

# Total quality madness?

In 1993 I attended a seminar on education and training in the management of quality, sponsored by the Department of Trade and Industry. The message was clear: people bought Japanese products because of their quality and reliability. Now we had to learn from their methods to make British industry more competitive and to 'take the heads off the opposition'. We would make more profit and everyone would be happy: the customers, the bosses and the workforce (who would deserve a rise). I was there to see how the principles of Total Quality Management (TQM) might apply in the health service, particularly in the field of education.

TQM sounds like heaven on earth. First you make contact with the customers and find out what they really want. Then you work out how to supply it cost-effectively. The workers need to understand their role in this process and you need to listen to their problems in delivering it. Listen and support them in solving the problems. Aim for doing the right things first time. Establish trust and get commitment. Trust them to do a good job and check only a sample of the output. Make use of continuous feedback from customers and workers to refine the process. The customer is delighted. Everyone gets a rise.

Only kidding. The competition just became hotter. Everybody's doing it — TQM that is, and now we even have Japanese car factories in the UK. At least the customers should be pleased. Patients should be pleased, too, because a version of TQM has become embedded in the health service — it's called clinical governance.

At first sight the two systems are very similar. Patients' views are sought by satisfaction surveys, and their voice is also represented by the government, which sends its requirements to the health service managers and sets up national bodies to write quality guidelines and directives. The workforce are supported by an appraisal system and

the delivery of care is constantly audited with the aim of continually driving up quality. So why are so many patients, health workers and managers unhappy?

Perhaps it is because there much less connection between profit to be made and gaining a greater share of the market, as you would if you sold more cars. In industry, a proportion of the profit is reinvested in the manufacturing process and rewarding the workers, whereas investment in the NHS is funded from taxes. I know that there are still vestiges of the internal market, but these often seem to operate as obstructions to the system as organisations in secondary and primary care seek to shift costs onto each others' budgets. There is little business sense in a GP practice taking over anticoagulant monitoring for more patients if the resources available (mainly to pay for phlebotomists' and doctors' time) are insufficient. Although an element of practice income will derive from 'quality' points and enhanced services under GMS2, precisely how this will have an impact on profit in the short and medium term remains unclear, especially in view of the financial constraints of the primary care organisations.

Ideally, if the public want to buy more and better quality healthcare products, they can elect to pay more tax by voting in a suitable government. Recently there have been attempts by some politicians to raise public awareness of the need to consider higher taxes in return for improved services. However, the argument seems to be shifting back to cutting back on waste rather than increasing the budget. Revisitation of the 'value for money' scene could again be associated with increased administration and accountancy costs, and result in proportionately less resources for patient care. Ultimately it will depend on the sophistication of the electorate whether 'populist' policies (the notion that you can have it all and pay less) continue to hold sway. While they do, it is likely that political

'spin' will remain remote from the experience of the health service users whose needs do not fit neatly into government initiatives, such as the 2-week rule for suspected cancers.

The other consequence of unrealistic pressure on budgets is the increasing demoralisation of people who prop up the health service by working in it. Being subjected, on a daily basis, to ever more public demands (driven by political promises), central directives ('evidence-based') and detailed scrutiny (clinical governance) may lead health workers to adopt survival tactics and a cynical attitude that conflicts with professional values. Indeed, the term 'workforce' may have connotations with 'stick and carrot' policies that take little account of professionalism. Working on an industrial production line does not, on the whole, resemble conducting consultations in primary care.

James Willis has suggested that evidence-based medicine should be reserved for what is certain.<sup>1</sup> Coping with uncertainty is a major preoccupation of primary healthcare professionals, dealing with relatively undifferentiated presentations by individuals, where the relevance of international pooled research findings (often not from primary care settings) can be difficult to establish. There may also be conflicts of interest, connected with multinational corporations, funding of political parties and academic research, which are not immediately obvious and that may have the potential to influence guidelines on 'good practice'. Not all health professionals have the skills to do their own evaluations and most do not have the time, in the context of the other demands.

Phil Hammond referred to the phenomenon of spending half the working day proving that you are doing a good job.<sup>2</sup> The concept of accountability is central to clinical governance and has perhaps arrived with a vengeance in the form of the computer templates for

GMS2, which require to be completed during consultations. While the templates are based on good evidence, some clinicians experience a degree of conflict with the agendas brought by patients. Scrutiny is also creeping into the system of annual appraisal, originally supposed to be formative, but now criticised for not assuring fitness to practice. 'Whistle-blowing' is now the duty of all health professionals, not just appraisers, and failure to 'blow' puts registration with the professional body at risk. I am increasingly reminded of part of Solzhenitsyn's *Gulag Archipelago*,<sup>3</sup> which deals with Stalin's attack on the professional classes. Failure to meet unrealistic targets (for example, engineers being asked to design adequate bridges with inadequate materials) resulted in transportation to Siberian work camps or execution. Perhaps this will be thought an extravagant comparison by those who are surviving under the clinical governance regime.

Nevertheless, it is in contrast with the experience of industrial workers under TQM. Their concerns, in relation to doing a good job, are actively sought and addressed by management with adequate resources. Making a profit makes such a difference. In primary care, the appraisee is often sure that his or her concerns will be ignored, especially if resources are involved. Moreover, those concerns may have the potential of rebounding on the individual in the form of 'underperformance' procedures. Admittedly, the scale of retribution is not in the same league as transportation or liquidation.

Investment in education and training is treated as a priority under TQM. Maximising the effectiveness of the workforce is a major factor in increasing profits, which are then available for reinvestment, and so the cycle continues. That education is vital to improving quality in the NHS is obvious, but the reality is that it is underfunded and reliant

on the enthusiasm and commitment of health professionals, because people are not keen to pay more taxes. Unfortunately, the effect of clinical governance, with its emphasis on accountability, may be to erode that enthusiasm for education which is unsupported by adequate resources. I believe that we are about to see the results of this process in training practices, where extra responsibilities and throughput are proposed, but the remuneration remains at the level of half a locum. Two practices in my neighbourhood have decided to suspend training, in order to concentrate on scoring QOF points.

Is TQM a form of madness? Probably not if properly applied in a free market economy. Applied in the NHS, with many sticks and few carrots, it makes less sense. What we need instead is a system that really supports professionals and responds to their concerns, including education and training, with adequate safeguards, but perhaps less routine and detailed scrutiny. Actually this is a definition of TQM.

**John Middleton**

## REFERENCES

1. Willis J. Retarded access. *Br J Gen Pract* 2005; 55: 72.
2. Hammond P. Trust me, I'm a communicator. *Br J Gen Pract* 2005; 55: 3-4.
3. Solzhenitsyn A. *The Gulag Archipelago*. Glasgow: Collins, 1974.