health concluded: “Patients should be able to see how individual senior doctors are performing. If there are legal grounds for individual doctors opting out, any patient and their family would be entitled to ask why and may prefer their operation to be carried out by someone who was prepared to be fully transparent” (Daily Telegraph, June 13, 2013, no. 49, vol. 157, 2).

In the midst of all this controversy and the challenges surrounding transparency, there are some guiding lights. There does seem to be a growing realization, even on the part of providers of care, that greater transparency in health care is not only a good thing but an inevitability. So, how can leaders become better prepared to address the transparency issue? Dr. Jim Reinertsen, a senior fellow at the Institute for Healthcare Improvement (IHI), developed guidance for increasing an organization’s awareness of and practice in transparency. He calls it “how to go naked” (Reinertsen, 2012). Reinertsen identifies four specific things leaders can do to motivate greater transparency:

■ **Start undressing at the top.** By this he means that board reports are too often all about good news, which leads the board members to think that quality and safety are much better than they really are. He encourages senior leaders to clearly identify the good, bad, and ugly events for the board without rationalizations and language that “explains away suboptimal performance.”

■ **Don’t hide behind your lawyer.** Dr. Reinertsen stresses that too many healthcare organizations’ lawyers “require that safety data discussions occur behind a thick veil in apparent belief that they are protecting the institution from legal risks” (p. 42). He suggests having a dialogue on this stance is critical to an organization’s orientation to transparency. He also points out that as one health system lawyer told him, “Patients don’t learn they got hurt by seeing a PowerPoint slide. They don’t sue us because of our data. They sue us because of broken relationships. How can we get on with the job of making care better if we can’t talk openly about what goes wrong?” (p. 42). Increasingly healthcare providers are being more open with their data despite the legal concerns of some. It is not uncommon, for example, to see data on the number of days since the last pressure ulcer or fall posted on the wall of a hospital unit. This is occurring more in countries outside the United States where malpractice claims are not as prevalent but there are plenty of organizations that are not hiding behind their lawyers.

■ **Keep it simple.** This point is an extension of the previous recommendation. The essence of it is that you do not need to purchase and install an expensive, complex, and automated data repository in order to understand the current status of quality and safety within your organization. Plotting run or control charts by hand and posting them on the unit for staff and the public to see provide the foundation for improvement. Rather than wait for monthly or quarterly data to be aggregated in the expensive, complex, and automated data repository in order to understand the current status of quality and safety, the previous recommendation stresses (1) establishing a baseline on current performance, (2) posting data as close to production as possible (e.g., daily or weekly), and (3) making sure that even suboptimal performance is posted when it occurs rather than calculating averages that meld the anomalies into large aggregations and make them invisible.

■ **Shape up!** The final recommendation on how to go naked is based on a phrase from Tapscott and Ticoll (2003), “If you’re going to be naked, it’s good to be buff.” Basically this refers to the fact that patients do not seem to make choices about healthcare providers (doctors or hospitals) based on publicly reported data, even when these data are available. But when staff sees data
that show their department or unit is not performing well they do take notice and start to ask how they can shape up. Because staff and managers are frequently engaged in the details of day-to-day work, they frequently do not step back and ask, “How are we performing over time?” Caregivers struggle with the N = 1 challenge; that is, they think of the individual patient, surgery, or procedure and generally do not look at how their systems and processes are performing for groups of patients over time. This would be similar to a person who wants to get into shape and lose weight saying, “I ate only a salad yesterday and some fruit, so why do I weigh the same today?” The question of getting into shape is not answered by the detailed analysis of one meal or even one exercise session or the average hand hygiene compliance for the year. The answer lies in being able to track performance over time, not at a single point in time. Improvement is more like running a marathon rather than engaging in a sprint.

Some organizations have started to adopt some of these suggestions for “going naked.” For example, in an effort to promote price transparency Steven Sonenreich, president and chief executive officer of Mount Sinai Medical Center in Miami Beach, Florida, made a promise during an interview with a local radio station to post the contract rates Mount Sinai Medical Center pays private payers for diagnoses and treatments. Sonenreich then went a step further by challenging all other hospitals in the Miami area to do the same. Sonenreich gained national attention for his candid promise of transparency and his challenge to the other hospitals (Gamble, 2013). This example illustrates what can be done to change the status quo and move toward greater transparency not only of pricing structures but also results and processes. Hospitals that make public promises, set measurable goals, and execute strategies to share price information and results can use this transparency as a competitive advantage. If one hospital in a community demonstrates transparency with its data while other hospitals hold back, this will undoubtedly send a message to patients, political leaders, and groups that commission healthcare services that at least one provider is not hiding behind its lawyers or being secretive. The transparent hospitals will benefit from increased patient and public trust, which is especially valuable in this time of growing mistrust of healthcare providers.

Reinertsen’s recommendation on “how to go naked” provides a starting point for dialogue on where the organization stands with respect to transparency. To dive even further into the specifics of how transparency will play out in your organization, I suggest that you address three critical questions:

- Transparency of what?
- Transparency for whom?
- Transparency at what level?

I developed the Transparency Assessment Tool (TABLE 1-1) as a way to help build a dialogue around this topic. There is no right or wrong answer to each of the 15 questions in this assessment. Without such a dialogue, a provider of healthcare services will be placed in a defensive posture when asked to reveal the quality of the care they offer or their results. The time to think about transparency is not when the Channel 5 TV mobile unit parks outside your hospital or clinic, cranks up their satellite dish, and asks to “talk with someone in charge” about why your data placed you in the bottom decile of a recent rating and ranking of providers.

In order to gain a clear understanding of the full range of opinions on transparency within your organization, the following questions need to be addressed:

- Do you know your data better than anyone else?
- Do you use data that are made available to the public to identify opportunities for improvement?
- Or, do you look for ways to deny the public released data and develop rationalizations as to why you think you are actually better than the reported outcomes?
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Do you share all your results openly with staff?
- Do you share all your results with patients, family members, and caregivers?
- If not, why not?

The specific steps I recommend in using the Transparency Assessment Tool include:

- Distribute the assessment tool to the organization's leadership team. This could include the governing board and senior and middle management groups.
- Ask each person to complete the tool without talking to other members of the leadership team.
- Have the completed assessments tabulated to show the spread of responses for each question and distribute the summary back to the participants for review and reflection. A graphic summary rather than a tabular or numeric summary is a preferable way to report the results.
- Convene a leadership meeting to discuss the results and the variation within and among each of the questions.
- Finally, create a work group to begin drafting an organizational position on transparency and how the organization will respond to the specific types and levels of transparency referenced in the assessment tool.

In summary, the work that Nightingale, Codman, and Peabody started years ago continues today. This issue will not be going away anytime soon and will only grow in intensity over the next 5 years. Organizations certainly have a choice in building a philosophy and strategy for dealing with the growing pressures for a more transparent healthcare industry. Some will meet this challenge and approach it from a proactive perspective. They will build measurement systems that enable them to understand their data better than anyone else and share it internally and externally before they are forced to do so. Others will sit back and "hope" that their data will at least meet standard expectations or that their performance is more or less "about average." They will wait till data are released on them by external bodies and then circle the wagons to justify or rationalize why they end up where they do in the rating or ranking system. Life is full of choices. The choices you make over the coming year related to transparency of your performance will have a major impact on your organization's future.

The Growing Focus on Patient-Centered Care and Service

The second major development that has had and will continue to have a dramatic impact on the role of measurement in healthcare settings is the growing concern by both consumers and political leaders that healthcare professionals not only do not listen very well but in many instances act as if they just do not care about those they serve. This is a stark criticism for an industry that supposedly is designed to “care for people” and a far cry from what Francis Peabody was teaching back in the early 1900s about the “care of the patient.”

I am always intrigued at the response I get when I ask participants in one of my workshops, “Why did you get into health care?” The most frequent response is something along the lines of, “Because I want to help people and make a difference.” Although this is a fairly consistent response, irrespective of the country in which I ask it, it is interesting to follow up on such responses by unobtrusively walking the halls of a hospital, clinic, or nursing home and observing the interactions of staff and patients to gain a sense of the quality of these interactions. Even though most healthcare professionals will say that the patient and family are at the center of what we do, the casual observer walking around the hospital will probably conclude that there seems to be a conflict between what healthcare professionals frequently tell you about their reasons for entering the profession and the degree to which this intention is demonstrated moment to moment and patient to patient.
All too often, the patient is not really placed at the center of the healthcare universe. Instead, we frequently place ourselves in that center and expect the patient and family to rotate around the structures and processes that meet our wants and needs. For example, we tell a patient, “Oh, I’m sorry, we are open here at the outpatient testing and therapy center only from 9 a.m. until 4 p.m. Monday through Friday. We are closed from noon to 1 p.m. for lunch. No, I am sorry, we are not open during the evenings or on the weekends.” If we really placed the patient at the center of our universe, we would offer hours that accommodate patient needs and schedules. Just imagine if restaurants, movie theaters, or shopping malls took this approach and were open only during times that fit the workers’ schedules. They would be out of business very quickly. Customers would walk away from these businesses and look for those that accommodated their requirements.

It is actually rather surprising that it has taken the consumers of health care so long to become concerned about the lack of listening in health care and start to take action. Historically, the healthcare profession has been characterized as a profession that tells patients what they want, need, or can expect rather than asking them for their opinions or desires. The standard approach historically has been that healthcare providers do things to people or for people rather than with people. Francis Peabody argued that engagement with the patient was essential. But it has taken decades to chip away at the old paradigm that places the providers of care at the center of the universe.

A variety of books, reports, and consumer organizations supported by the growing push for transparency and the availability of data and information on the Internet, all have set the stage for creating greater involvement of the patient and family in making healthcare decisions. It has also forced healthcare providers to rethink how they measure the voice of the customer (VOC). Patient advocacy groups, in particular, have been very instrumental in driving the emergence of a more participatory model of healthcare delivery. One of the early leaders in this area has been a rather controversial physician by the name of Charles Inlander. Inlander, with backing from Robert Rodale, board chairman of Rodale Press and publisher of Prevention magazine, became president of the People’s Medical Society (PMS) in 1983. Inlander, Levin, and Weiner then wrote Medicine on Trial in 1988. This book was not merely a criticism of the medical status quo; it was a direct attack on the very foundations of medical training, practice, and the business of medicine. The foreword to Medicine on Trial states:

> It is a catalog of ineptitude, malfeasance, gross neglect, indifference, and incredible arrogance. The indictment is not ours. It is an unabridged exposé of medical mistakes taken directly from the annals of medicine and public research. No one can count on reform from within the medical establishment. There are simply too many vested interests in the system trying to protect the status quo. (p. 11–12)

The authors conclude, “It is amply clear that the medical care system is not capable of significant and sustained efforts to improve the quality of its services. It simply has too much at stake in preserving benefits to its own members. Their proposal for improvement lies with the people who are the recipients of care” (p. 15). They write, “The people who should—and, indeed, must—alter the practice of medicine are the people it is practiced on” (p. 19). The remainder of the book provides detailed examples of how the healthcare system has failed those it serves.

Chapter 12 of this book has an intriguing title: “What Did He Say? What Did I Hear? What Did We Do?” In this chapter, the authors cite case after case of how providers (especially physicians) have demonstrated a total lack of listening to patients. They cite a study at UCLA’s Cancer Rehabilitation Project, for example, that concluded, “9 out of 10 physicians had never received any formal training in how to disclose
a cancer diagnosis to an afflicted patient” (p. 192). Although many of the clinical recommendations of the PMS have been called into question for promoting “unscientific methods” (Barrett, 2011), Inlander et al. at the PMS did contribute to rejuvenating the early messages of Codman and Peabody about the role of the patient in medical practice.

In 1988, a second book was released that served as a complement to Medicine on Trial. Taking Charge of Your Medical Fate (Horowitz, 1988) provided a roadmap to guide the patient through the healthcare maze. This book actually received more recognition than Medicine on Trial especially when Senator Edward Kennedy claimed that “the Horowitz method can save your life—the way it saved my son’s.” The author, Lawrence Horowitz, MD, was director of the U.S. Senate Subcommittee on Health and is considered a very astute observer of the healthcare industry. He meticulously laid out the steps for patients to take control of their own healthcare decisions and how to behave when interacting with healthcare professionals. Despite Horowitz’s efforts, however, consumers of the late 1980s did not take charge of their own medical fate.

It was not until the early 1990s that the consumer movement in health care actually started to gain serious momentum. Television talk shows, magazines (e.g., on January 22, 1996, Time magazine had the following cover page: “Special Investigation—What Your Doctor Can’t Tell You”), investigative reports (e.g., the TV show 60 Minutes), and the Internet all contributed to the growing concern that healthcare providers really did not listen or pay much attention to those they serve.

A third book that made a significant contribution to the role of consumers and measurement in health care is Demanding Medical Excellence: Doctors and Accountability in the Information Age by Michael Millenson (1999). This book picks up where the works of Inlander et al. and Horowitz left off. Millenson provides a detailed account of the major historical and political events that have shaped the U.S. debate over cost and quality. He then proceeds to offer a critical review of the serious flaws and fallacies in contemporary medicine. Through many examples, quotations, and case studies, Millenson traces the growing role of data and outcomes research in health care. He concludes that “the largest barriers to systematically measuring and improving the quality of American medicine are not technical but cultural” (p. xvi). He argues that the healthcare profession lacks the will to objectively measure and monitor the quality of what it produces and that it is only a matter of time before the consumers become more engaged in changing the profession.

One of the more consistent advocates for patient involvement over the past 20 years has been Consumers Union and their related publication Consumer Reports. Starting in 1996, for example, Consumer Reports began publishing ratings and rankings on health maintenance organizations (HMOs). In January 2003, Consumer Reports added a new dimension to its focus on health care by leading with the cover page headline, “How Safe Is Your Hospital?” In 2013, Consumer Reports and AARP both started publishing what they consider to be the “top” hospitals in America.

The publications that probably have had the most impact worldwide on patient involvement as well as quality and safety have been those released by the Institute of Medicine (IOM). In 1999, the IOM released To Err Is Human: Building a Safer Health System, which addressed primarily the fact that health care is essentially an unsafe enterprise. The chair of the committee that produced the report, William Richardson, states in his preface: “This report describes a serious concern (i.e., medical error) in healthcare that, if discussed at all, is discussed only behind closed doors” (p. vii). After outlining the current state of medical error in health care, offering estimates of the number of patients experiencing needless death and harm while under care, and explaining error theory, the report provides a series of recommendations on ways to improve the healthcare system, several of which address measurement and transparency issues. In the second IOM report, Crossing the Quality Chasm: A New Health System for the
21st Century (2001), the focus was on how the healthcare system can be redesigned to promote innovation and improve care. Redesign refers to “a new perspective on the purpose and aims of the healthcare system, how patients and their physicians should relate, and how care processes can be designed to optimize responsiveness to patient needs” (p. ix). The report proposes six aims for healthcare improvement. These aims are aligned with key dimensions in which today’s healthcare system “functions at far lower levels than it can and should” (p. 5). The six IOM aims are that health care should be:

- Safe
- Effective
- Patient centered
- Timely
- Efficient
- Equitable

Although all six aims ultimately are directed toward the patient’s healthcare experience and outcomes, the third aim explicitly addresses the patient-centered issue. The IOM defines patient-centered care as “providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions” (2001, p. 6). Inclusion of this explicit aim on patient-centered care provided a much needed stimulus for rekindling the vision that Francis Peabody had for the healthcare profession.6

The IOM reports raised the consciousness of many healthcare leaders to realize that poor quality, unsafe processes, and indifference to patients and their situations were unacceptable. The reports moved the dialogues about transparency, service excellence, and measurement to the forefront of healthcare professionals’ minds. They also provided the basis for the third key development within the healthcare industry that has had a profound impact on moving healthcare measurement and data collection in new directions, namely, making QI concepts, tools, and methods part of the operating strategy of many healthcare providers around the world.

The Growing Role of Quality Improvement Concepts, Tools, and Methods

There is no doubt that the healthcare industry is under tremendous pressure to demonstrate that it can transform itself. We have responded extremely well in many arenas. For example, the technological advances in medicine have been dramatic.7 The industry has also been very creative in developing a variety of outpatient and inpatient services (e.g., mobile dental clinics, home care services for individuals with special needs, and collaborative initiatives that have brought together healthcare providers as well as community groups to improve population health). What has not occurred, in my opinion, is the full-scale adoption and diffusion (Rogers, 2003) of the concepts, tools, and methods of QI. The same approaches to QI that have made many manufacturing companies very successful and known throughout the world are not being fully embraced by the health, social services, and educational industries. There are numerous health and social service organizations that can be singled out for their adoption of QI strategies, concepts, and applications. But the widespread adherence to quality principles and constancy of purpose for QI has been spotty at best (Deming, 1992).

Over the years a number of national and international organizations have worked tirelessly to spread the word about QI and how it can contribute to long-term survival, increase profits, and add value for customers. Probably, the longest standing of these organizations is the American Society for Quality (ASQ). Founded in 1946, ASQ has been leading the application of QI thinking throughout the world and across industries. With 25 different topic and industry divisions in over 140 counties and nearly 300,000 members worldwide ASQ can rightfully claim that they serve as the “Global Voice of Quality.” In the 1980s, ASQ began expanding beyond manufacturing and working to get quality thinking into education, service industries, and
health care. Although the healthcare division is one of the smaller subgroups within ASQ, it has become a viable group of professionals who are keen to learn from other industries.8

Within the healthcare field the IHI has been a leading innovator in health and healthcare improvement worldwide. For more than 28 years, the IHI has partnered with national and local leaders as well as frontline practitioners to improve the health of individuals and populations. The IHI work is focused on five key areas to advance its mission: (1) building capability for improvement within the healthcare professions; (2) enhancing person and family-centered care; (3) making patient safety more reliable; (4) addressing issues of quality, cost, and value; and (5) advancing the triple aim for populations (i.e., simultaneously enhancing the health of populations, reducing costs, and improving the quality and service components of the hospital experience).9

Another influential leader in promoting QI within the healthcare field, especially through quality measurement, has been the National Quality Forum (NQF). The NQF was created in 1999 in response to recommendations from the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. The commission recommended that a forum for healthcare quality measurement and reporting should be established to (1) develop a plan for implementing quality measurement, data collection, and reporting standards throughout the healthcare community; (2) establish measurement priorities focused on national aims for QI; (3) endorse quality measures and standardized methods for measurement and reporting; (4) ensure the public has access to quality measurement and performance data; and (5) support the development of health information technology systems to advance measurement efforts.10

Finally, it should be noted that the JC and its affiliate Joint Commission International (JCI) have a long history of establishing standards for quality and performance that can be traced back to the pioneering work of Dr. Codman. The JC was officially established as a not-for-profit organization in 1951. It emerged as a result of a collaborative effort by the American College of Physicians, the American Hospital Association (AHA), the AMA and the Canadian Medical Association who joined with the American College of Surgeons as corporate members to create the JC on Accreditation of Hospitals (JCAH) based in Chicago, Illinois. At the time of its creation, the JCAH’s primary purpose was to provide voluntary accreditation and standardization of practice grounded in the “end results” thinking of Dr. Codman. Over the years, the JCAH changed its name to reflect a broadening of its scope and coverage. Although one of many accrediting bodies, the JC is a leading force in promoting quality and safety across a very broad spectrum of healthcare services. In the United States alone, it accredits over 21,000 healthcare organizations and related healthcare services. JCI is currently accrediting healthcare organizations in Asia, Europe, the Middle East, Africa, and South America. To learn more about the JC, its history, and work around the world visit their website at https://www.jointcommission.org/about_us/history.aspx.

In addition to the numerous organizations that focus on the concepts and methods of QI, there are many professional organizations that are oriented toward supporting specific interest groups (e.g., the AMA, the AHA, the Voluntary Hospital Association, the American Nurses Association, the Veterans Hospital Association). If you drop down one more level, you start to discover a myriad of organizations and groups that advocate for various clinical and medical specialties and subspecialties (e.g., the Society for Thoracic Surgery, the American Osteopathic Association, the Royal College of Surgeons [United Kingdom], the Royal College of Surgeons of Edinburgh, the Pharmacists’ Association of Saskatchewan). My point in providing this brief historical review is to demonstrate that today there are many groups and organizations supporting, endorsing, and sponsoring QI meetings,
Quality has become a very popular phrase from the boardroom to the frontline staff. Who does not want to support quality? In many ways, quality has become a very popular buzzword that lacks a consistent and universally accepted definition.

Part of the challenge in defining quality is that everyone is essentially an expert in quality. We have all experienced good, bad, and downright ugly quality. We may not be able to define it or articulate the criteria precisely, but the general opinion is that “I know it when I see it or experience it.” When I teach introductory workshops in QI, I frequently start the class by asking everyone to take a sticky note and complete the following statement: “Quality is . . .” and let them fill in the blank. I then take all the notes and place them on a flipchart so that the participants can review them during a break. **BOX 1-1** provides a summary of some of the definitions I have received over the years. As you review these comments you will notice that people participating in an introductory class on quality have keen insights into the nature of quality.

Although numerous formal definitions of quality have been offered (see Schultz, 1994), I favor the simple yet straightforward perspective conferences, publications, and programs for healthcare professionals. Quality has become a very popular phrase from the boardroom to the frontline staff. Who does not want to support quality? In many ways, quality has become a very popular buzzword that lacks a consistent and universally accepted definition.

**BOX 1-1** Definitions of quality

- a combination of value and outcome in the eyes of the consumer
- a process with minimal opportunities for improvement
- a product or service delivered with 100% satisfaction the first time, every time
- a product or service that provides an expected value
- a product that lasts, for the best price
- a very good product—one you would want again
- above-standard results
- accountability
- an excellent product delivered by professional, friendly, knowledgeable people in a timely manner at the appropriate time
- an unending struggle for excellence
- anticipation and fulfillment of needs
- attention to detail, timeliness, competence
- compassion
- completing a job in an accurate, efficient, and timely manner
- customer-focused service at a reasonable price
- data driven
- difficult to define
- doing the job right the first time
- going above and beyond what is expected
- listening/responding
- listening to feedback and, it is hoped, making changes to meet customer needs
- exceeding expectations
- making others feel important
- meeting and exceeding customer needs
- meeting our customer/patient needs in a cost-effective manner
- providing a product/service marketed to your customer above and beyond his or her expectations
- providing the best we can to our customer through kind and understanding dealings
that Dr. Deming presented. He basically said that he refused to define quality in a few words or a sentence. What he did say was that “Quality begins with intent, which is fixed by management” (Deming, 1992, p. 5). Dr. Deming based his entire approach to QI on the assumption that quality has no meaning without listening to the VOC. He stated that “Quality can be defined only in terms of the agent” (i.e., the customer or end user of a process). “Who is the judge of quality?” he would often ask in his 4-day seminars. He clarified his position with the following statement:

The difficulty in defining quality is to translate future needs of the user into measurable characteristics, so that a product can be designed and turned out to give satisfaction at a price that the user will pay. This is not easy, and as soon as one feels fairly successful in the endeavour, he finds that the needs of the consumer have changed, competitors have moved in, there are new materials to work with, some better than the old ones, some worse; some cheaper than the old ones, some dearer. The quality of any product or service has many scales. (Deming, 1992, p. 169)

When you step back from all the theoretical and philosophical underpinnings offered by the recognized experts in quality (e.g., in Schultz, 1994), they all discuss, in one way or another, three fundamental activities that form the foundation of QI:

- Listening to the VOC
- Listening to the voice of the process (VOP)
- Using statistical process control (SPC) methods (i.e., using data to make decisions)

Organizations that clearly demonstrate quality and excellence (e.g., the Baldrige winners or organizations that have won state or international quality awards) are able to skillfully blend all three activities together. A singular focus on one or even two of these activities is not going to achieve QI. It is when all three activities are combined simultaneously and on a daily basis that quality, as envisioned by Deming and his contemporaries, will be realized. **FIGURE 1-2** depicts the interconnectivity of these three activities.

When considering the implementation of QI, it must be remembered that it is a never-ending process of continuous improvement. Deming
made this point abundantly clear in his writings and seminars. “If I have to define it,” Deming would say in his 4-day seminars, “it would be meeting and exceeding the customer’s needs and expectations, and then continuing to improve” (Shultz, 1994, p. 47). It is acknowledging that past success is no guarantee of future success. Quality does not happen by accident or because you want it to, wish it to, or hope that things will get better. Remember, hope is not a plan! Quality results from the deliberate and intentional actions of individuals within an organization. Quality is not a program or a single project, nor the responsibility of one individual (e.g., the director of quality) or those assigned to the quality department (Lloyd, 2016). In short, quality is a way of thinking about work, approaching its improvement, and getting everyone involved. Quality is about achieving and sustaining excellence—nothing less.

If quality is viewed as something that has to be done, “in addition to everything else I have to do,” then the organization will never understand quality, be able to achieve it, or demonstrate excellence over time.11 The essential ingredients, therefore, that enable an organization to achieve quality and excellence and sustain it over time include:

- A commitment to quality starting with the board and senior management
- A strategically defined role for quality throughout the organization
- A model or framework upon which to build QI strategies
- A plan for deploying quality thinking and application throughout the entire organization
- QI education and professional development at all levels of the organization including the board, senior leaders, middle managers, and frontline staff
- A measurement philosophy and the use of SPC methods
- Strategies to determine when a process or system needs to be improved (e.g., reducing variation) or redesigned because it is fundamentally broken
- Plans for testing, implementing, sustaining and spreading improvement (Langley et al., 2009)

These are critical aspects of an organization’s quality journey. When they are in place and sustained over time, QI will be part of the very fabric of the organization. Anything less will relegate quality to just a word in the organization’s lexicon or a mere focal point of a banner or poster.

### The Quality Funnel

One final point about the use of the word “quality” especially as it relates to the delivery of healthcare services. As I work with teams and organizations to help them develop capacity and capability for improvement I usually ask, at an early stage of our work together, “What aspect of quality do you want to improve?” Quite often I get quizzical looks and interesting responses. I point out that quality is not a unidimensional concept and that there are three basic modifiers that historically have been associated with this word: quality assurance (QA), quality control (QC), and QI. After making this distinction, most healthcare professionals acknowledge the three approaches but they do not see how they relate to each other. Some even point out that they are separate and distinct and do not have any connections. This is when I show them the quality funnel (FIGURE 1-3). The characteristics of the three approaches to defining quality are summarized in this figure.

The three aspects are shown in a funnel because they do have close connections. In health care, there is often almost a singular focus on QA. QA has also been a central approach to the delivery of healthcare services for a longer period of time than either QC or QI, which in my opinion has created many of the challenges we face in our industry today. The problem is that QA should be done only when there is such a high level of QC that
you can afford to check or audit the process or system performance periodically. What I find is that QA, especially point prevalence audits, are conducted on healthcare processes and systems that have very low levels of QC and, therefore, low levels of reliability. Then when the results of the audit are not favorable the organization’s management team becomes very concerned and wants to know why there is poor performance. Well, the answer is easy and should be obvious, but it is frequently not acknowledged or discussed. Namely, if a process does not have high levels of QC, defective products and services will naturally be produced. The manufacturing industry knows this principle very well. Manufacturers of everything from cars to computers to ballpoint pens or processed lunchmeat first establish systems for QC before going ahead with ongoing production of the item. When they have a high degree of control of the production of the product (e.g., they are confident that 99% of the time the product is produced exactly as it was designed or planned), then they can periodically conduct audits on a sample of the product to check for consistency and reliability. QA is not the first thing they do. This is done only after they have put in place reliable QC standards and procedures. If they detect through a QA audit, however, that the product is starting to drift away from the production specifications or tolerances then they initiate QI strategies and methods. This approach was laid out very nicely by Joseph Juran in his quality trilogy (Juran, 1992). Juran’s quality trilogy has served as a standard for decades and describes clearly the critical roles of quality planning, QC, and QI.

In health care, we seem to have this sequence backwards. We engage heavily in QA and apply it to processes or systems that have very low levels of QC to begin with. Then we become surprised when the QA audits reveal that either internal or external expectations or targets are not being met. The result is that more QA is put into place when in fact what is needed is better QC. Even after a QA audit reveals poor performance, applying principles and methods of QI to the process frequently does not produce the desired results. This is because the QI approach is being applied to a process that is most likely not stable and therefore not predictable. Trying to improve a process that is not in a state of statistical control will only make things worse. So, as you begin your quality journey, make sure you have agreement on what approach to quality is guiding your journey.
Notes

1. Regardless of the industry in question, bad outcomes, unethical behavior, or scandal rapidly lead to increased scrutiny and the demand for more data to discover “what is going on.” A classic example in the healthcare industry can be found in the Mid Staffordshire NHS Foundation Trust scandal (http://www.midstaffs public inquiry.com/home). From January 2005 through March 2009, hundreds of patients were routinely neglected and many have been classified as dying needless while in the Trust’s care. One of the conclusions in the Francis Report as it is generally known is that the Trust’s leaders were so preoccupied with cost cutting, achieving targets, and qualifying for incentives that they lost sight of Mid Staffordshire’s fundamental responsibility to provide safe care. One of the major outcomes of the inquiry is the increased demand for greater scrutiny of all the Trust in England and the need for more data, so that the scrutiny bodies can track and assess performance of providers. Examples from other industries reveal similar response patterns. For example, one only has to look at the television evangelist scandals of the 1970s, the damaging claims (still disputed by the way) in 1978 that the gas tanks of Ford Pintos were more susceptible to fire and explosion than the gas tanks of other cars, the Enron financial scandal of 2001, and the ongoing investigation of Catholic priests. All of these examples have led to loss of trust in the product, service, or institution under the microscope, a demand for greater transparency of what the group does, and a push for “more data.”

2. It is important to note that this phenomenon is not limited to one country, state, region, or province. The move away from an absolute trust in the medical system and its providers to a perspective that demands data as proof of the quality, safety, competency, and value represents a worldwide concern. It does not matter how healthcare services are structured, organized, delivered, or financed (e.g., employer-based insurance plans as we have in the United States or national health systems as we find throughout a majority of the rest of the world). All countries today are concerned about the value being delivered by its healthcare system and the money being spent on that delivery of services in light of the results being tracked. There is no such thing as “free health care” despite what some people think or say. Somebody pays for healthcare services whether it is through taxes to support a national health system, companies paying for the healthcare benefits of workers, or individuals paying out of their own pockets for coverage. Value, quality, safety, access, and service are the driving factors challenging healthcare providers today and they are concerns throughout the world.

3. The AHA DataViewer is a classic example of this type of administrative data: https://www.ahadataviewer.com/. Other examples include the annual reports produced by state data commissions in the United States (e.g., the PHC4, http://www.phc4.org/) and the Quality and Efficiency in Swedish Health Care reports published annually (e.g., http://www.socialstyrelsen.se/publikationer2011/2011-5-18).

4. In this text, I am using the term quality improvement (QI) as the generic reference to a broad set of terms that have been used over the years, including total quality management (TQM) and continuous quality improvement (CQI). Other terms that have also been used to refer to improvement in various forms are quality control (QC), performance improvement, performance management, quality assurance (QA), quality management (QM), quality circles,
quality of care, and clinical QI. If you study the history of the quality movement, you will find many terms used to describe and define this notion. I would encourage the reader to explore a bit of this history and become knowledgeable about the different paths that the discipline of quality has taken. It is a fascinating journey that is quite enlightening.

5. For more information on hospital charges in the United States, visit the CMS and Medicaid website: https://www.medicare.gov/hospitalcompare/. Similar profiles can be obtained for each U.S. state by visiting the state’s healthcare report card site. The actual titles of state organizations responsible for tracking and reporting healthcare services vary by state. A search under the general title of “state healthcare data commissions” or some variant of these terms, however, will provide a good starting point. In my home state of Illinois, for example, the data may be found at http://www.healthcarereportcard.illinois.gov/.

6. Since 2001 when Crossing the Quality Chasm was released a myriad of initiatives both public and private have advanced the role of patients, families, and caregivers in making healthcare decisions. Some groups like AARP, National Quality Foundation, the Agency for Healthcare Research and Quality (AHRQ), and the CMS have developed programs and initiatives designed to increase the involvement of patients and their caregivers in making healthcare decisions. Individuals who have experienced either personal harm or the loss of someone close to them through medical error have also been playing major roles. The Josie King Foundation is one of the early leaders in this area. Josie’s Story, written by her mother Sorrel King (2009), tells the painfully honest story about how medical errors led to the premature death of a vibrant 18-month-old little girl. It recaps the family’s struggles to deal with their grief and how Sorrel started a journey into a world she never had thought about. Today, Sorrel and her family are patient safety advocates working tirelessly to improve quality and safety in Josie’s memory. More about the Josie King Foundation may be found at http://josieking.org/Home. At the IHI, we too have been heavily engaged in patient-centered work for over a decade. It is one of the four IHI strategic aims: (1) Optimize Healthcare Delivery Systems: Encourage, empower, and enable healthcare delivery systems to provide truly value-based care that ensures the best healthcare outcomes at the lowest costs; (2) Drive the Triple Aim for Populations: Strive to achieve the Triple Aim, simultaneously improving the health of the population, enhancing the experience and outcomes of the patient, and reducing per capita cost of care for the benefit of communities; (3) Build Improvement Capability: Build improvement capability into every organization, healthcare executive, and professional, while driving innovation to dramatically improve performance at all levels of the healthcare system; and (4) Realize Person—and Family—Centered Care: Usher in a new era of partnerships between clinicians and individuals where the values, needs, and preferences of the individual are honored; the best evidence is applied; and the shared goal is optimal functional health. Our focus on person-centered care recognizes that one of the reasons that the needs of individuals are often overlooked when they enter the healthcare system is because they are defined as patients not as people. Webster’s dictionary (1984, p. 862) defines a patient as one under medical treatment or one who suffers. It also offers the alternative definition of patient as one who is capable of bearing affliction calmly or one who is capable of bearing delay. These too seem like good definitions of what happens to individuals when they enter the
healthcare system. So IHI is striving to get healthcare professionals to realize that person-centered care should address all the needs of the individual and do so in a manner that respects their values, beliefs, and culture. The individual seeking care is the primary focus of this IHI aim but it also is encompassing enough to include the individual’s family or caregivers as well as staff, who are often the individuals “bearing affliction and delay” as well. There is no doubt that progress has been made. But we still a have long way to go before healthcare systems and providers of care emulate the words and actions of Francis Peabody. A recent study (Lavizzo-Mourey, 2006) demonstrated that things have not changed much since 1988. The study set out to measure how well physicians are practicing patient-centered care. Between 80% and 90% of physicians surveyed said they favored patient-centered care, 83% of the respondents said they supported sharing medical records with patients, and 87% responded that they support team-based care. But upon observation, less than a quarter of doctors actually practice patient-centered care as defined by the study’s authors. The authors concluded that the physicians basically don’t “walk the talk.” I am reminded of an episode of the TV show House where the ever so smart and ever so rude Dr. House is telling a mother what he plans to do to her sick daughter. The mother is politely objecting and asking questions about his plan of care. In his usual brusque and arrogant manner, he cuts her off and turns to leave. She tells him to stop and delivers an absolutely marvelous line. She says with a very stern face and pointing a finger in his face, “Look, I am the mother and you’re the doctor. I outrank you. This is what I want for my daughter.” QED!

7. For example, today a patient can have laparoscopic gallbladder surgery at an ambulatory surgery center and be back to work in a day or two. In the 1970s, that same patient would have stayed in the hospital for at least a week and be off work for several more. Cataract surgery is routinely done on an outpatient basis. Many hospitals are getting patients with total hip replacements discharged in 2 days or 3 days max. I had a total hip replacement several years ago and was out of the hospital in 2 days after surgery. In October 2016, my wife had a total knee replacement procedure that was done as outpatient surgery. At Rush St. Luke’s Presbyterian Hospital in Chicago, they are now performing same-day hip replacement surgery. Another technological advancement has been in the area of micro and robotic surgery. The use of the da Vinci robot to repair mitral valves in the heart, for example, is now common practice at many hospitals. We have the technology to look inside the patient without penetrating the skin. In the past, it was not uncommon to do “exploratory surgery” to determine whether there was a problem. Today, we rely on CT scans and MRIs as primary noninvasive diagnostic tools. The application of new technology seems endless. It will continue to change not only how we think about medicine but also how it is taught and practiced.

More on the ASQ may be found on their website: https://asq.org/about-asq/history.

9. A more detailed history of the IHI along with its current programs, resources, and initiatives may be found at http://www.ihi.org/Pages/default.aspx.

10. More about the NQF may be found at http://www.qualityforum.org/Home.aspx, including a listing of the more than 700 measures they have been assembling on healthcare topics, their programs, and other resources.

11. I actually had a participant in one of my workshops say this in class one day. I was speaking about the issue of making quality thinking and practice part of daily

8. More on the ASQ may be found on their website: https://asq.org/about-asq/history.
work. This individual was sending body language messages that said “Boy this is really a lame idea” or something similar. So, I asked her if she would care to make a comment on my points or if she had a different perspective. She then came out with this classic response, “In addition to everything else I have to do I am now expected to work on quality. Where do they think I can find the time to do this?” I will never forget it. But before I could respond others in the class challenged her response. The best comment was from a quiet woman in the back of the class who raised her hand and simply asked, “Well if quality is not your job, why are you here?”

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