Whether for life or death, do your own work well.

—John Ruskin

Quality

Where It Came From and Why It Matters

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A movement has emerged within health care over the past several decades that sees *quality* as the combined and unceasing efforts of everyone involved in health care—professionals, patients and their families, researchers, payers, planners, and educators—to make the changes that will lead to better outcomes, better system performance, and better professional development; in other words, better health, better care, and better learning. This sweeping view recognizes that the pursuit of quality and safety is a dynamic process, not a static and narrowly focused endpoint. People associated with the quality movement accept this pursuit as both a moral responsibility and a serious applied science. They also believe unequivocally that everyone in health care has two jobs when they go to work every day: to provide care, and to make it better—a view that is entirely congruent with the idea that "unceasing movement toward new levels of performance" lies at the very heart of professionalism.

Several centuries ago, the widespread adoption of commercial values arguably paved the way for the flowering of science. This essay explores the seemingly unlikely proposition that commercial values have also served as the principal catalyst for the quality movement in medicine when they have come up against the decidedly noncommercial values that medicine has held sacrosanct. Improving the quality of health care is likely to be crucial in the success of health care reform, in part because, like science, improvements in quality can bring benefits that serve as a powerful counterweight to the potentially corrosive effects of commerce on professional and social relationships.

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Guardians and Gifts, Science and Commerce

Medicine has historically shunned commerce. Until quite recently, for example, it was not acceptable for doctors and hospitals to advertise. The admonition to "shun trading" is a key element in what the scholar and social critic Jane Jacobs has called the "guardian moral syndrome"—a code of tightly linked moral values that governs one of the two systems of human survival, "taking" (the other being "trading"). In public life, the guardian moral syndrome, which includes the exertion of prowess, adherence to tradition, and the dispersing of largess, is expressed most clearly in government, but also in the military and religion—all of which support themselves through the taking of taxes, tithes, and territory.

Since healers were initially members of a priesthood, it should not be surprising that from its beginnings, health care was essentially a creature of the guardian moral syndrome. Of course, like everyone else, healers need to put bread on the table. But since they neither taxed nor tithed, they were forced to engage in trading. Until about fifty years ago, however, they did so on a limited scale; to a substantial degree, they relied instead on nonfinancial rewards from the "gift relationships" inherent in medical practice. That is, they relied on deferred and uncertain (but ultimately increased) rewards offered in response to

their gifts of care and healing. Rather than devoting themselves to the immediate, calculated exchange that defines commerce (such as contracts, investment, capital, and interest), healers felt themselves to be rewarded through their high social status, enormous respect, and great professional autonomy.

The underlying moral values of health care in the West changed at a glacial pace, if at all, until about the beginning of the nineteenth century. That was a time of enormous social and intellectual change: the latter stages of the Enlightenment, the beginning of the end of slavery, the spread of democracy and republicanism, the emergence of the industrial revolution, and the rapid evolution of science. Jacobs argues that a major—and perhaps *the* major—force that drove most of these social changes was the progressive shift from the small-scale exchange of goods and services (much of it in gift relationship mode) into full-blown commercial enterprises.

Commerce depended for its success on the assertion of its own moral "syndrome," which consisted exactly of the moral values that science needed in order to flourish. In commerce, as in science, the questioning of dogma—dissent—became a virtue rather than a heresy. Likewise, meticulous observation, insatiable curiosity, and innovation were prized qualities rather than distractions; the generation of new knowledge was recognized as a productive investment, rather than a threat; and honesty and transparency became the bedrock of marketplace conduct, for the very concept of money rests entirely on trust.

Medicine Becomes a Commodity

The scientific awakening slowly made its way into medicine during the nineteenth century, leading to many new, more rational, and improved ways to care for patients, including anesthesia, antisepsis, and x-ray imaging. But until about the time of World War II, the guardian moral syndrome continued to dominate health care's social values, and explicit concern for quality and safety remained strangely muted.

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Two events that emerged in the 1940s were instrumental in prompting medicine to take quality and safety seriously: the discovery of antibiotics, with their seemingly miraculous power to cure humanity's traditional scourge, infectious disease, and the evolution of improved study designs and statistical methods, which made possible the subsequent development of quantitative clinical research. The arrival of potent pharmaceuticals, plus better ways of documenting their effectiveness (not to mention better surgical techniques), led to a sweeping epiphany: what doctors do actually "works"! Equally important, most of these dazzling new interventions could be separated from the "learned intermediaries"—namely, doctors—who delivered them, which made it easier to give them commercial value and to buy and sell them in the marketplace.

And to be sure, during the past thirty years, health care has become at least as much a business as a profession: patients are now considered "customers," doctors and hospitals advertise product lines, and medical insurance companies consider money spent on clinical care to be the "loss ratio." The preoccupation with quality and safety in health care has emerged exactly in parallel with this surge in medical commercialism. The commercial values of comfort, industriousness, thrift, and efficiency have been instrumental in industry's development of an entire science of improvement and safety that is now slowly working its way into health care. And although it would be hard to prove conclusively that the two are related, the striking resemblance between these commercial values and the Institute of Medicine's rules for achieving quality—which include transparency and the free flow of information, continuous decreases in waste, and customization based on patients' needs and values—argues strongly for a causal connection.

The Value of Quality

Both commercial and guardian enterprises are essential in well-functioning societies: when either has pushed the other aside, the result has generally been disastrous. Consider, for example, the devastation that has resulted from total government control of economies such as in the Soviet Union and, more recently, Zimbabwe; or, conversely, the chaos and destruction that has occurred when radical free-market policy has replaced most major governmental functions, as in the recent history of Indonesia, Chile, Argentina, and South Africa, among other places. Further, the two moral syndromes must be held together in tension: they cannot be blended together into some entirely new enterprise, nor can they be rigidly separated. The only viable option then is for the two enterprises to develop a symbiotic relationship that leaves intact the values characteristic of each, but at the same time fosters close, respectful interaction between them. This is what hap-

pens, for example, when government legislates a goal, such as increased automotive fuel efficiency, but leaves it up to industry to figure out how to accomplish that goal, whether by improving engines, or making vehicles lighter, or developing some other, entirely new strategy.

As things stand now, a complex and often contradictory mix of guardian and commercial moral values is roiling the health care system. For example, the moral obligation felt by providers to do everything possible to meet every patient's medical needs can be seen as a form of guardian "largess" that supports—and is supported by—commercial interest in financial gain, but at the same time conflicts with the commercial values of thrift and efficiency. And the fragmenting effects of commerce on social relationships can result in distressing "buyer beware" scenarios. Take, for example, the recently proposed system of consumer-driven care, in which trust in physicians, based on unverifiable assertions about the cost and quality of individual physicians' services, could be converted from a purely instrumental good into a commodity that would be bought and sold; a marketplace for such behavior could end up pitting physicians and patients against one another as suppliers and customers.

★ Policy Implications ★

For it to be successful, health care reform will need to manage extremely effectively the tension between guardian and commercial values that currently pushes and pulls medicine in wildly different directions. If it fails to do so, we are likely to face increases in the fragmenting effects of commerce, including increases in the damaging effects of conflicts of interest, particularly in clinical research; worsening of the destructive drive for "hamster wheel" productivity in clinical practice; and further distortion of undergraduate, graduate, and continuing medical education under pressures of money and time—while at the same time we could fail to overcome guardian legacies such as inefficiency, uncontrolled largess, and difficulty in responding to patients' values and preferences.

But if we're clever and tough enough to build in "moral syndrome-friendly" interaction throughout a reformed health system, there's no telling how much better off patients, providers, and everyone else might be. In fact, the many existing examples of syndrome-friendly interactions that support *both* better clinical outcomes *and* increased efficiency already give some cause for optimism. Thus, pay-for-performance, although hardly a panacea, honors the principle of making better clinical "widgets," rather than just more clinical "widgets." Pragmatic clinical trials are beginning to provide valuable information on the comparative effectiveness of new and existing interventions, strengthening further the marriage between effectiveness and efficiency. And exploration of the business case for quality suggests that better care can save "dark green dollars"—real, bankable savings, that is, not just the "light green dollars" of potential, on-paper savings.

Finally, consider patient-centered care, a concept that found little support in medicine over the centuries, but that is now emerging as a core precept in medical quality improvement. It seems right that the long-standing and widely honored commercial adage "The customer is always right" is creeping into patient care. Who would have guessed?★