The future of quality leadership

At the opening session of the 18th international conference of the International Society for Quality in Health Care, which convened in Buenos Aires, 2001, the following two subjects were presented for discussion:

1. How are quality leaders developed.
2. How is quality leadership supported and sustained.

There is no doubt that quality organizations need quality leaders, and that quality care needs to be delivered by quality organizations. The questions that still remain to be addressed, therefore, are who will these quality leaders be, and where are they to be found, if they are to be suitable as providers of quality care in the quality institutions.

Over the last decade, medicine has advanced in giant strides, both in technology and in clinical methodology in the treatment of a number of diseases, as well as in the standard of benefits the individual may derive from the health services. Many diseases are still incurable, whilst only partial or palliative treatments have been found for others.

The key to success in the daily competition lies in the concept of fitness for survival, which is mainly based upon calculations of cost and quality versus considerations of reputation or actual delivery. The training of quality leaders is the next phase in the evolution of modern quality management, which is one of the most prevalent and accepted methods of surviving in the health care market.

In actuality, the strategy of quality improvement now exists in most health organizations, hospitals, clinics, and health insurance funds, as well as in private medical practice. We in the health field are involved in quality improvement, and are engaged at various levels and in varied ways, in improvement of medical treatment, the services associated with it, and in fact, in all the components of the entire system of health service. It is obvious that good doctors and nurses have always striven for the best for their patients, but were perhaps frustrated by lack of resources or differing priorities of the administration.

The problem here lies in the lack of a uniform line of approach, transcending controversies, and a lack of shared interest between the parties involved, which is shown by each individual concerned with quality improvement performing in accordance with his own experience, his own resources, and in pursuit of his own goals. For instance, the nursing profession has shown outstanding initiative in the sphere of quality improvement and advancement. However, from the wealth of accumulated experience it emerges that without the physicians and their active participation in steering the improvement processes, the efforts of the nursing profession cannot achieve total success [1].

There is evidently a tendency, specifically among physicians, to experience various kinds of blocks – professional, psychological, cultural, and others, which prevent their recognition of, and participation in, the implementation of the change necessitated in the traditional concepts of medical care. We know that it is difficult to involve physicians in quality improvement projects – they tend to be unavailable for work on teams, too busy to join, and perhaps too sceptical about the possible effectiveness of quality improvement. This problem was found to be especially grave in institutions where physicians were not salaried employees of the hospital. However, there are instances of shining success from hospitals where physicians played a leadership role [2]. The experiences gained show that not only were the physicians willing to participate in quality improvement processes, but they were also able to make major contributions when they did so. On the other hand, barriers to physician involvement may turn out to be the most important single issue impeding the success of quality improvement in medical care. An analysis of the factors involved in these blocks and barriers might help toward their dissolution, and dispel the reluctance and inertia that have been encountered.

In order that the physicians should be positive participants, and be prepared to invest their time and energies also in the issues of quality, which are not solely medical issues, they need to understand that quality improvement is one of the chief aims in every aspect of the medical institution in which they work, and that it is the clear and unequivocal obligation of the hospital director to promote it. Accordingly, the first step in this process is to obtain the commitment of the hospital director. Once the director is convinced of the need and the importance of adopting the quality improvement process, and is prepared to dedicate his total commitment to promoting it, then, and only then, will it be feasible to embark upon it. The next step is to obtain the commitment of the heads of departments and divisions. They, likewise, must be convinced, and be committed to its persistent continuance. There will naturally be those who are sceptical of the special need for emphasizing issues of quality improvement, of the benefit it will bring them personally, and of its importance. It would seem advisable therefore, to start the process with those department heads who support the concept, and to trust that the sceptics will gradually join in. Only after the heads of departments have confirmed their commitment can the process be commenced with the rest of the physicians. Among these physicians will be found the future leadership. Therefore, the issues of quality improvement must be deeply inculcated in departmental life. Every physician will be required to participate in the processes as an integral component of his postgraduate specialty training.

It would probably be advisable to require the junior physicians, at a certain stage of their postgraduate specialty training, to complete an assignment with the aid of other junior physicians and nurses. The subjects of these assignments would be chosen by the head of the department, on issues relevant to the work of the department, and entailing quality improvement and
assessment procedures. The junior physician would be allowed choice of subject. He would then research the activity, collect the data and then work it up for presentation and discussion, so that the conclusions would provide a useful tool for the head and team of the department in evaluating departmental improvement. Here in Israel, the 5-year specialization period includes a mandatory six months of basic or clinical research, and the physician is allowed to select a project of interest to him. If the physician should choose a subject related to quality, and approved by the Board of Examiners of Postgraduate Specialty Training, he or she might decide to research, for example, indicators of outcome, or processes in a trauma registry, or to examine approved quality indicators such as pulmonary embolus or post-operative infections, or any other indicators standardized by the authorized associations. Such physicians would be required to complete the chosen project during their postgraduate specialty training, and would be expected to present the data and results before the Board of Examiners of Postgraduate Specialty Training. Each physician engaged in the improvement process would have a senior physician in the department appointed to him as his tutor, to provide aid and direction as needed. Extra credit would not be gained for the physician by fulfillment of this assignment, which would be a built-in and recognized integral component of the postgraduate specialty training program. The procedures must be run on a daily basis, as an inherent constituent of the hospital departmental system. The hospital departmental system was founded on the medical school curriculum. The medical school has a significant role to play in this process. Today, various medical schools offer preliminary courses on subjects of quality of care. Obviously this method is not sufficient, and other modes must be found by which the issues of quality may be assimilated into the pre-clinical studies, and particularly into the clinical instruction, throughout the hospital departments, as an indispensable aspect of the clinical curriculum of the medical school. Graduate students should be guided in planning their MD theses on subjects of relevance. Only through such efforts will the students be made to recognize the significance of the issue, and be enabled to continue to develop and foster it further as they become specialists, and onward as they reach the higher echelons of the hierarchy as medical officers in the various health care institutions.

At the institutional level, presentations will be made by each departmental head at a forum of other heads of departments or of the hospital administrators, demonstrating the procedures being performed by the junior physicians in their department and the outcomes. In this way, every junior physician, in the course of his postgraduate specialty training, will conduct, or be exposed to, departmental improvement processes and test quality assessment. I hope that, at the conclusion of such demonstrations, there will be those physicians who will be interested in continuing the process. They will be the leaders of the future [3]. The departmental heads and the hospital administrators will need to identify these potential leaders, and continue to encourage their advance in the necessary direction along with their medical progress. They should be sent on further study programs, attend conferences, and be given the opportunity to engage in research in related fields. These physicians, in their turn, will act as the tutors to the junior physicians in the department, who will be responsible for conducting the improvement procedures. They will also attend the various quality forums and institutional quality committees, and will actively participate in the institutional improvement process.

At certain later stages in the medical career, there are further opportunities for the specialist physician to be involved in quality issues. There is the possibility of creating a specific course within the Master of Public Health degree curriculum for physicians interested in the quality processes. The period of study would extend through one year, during which the physician would be concentrating on the subjects of quality and epidemiology, or on evidence-based medicine. At the end of the year, he or she would receive the degree of Master of Public Health, and would then resume work in the department as one of the quality leaders. Another method is to encourage physicians to undertake research during their sabbatical period in the subjects of quality or epidemiology, so that they acquire the tools and skills for research, and for the advancement of quality in their departments. In summary, the quality leaders of the future must be drawn from the ranks of the physicians. Their identities will need to be formed during the postgraduate training period, when the junior physician selects and consolidates his choice of a future professional specialty. This period, which may provide the determining direction for a career in quality leadership, extends over several years, varying from 3 to 5 years according to different national policies worldwide. As an undergraduate at medical school, the student learns of quality as part of his education; then as a junior physician in postgraduate specialty training in the hospital departments, he will be actively engaged in various quality assignments; there will be further involvements in the general institutional quality improvement projects. All these experiences will serve as influences in attracting a number of physicians to a career in quality specialties. Only thus can the process of leadership formation be truly integrated into the system, and the function of quality improvement in the promotion and advancement of medical and nursing care be sustained under the impetus and initiative of its trained leaders.

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References