COMMENTARY

# Quality of Care

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"Quality of care," due to both its nebulous nature and its vital importance, has always been a much-discussed issue in medical ethics. For example, the Codes of Hammurabi, the Hippocratic writings, and other early medical treatises discuss quality of care.

Today, the changing goals and priorities within healthcare systems and the ongoing attempts to restructure local, state, and national health treatment delivery systems have increased the importance of defining the term "quality."

Healthcare professionals commonly face conflicts between what they see as their obligations to their patients and the legal-economic constraints imposed upon them by legislators and healthcare administrators. Yet with increasing pressure for greater cost-containment, and with the advent of alternative healthcare delivery systems, it has become more difficult for healthcare professionals always to act in the best interests of their patients.

"Quality" refers to the essential character or nature of medical care. It is an elusive concept. The definition, in part, relies upon the perspective of those applying the term—healthcare providers, patients, or those who regulate the profession:

- Medical professionals often view quality of care as encompassing the best method of practicing medicine. However, they use their own "process standards," sometimes called clinical protocols, as their true yardstick.
- Patients view quality medical care as including appropriate, rapid, and caring treatment—at a low cost.
- Regulators increasingly see quality care as the delivery of measurably improved outcomes using limited resources.

Each of these perspectives has some validity.

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**Urgent Care Medicine and Quality of Care**

The medical practitioner's goal has always been to benefit the patient whenever possible. Echoing comments from physicians throughout the ages, the American Medical Association defines quality of care as "the degree to which care services influence the probability of optimal patient outcomes."[1] Many other physician organizations use the term "quality" without defining it—assuming, incorrectly, that there is a commonly understood meaning.

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Patients expect quality care from their healthcare providers; providers expect this from themselves. Yet, in our beeping, buzzing, and flashing medical environment, the goal of providing quality care can be lost as the urgent care medical practitioner is inundated with brief visits from new patients with serious and not-so-serious problems, continually short on time and personnel, necessarily focused on a single patient complaint, and harried by constantly changing administrative constraints.

Since urgent care medicine relies on teams of individuals working together to achieve optimal patient care, a breakdown in any part of the team can adversely affect the quality of care delivered.

In arranging their schedules, for instance, urgent care providers frequently make difficult decisions affecting their quality of life and patient care: working multiple sequential shifts (perhaps due to staffing problems) and the resulting lack of sleep, for instance, may result in differing practices and abilities at different spots in the schedule.

Quality may also suffer due to distress after conflict-laden interactions with other healthcare practitioners (re-

garding, for example, transfers to an ED or referrals for consultation) or with patients, since many drug abusers see urgent care centers as an "easy mark."

Personal issues always have the potential to affect the quality of care. Some urgent care staff may be so overwhelmed by their personal problems that they are unable to concentrate on the patients. Any urgent care staff member may compromise quality care due to deteriorating technical skills, substance abuse, incompetence, or consistently poor interpersonal relations with other staff or patients. In each case, the system would fail to provide quality care.

Yet, despite these potential problems, most urgent care centers provide what clinicians and their patients consider is quality care.

### Patient/Societal View

Generally, patients recognize the intrinsic limitations of urgent care, and will tolerate brief clinician encounters as the tradeoff for faster service than they would receive in emergency departments.

Understandably, the patient's view of quality care includes receiving an accurate diagnosis with subsequent appropriate treatment or, if necessary, referral. Coming to an urgent care center, they expect to be seen promptly and hope that minimal pain or discomfort is required. They also expect the costs, at least to them, to be low.

Above all, they expect to encounter a caring attitude. In fact, patients' views of quality care may place caring above curing. Studies of malpractice litigation, for example, suggest that many patients view caring practitioners as delivering quality care, even when they have poor outcomes.

Unfortunately, the nature of illness and medicine mean that not every patient will receive exactly the type of care they desire. Hopefully, each will receive the thoughtful attention that he or she deserves.

### Standards, Competence, and Quality Care

The various regulators of medical practice use the term "quality" to imply that medical care is somehow rated against a "gold standard" of optimal medical care. Yet systems to measure the quality of medical care remain elusive. Delivering "quality care" implies clinician competence; patients, healthcare professionals, and quality assurance organizations, however, have differing views of what those standards should look like.

Moreover, clinical standards of urgent care medical treatment change constantly. This makes acceptable "quality of care" even more difficult to define. For one, medical technology and knowledge change so rapidly that new standards of care are being introduced constantly.

Second, different facilities and areas of the country are able to offer different levels of care; a patient cannot expect a small community in a very rural area to have the same type of expedited urgent care service as a large metropolitan area, for example.

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In addition, the clinical parameters that healthcare providers use to measure "quality" are themselves a matter of debate. Physicians frequently disagree over what specific therapies should be used in particular cases and, when confronted with the same symptoms, will advocate contrasting therapies such as rapid ambulation versus bed rest for low back pain.

Even standards developed by consensus, and in many cases widely promulgated by national organizations, may represent only the "point at which all the errors, oversimplifications, and biases converge; it does not necessarily identify what is best."[2]

### What is 'Quality'?

What, then, is "quality" urgent care medicine? Following the verbose lead of the World Health Organization, the American Academy of Family Physicians says that "Quality healthcare . . . is the achievement of optimal physical and mental health through accessible, safe, cost-effective care that is based on best evidence, responsive to the needs and preferences of patients and populations, and respectful of patients' families, personal values, and beliefs." [3]

On the succinct end of the spectrum, Dr. Otis Bowen, former U.S. Secretary of Health and Human Services, said, "Quality is about people." That, however, seems a bit too simplistic.

Perhaps it is easier to think of quality medical care as patient-centered, elegant care—optimizing patient-desired outcomes delivered with the least expenditure, discomfort, and delay. This description accepts that healthcare professionals are not god-like creatures who never make mistakes or fall short. Rather, they are individuals expected to provide acceptable, reasonable care that does more good than harm. ■

**References**

1. American Medical Association. *Policy Compendium, 1992*, Chicago, IL, p. 315.
Eddy DM. Clinical policies and the quality of clinical practice. *N Engl J Med*. 1982;307:343-347.
2. American Academy of Family Physicians. *Quality Healthcare in Family Medicine* (Policy). Adopted 2000; Reaffirmed 2006.
3. Bowen OR. Shattuck lecture—what is quality care? *N Engl J Med*. 1987;316:1578-1580.