# Evangelism of quality

THE movement for health care quality improvement has many of the features of a religion. There are gurus — leaders whose ability to communicate their ideas and beliefs gives them a great deal of power and influence. There are adherents or followers who adopt those ideas and beliefs wholeheartedly and find great strength and comfort in the community of fellow believers. There are belief systems — sets of values and ideas about how health care organisations should work and what should be done to bring about improvements in quality. And perhaps most importantly, there is faith — in the effectiveness of quality improvement techniques in delivering sustained, meaningful improvements in the quality of health care.

The fervour and commitment that the quality improvement movement inspires in its followers may be powerful positive forces for good, helping to spread the ideas and expertise needed to improve quality, and making inroads into health care organisations where the quality of care has often not been a priority. However, they may also lead adherents to overstate or exaggerate the achievements of quality improvement, to generalise too readily from individual examples of successful implementation, and to ignore or disregard accounts of failure or disappointingly limited benefits. In the longer term, the use of quality improvement techniques or interventions in health care organisations should depend on whether they work — not on whether people believe in them, like using them, or find them intellectually or spiritually comforting. Reason and rationality — not faith and belief — should be the currency of debate and discussion.

However, the research evidence on a wide range of different approaches to quality improvement in health care suggests that there are no miracles or panaceas.[1-3] The harsh truth is that the effectiveness of quality improvement interventions is highly variable, and seems to depend crucially on the context in which they are used, and how and by whom they are implemented. Successful implementation requires commitment, investment, perseverance, attention to detail, and a lot of hard work. There are no simple solutions.[4,5] For health care organisations this has two implications.[6]

First, it suggests that the approach to quality improvement that is used may matter less than how it is used and by whom. The 'within-approach' variance in effectiveness may be as large or larger than any 'between-approach' variance. But there is a history in health care (and in other settings) of organisations chasing fads and fashions in quality improvement — taking up, using, and then discarding one technique after another. As a result, clinicians and managers are often confused and discouraged by the transience of quality improvement ideas and terminology. No-one wants to invest much time and effort in establishing systems for quality improvement if it is likely that next year they will be torn down and reshaped into 'the next new thing'. But that search for novelty looks distinctly foolish, given that most quality improvement techniques have varying but fairly similar records on effectiveness. Research suggests that organisations should choose their approach to quality improvement carefully, and then stick with it and make it work, showing what Deming long ago labelled 'consistency of purpose'.[7]

Secondly, it means that no organisation should assume that its quality improvement activities are effective. These interventions are complex and uncertain technologies that need continuing attention if they are to continue to work. In a sense, every quality improvement programme is an experiment. This suggests that health care organisations should design their quality improvement programmes to be 'autoevaluative' — in other words, to produce information that allows their effectiveness to be monitored on a continuing basis and which is capable of supporting and informing changes when effectiveness problems are identified. The content of that evaluation does not have to be especially complicated. It should include some activity data (on numbers and types of quality improvement activities), some outcomes or impact data (on the changes in practice that result from quality improvement activities), and some data on the costs or resources used. The aim should be a reflective process of self-evaluation that is used to bring about what could be called 'second order' improvement — improvements in the system for improvement itself.

In conclusion, those who market the latest technique for quality improvement to health care organisations — be it continuous quality improvement, process redesign, collaboratives, or whatever — as some kind of miracle cure, are the quacks of our age. They are snake oil salesmen who often stand to benefit from the take-up of the latest fad or fashion and who next year will probably be selling a different product with equal enthusiasm. Quality improvement in health care demands leadership, commitment, investment, perseverance, and hard work. There are no short cuts to success.

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