An Old Look At Quality Assurance*

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ABSTRACT

The medical-hospital-regulatory complex has perhaps gone too far in the amount of energy and money devoted to data gathering. If the intent of all of this effort is to benefit patient care, it seems fair to ask whether or not the right kind of data is being accumulated. This paper raises the question and points out that the appropriate questions were asked 85 years ago, — and remain largely unanswered.

Clinical scientists have long been engaged in quality control. The work of Dr. F. William Sunderman, Senior and his colleagues pioneered the methods that we all now take for granted in our laboratories. We can take considerable pride in knowing that we mastered the concepts of accuracy, precision, sensitivity, and specificity long before any of our medical confreres; and we did this with alacrity because it was apparent that it benefited patient care. Under Dr. Sunderman’s aegis and that of the College of American Pathologists (CAP), we introduced the concepts of outside audit, consensual standards, and proficiency surveys. Here, too, we knew that this helped keep us honest and redounded to the patient’s benefit. The success of the CAP Laboratory Accreditation Program speaks for itself; and the position it occupies is unique in medicine.

We have in the past twenty or so years seen some good ideas, Joint Commission on Accreditation of Hospitals (JCAH) and Professional Standards Review Organization (PSRO), for example, develop into organizations increasingly removed from the concerns of patient care. In fact, the flap about quality assurance came about because the JCAH was challenged by the government to show that what they were doing and the standards they were enforcing had anything to do with better patient care. And so the confusion of quality assurance descended upon us! We were told to set up regular periodic surveillance, detect trends, identify problems, and correct them. All well and good, and the patients would thereby benefit! The accredited hospitals have done all this. Excepting for brutality, frank neglect, and obvious malpractice, have we indeed improved the patient’s lot?

The idea of writing this paper came while reviewing a 30 page protocol describing the functions of my hospital’s medical appraisal committee. As I

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encountered the first statement, "The purpose of this committee is to monitor the quality of patient care", I couldn't help asking who else in my hospital was doing this and, taken altogether, were the patients benefiting? Were we, indeed, improving patient care and if so, how did we know?

We are dedicated to monitoring patient care in my hospital. The medical appraisal committee looks at the necessity for admission, the length of stay, the efficacy of discharge planning, and, indeed, the medical necessity for each day of hospitalization. Our medical audit committee selects a disease or syndrome, constructs the paradigmatic criteria and then does a retrospective study of consecutive patients to determine how well the criteria has been met. The infection control committee reviews antibiotic usage. The transfusion committee oversees the use of blood products. Our tissue committee investigates every discrepancy between clinical and pathological diagnoses. Our clinical departments conduct mortality reviews. The house staffs conduct rounds and case reviews. There is a quality assurance committee that monitors care according to JCAH guidelines, investigates all incident reports, and coordinates its activities with those of the risk management committee. The numerous committees of the medical staff culminate their efforts in the executive committee whose main concern, along with that of the Board of Trustees, is patient care.

That all of these activities are laudable is unquestioned. That they redound to the patient's benefit is moderately clear. That they provide an elaborate protocol that gives aid and comfort to the provider of care, rather than to the recipients, is a proposition that at least must be stated and, at most, entertained and examined. The entire structure relates to patient care, mainly by inference. Presumably, if we monitor sufficiently and wisely, care improves and the patient benefits. Indeed, this is the bedrock principle of quality control and quality assurance. One sets standards of performance or limits of tolerance and then uses surveillance to determine the conformity of performance within those limits.

But suppose we do not monitor well or wisely. Suppose our monitoring is too sporadic or too short term. Suppose the questions we ask are mainly the easy, convenient, bureaucratic ones. Perfect answers then, will provide only an illusion, a facade of excellent patient care. Or perhaps, more substantively, those answers determine a standard of care that enjoys popular acceptance. We thereby attain the mean and achieve the mediocre. Perhaps we legitimize in this way a complaint that an ever increasing number of patients voice, — that over being sick, going to the hospital is a traumatic and unpleasant experience. All this, mind you, in the face of impeccable paper work. So maybe we're not asking the right questions.

What are the questions that we are not asking? Let me state only a few:

1. Do we know the incidence of iatrogenic disease in our respective hospitals?
2. Do we know the death rates for specific diagnosis and how they compare with other hospitals?
3. Can we reconcile our current autopsy rates with good medical practice?
4. What is the current rate of medication and dietary errors?
5. What is the performance, as measured by mortality and morbidity, of individual physicians?

These are but a few of the questions that could be asked; and they are uncomfortable, disturbing, and difficult. They are not new. They were, in fact, embodied in the questions that Dr. E. A. Codman asked in 1900 "What is the end result?"
Anyone encountering Dr. Codman's book, *The Shoulder*, for the first time is in for a treat. The book was published by him for the American College of Surgeons in 1934 and, aside from its surgical and anatomical information about the sub-acromial bursa and the ruptured supraspinatus syndrome and other shoulder conditions, it amply illustrates the scholarly originality and the quixotic character of its author. I use the term "quixotic" to define the persistent pursuit of the unattainable ideal against all odds, the tenacity with which an idea is held despite overwhelming "reasonable" opposition, and the willingness to continue to make sacrifices with no apparent gain in sight. To begin, the quixotic Dr. Codman felt that the reader of any monograph is entitled to know something personal about the author since, no matter how arid the subject, what we write is conditioned by our cultural compulsives and our personalities. In his autobiographical preface, Dr. Codman states, "If an author has conscientiously labored to present his material in clear English, properly punctuated and painstakingly illustrated for the benefit of the reader, surely he deserves to be allowed to indulge himself in his preface." Further on he writes, "I want egotism in my author or teacher. I want to know what life he has had, what were his aspirations, and what are his regrets. Let him be as unconventional as he wishes, but let him refrain from even customary lies and give freely of himself. Things which have become conventionalized like prefaces, funeral services, wedding vows, and legal preambles are to be suspected of evading responsibility."

Accordingly, Dr. Codman presents his life, upbringing, schooling, religion, marriage, surgical experience, and income in graphic form and proceeds to relate it all in a fascinating narrative to the development of his End Result System of Hospital Organization. It is interesting to note that Dr. Codman in his first five years in practice was one of this country's pioneer radiologists, and his choice between radiology and surgery was serendipitous.

As early as 1900 he had developed the "common sense notion that every hospital should follow every patient long enough to determine whether the treatment has been successful, and then to inquire 'if not, why not?' with a view to preventing similar failures."

The idea was and is overpowering in its simple logic. Indeed, in 1910 it served as a catalyst in the formation of the American College of Surgeons. It was believed that the College would be the perfect instrument to introduce the End Result System into hospitals. To some extent the ACS succeeded in this, along with its many other distinguished endeavors; however, today it is hard to find any evidence of it except for the tumor registry. Dr. Codman goes on to recount his attempts to introduce the End Result System into the Boston hospitals and medical community. His efforts were unsuccessful, and his attempts to use ridicule as a tool backfired to his personal loss of professional status and income. One dividend from this was the five years he spent in the department of pathology at Harvard Medical School, culminating in the Registry of Bone Sarcoma, — the first of the famous registries. It also gave us the Codman tumor, — the chondroblastoma.

Dr. Codman conceived his idea around 1900. It was revolutionary then, and it still needs application 85 years later. Briefly re-stated, Codman wanted to look at the performance of physicians in terms of mortality and morbidity, — particularly the latter. He thought that patients discharged from the hospital should be followed to determine the outcome of treatment: how did the patient feel, when did he return to work, had he
died? Today we use his idea, but only in a limited disease oriented sense. We study cases prospectively or retrospectively to determine outcome. In this way we assess treatments and add to our knowledge of the natural history of disease. But we still have not applied the idea to determine the quality of care. In addition, we must recognize that the quality of care in a hospital encompasses considerably more than diagnosis and treatment of disease, and that it goes considerably beyond the provision of creature comforts, although these three elements are paramount.

Industry and business are well acquainted with Outcome Analysis. If products or services leave something to be desired, it must be known and acted upon to stay in business. The growing competitive climate of the hospital business will produce the same considerations. Medicine, too, is having its industrial revolution, and physicians are being forced to abandon guild practices and enter the modern industrial world. Here, too, competition will cast a cold appraising eye on what they do, how they do it, and the end results.

I suggest that the time has come for hospitals and the JCAH to proceed to the next stage of quality assurance and address the real question, — Dr. Codman’s question, — what is the end result of what we do, therapeutically, functionally, and psychologically? Are we trading short term therapeutic gains for long term misery? Can we do better?

Were this enquiry to be instituted, we could answer in a few years all sorts of questions that can barely be formulated now.

To be sure, all data gathering is expensive, but I venture to suggest that in time, with an End Result System in place, much of our current expensive data gathering would prove redundant. If not redundant, current data would certainly require re-interpretation in the context of End Result data. It seems ironic, that despite the scientific medical revolution and the development of a society devoted to gathering of data about everyone and everything, Dr. Codman’s idea still goes begging. Maybe we in the medical community don’t really want to know! None of us likes change, and one may safely predict that the End Result System would make us change a great deal!