Evaluating Health Care Appropriateness Means Putting a Value on its Goodness: The Role of Expectations and Trust

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ABSTRACT

The measurement and evaluation of healthcare services continues to be challenged when the appropriateness of the services is its focus. Good outcomes do not mean the services were needed or that the process of delivering care was efficient. Further, patient and family satisfaction with the care episode is influenced by the promises the healthcare system in general and physicians in particular made to the patients. As such, physicians have the dual role of educating patients while they are managing their health status changes. Eventually, it is a question of accountability about the processes and outcomes of the care, which are expected to both demonstrate the social responsibilities of health care professionals and gauge the expectations of patients, families, and communities. The purpose of this article is to explore the determinants of what and why patients expect from healthcare and caring. Within the concept of accountability, the role of physicians as educators rather than exclusively healers of disease is explored.

Keywords: EBM, Health Care, Health Care Quality, Patients Expectations, Physicians as Educators

INTRODUCTION

A culture is perhaps most simply defined as the interaction of what people take for granted. Growing up in countries around the Mediterranean, I learned the importance of knowing what people took for granted. From “if you see the teeth of the tiger don’t think the tiger is smiling at you” to “if it is written upon your forehead, it will happen”, culture was the environment within which we accepted, changed, or celebrated what we had. What people take for granted has to be considered their reality, and during my three decades of healthcare research in four continents I made the conscientious effort to not immediately challenge what is locally believed to be right or wrong, even if à priori I may not always know the intrinsic rationale for their belief system.

This was (and remains) my guiding principle when, like many others, “accidentally” I became involved in the field of health care quality improvement. Accidentally, because in 1982 I was a junior epidemiologist in an Arab country in the Persian Gulf involved in helping the
Ministry of Health build a national healthcare information infrastructure as well as construct primary care centers based on the “reservoir of need”, mainly involving maternal and child care. After establishing a baseline of need, the population distribution helped decide where to locate the centers. After a few months, we looked at utilization patterns in the centers. One center had a higher utilization rate than expected, and we decided to find out why. Since I spoke Arabic, I volunteered to interview patients and providers. When I entered the “Women and Children wing” of the center, I saw children running around and playing as if in a playground. Mothers, wearing the traditional Arabic dress, had most of their bodies covered, showing only their eyes, hands and feet. I approached one mother and asked what brought her to the health center. She told me she comes here every day, “mostly for a back pain”, and added that her 4 children always come with her. When I asked if her back pain was getting better, she said “may be, God willing it will be fine.” When I pushed more about the real reason for her visiting the center, she looked at me in surprise and said “but this is the only place in the desert that has cold water fountains and air conditioning!” I realized that we had built community centers not primary care clinics. And that was the “accident” which brought me to quality in health care.

**PURPOSE**

This article touches on the topics of local expectations about quality, as influenced by the belief sets, i.e., what people (patients and providers) take for granted. Within that context, I would like to discuss how education and communication about quality could be best structured and carried out.

**Doing the Wrong Things Well: How to Challenge Old Assumptions?**

Quality Assurance and later Quality Improvement professionals are trained to identify what has gone wrong.

Three aspects to consider:

- Assurance means a promise—that we can assure the service is of good quality;
- Improvement already indicates that things can be done better; and
- Wrong means that we know what is right.

I would like to look closer to these concepts, as I believe they constitute the template for all education programs.

1. Physicians, and later the health care system, have been the traditional keepers of the medical wisdom. Indeed, before science, it was the wisdom that made a physician a special social person. In this instance, wisdom may be defined as the synthesis the physician is able to make by combining observations from his experience with the available science. Interestingly, “wise” people may be more noticeable when the science is limited but they can do deductive thinking based on observations. In fact, when the deductive thinking was substantiated, it elevated him (later her) beyond the status of a “person”—to that of a mystical creature, often hearing from and responding to higher authorities. As such, the word of a physician was indeed the assurance needed that all wisdom, knowledge, art and skill were applied to treat the disease of the patient. Therefore, quality assurance was a logical qualification of the role of the physician, and later of the health care system itself. People took that for granted, therefore did not challenge. More, people unequivocally trusted the physician to do only the right things for them.
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