

– We are members of one another instead of autonomy.

What theological language presupposes: The uniqueness of self is founded by co-presence of the other. We know ourselves only within our relationship with others.

• We will enlarge the role of the primary narrators—patients, families, physicians, nurses, social workers. We will be dealing with a much denser complex of interrelationships that may affect the ethos of the context in which we do bioethics.

The Theologians' Contribution to Bioethics

The focus here has shifted from theology to the person doing the theology, namely the theologian. The essential role of theologians has always been: Directing attention to dimensions of human situation that may have escaped our notice, “to account for the interpretive frameworks” people bring to their experiences of health, medicine, suffering and death within a vision of human nature and destiny. In doing this basic function, the theologian assists in placing a particular decision within the context of a fuller account of purpose and meaning in life. And when that is done, it can deepen our appreciation of the moral dilemmas we face and of the options available to us for responding to them.

One example of alternative to moral dilemmas is that of the physician-assisted suicide. A physician who opposes physician assistance in dying is physician-philosopher Leon Kass. In *Why*

Doctors Must Not Kill, he argues:

The deepest ethical principle restraining the physician's power is not the autonomy or freedom of the patient; neither is it his [sic] own compassion nor good intention. Rather, it is the dignity and mysterious power of human life itself, and, therefore, also what the oath calls the purity and holiness of the life and art to which he has sworn devotion. A person can choose to be a physician, but he or she cannot simply choose what physicianship means.⁷

One can respect the wishes of a physician who believes it is the deepest constitutive essence of the physician to respect the dignity and power of human life. Yet a theologian will raise another point of view, “to participate in covenant with their patients to explore the meanings of death which challenge all of us, not only as physicians but as human beings.”⁷

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Ethics, Standards, and TQM

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The most important ethical issue for our profession is the responsibility to assure the care delivered by our colleagues and ourselves meets a self-imposed standard of excellence. There is anecdotal and experimental evidence that we have not fulfilled this obligation. Peer review has proven, for a number of reasons, to be ineffective; however, improvements in the epidemiologic sciences should provide better standards and total quality management (TQM) might prove to be of value in monitoring, comparing and improving the decisions made by physicians. Its promise lies in its emphasis on statistical analysis, its focus on systematic rather than human error, and its use of outcomes as standards. These methods, however, should not diminish our other professional responsibilities: Altruism, peer review, and in Hippocrates' words “to prescribe regimens for the good of our patients—and never do harm to anyone.”

Now that we are an industry, medical economic concerns tend to dominate our professional debates. So it is refreshing to be a part of this special issue of the *Hawaii Medical Journal* focusing

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on medical ethics. Our profession should participate in the debates over ethical dilemmas such as the impact of genetic discoveries, society's responsibility to provide universal access to health care, the rationing of health care services, and the extent to which patients should have a choice in treatment decisions. To be an effective voice in these debates, however, we must resolve some internal issues that have been avoided. These relate to our ethical responsibility to assure that the care delivered meets a self-imposed standard of excellence.

Standards are a prerequisite for professions. *Webster's New Collegiate Dictionary* defines a profession as a calling requiring specialized knowledge and often long and intensive preparation.¹ This narrow definition, however, does not do justice to the full import of the medical degree. The obligations, responsibilities and power of physicians go well beyond the intensive study required to obtain our specialized knowledge. Starr and Friedson have pointed out that the medical profession is a legal, institutional and moral privilege granted by society that must be earned by physicians through observing certain standards of behavior.² According to these authors, standards of behavior include, at least, altruism, a commitment to improvement and peer review. I would add to these the admonition of Hippocrates, “I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone.”³

Physicians are better decision makers than patients because their years of intensive study have resulted in what economists refer to as "asymmetries of information." This means physicians have more knowledge than patients so that medical care decisions are left to them. Furthermore, most patients expect and want to rely on the knowledge of their doctors to help them decide what they should or should not do when they are ill. No amount of patient education is likely to change these asymmetries, and thus relieve physicians of their responsibility, and patients of their vulnerability. To use this knowledge "for the good of my patient" is the most solemn ethical obligation of a physician who wishes to earn the privileges of our profession.

On the other hand, physicians are subject to economic conflicts of interest regardless of the method of reimbursement. In a fee-for-service environment, the temptation is to provide more services than required; in a capitated system the opposite is true. To remain professionally responsible, the physician must resist taking advantage of these conflicts. Furthermore, there are potent noneconomic factors that can at times influence physician decisions adversely, including individual patient desires, societal pressures, the physician's desire for self-fulfillment and her or his style of practice. So it is not enough to trust our "ability and judgment," which can be influenced by all of these factors that are extraneous to the clinical situation. We must depend on our profession to help us resist the temptations to which frail human physicians are heir.

How effective has our profession been in fulfilling this responsibility? The apparent answer is: Fair to good but certainly not perfect. The data is anecdotal and evidence based. McPheeters has compared the utilization rates for laparoscopic and operative cholecystectomy. He points out that patients who have asymptomatic gallstones are being operated on much more frequently now that the laparoscopic procedure has become the technique of choice, and that this increase cannot be justified by a change in indications for cholecystectomy.⁴ Previous studies had suggested that as many as 14% of coronary artery bypass procedures⁵ and 32% of carotid endarterectomies⁶ are performed for inappropriate indications.

The observation of persistent differences in the way patients are treated from one health care setting to another has been referred to as the variation phenomenon.⁷ It was first described by Wennberg who noted very large differences in the rates of tonsillectomy, hysterectomy, and prostatectomy in different small areas in Maine.⁸ The existence of this phenomenon has been established beyond a doubt; the variations having been observed in the care of patients of all ages⁹ and in all settings.¹⁰ These differences cannot be explained by statistical or technical factors such as differences in case mix, etc. Nor has a cause been identified. Interestingly, studies designed to test the hypothesis that inappropriate use might explain geographic variations did not establish a relationship between the two phenomena.¹¹ Regardless, the fact that physicians often treat apparently similar patients in very different ways has raised doubts about the scientific bases for their decisions. To some we have become just another interest group struggling to maintain its economic self-interest. And, while this is not true, it is easy to see how these variations have eroded our stature as a profession. It is difficult to fathom how these variations might be considered to be of value.

Virtually every hospital or health care institution has a peer review mechanism and that is presumably true of the institutions in which these variations were documented. So it seems fair to

say that peer review has had limited value in standardizing the level of care in different sites. Two incidents were reported by surgical and medical residents recently that strengthen this argument. Both involved patients who were operated on in spite of the fact that their cancers were inoperable. These were teaching cases and as such they were used ostensibly to teach medical and surgical resident physicians how to make decisions. In one of these instances, the surgery went so badly and the surgeons were so cavalier during the operation, that the surgical resident assisting at surgery was tearful as she described this experience to her professor.¹² To the credit of the Department of Surgery of the University of Hawaii, these incidents are being investigated to determine if the surgeon who performed these apparently unnecessary operations is a fit role model for students and residents. To the best of our knowledge, these cases have yet to be peer reviewed in the hospital in which the surgery took place.

There are of course technical problems that make peer review difficult. First, most peer review processes are directed at finding outliers, the assumption being that anyone who has had a bad result has been a bad physician. Physicians have difficulty doing this, especially in the closely knit culture of the medical center. Second, the process has been heavily influenced by lawyers so that the due process requirements are staggering. Third, there has always been a reluctance on the part of physicians to define quality in terms specific enough to be used as peer review standards. Finally, it has not been in the financial interest of the hospitals and medical centers whose responsibility it is to support and underwrite peer review activities to insist that they be done with conviction.

There have been advances, however, that should make us optimistic. In the first place we have the advantage of better data. Epidemiologic methods are improved and studies using these methods have resolved critical treatment issues. For instance, it is not difficult to identify treatment goals for patients with diastolic and systolic hypertension and diabetes mellitus. There is good data describing the preventive benefits of mammography, pneumococcal and influenza immunization, and prenatal care. The indications for coronary artery bypass procedures are clear, although compliance is not always certain.

There has also been experimentation with other methods to monitor, compare, and improve decisions made by health care providers.¹³ Among the most controversial of these is total quality management or TQM, alias CQI, QIP and IQMS. Whereas this method is popular among health care administrators and managers, it has not been utilized by physicians to help with peer review. The reasons for this are many and complicated, although perhaps the most important is that there is only anecdotal evidence that it can, in fact, improve physician patient care decisions. However, it has been used successfully in industry to control variation and so it deserves more consideration.

Suffice it to say that three activities are emphasized as being important to total quality management. Berwick used these words to describe these activities as: 1) efforts to know the patient and to link that knowledge to the day-to-day activities of the organization; 2) efforts to mold the culture of the organization to foster pride, collegiality, and scientific thinking; and 3) efforts to continuously increase knowledge of and control over variation in patient care through scientific methods of data collection and analysis and action on data.¹⁴

It is the third activity that has stimulated the development of specific tools which may apply to our profession's responsibil-

ity for accountability. These tools basically provide ways to display and analyze data quickly. One of these is the control chart used in statistical quality control (SQC) (Fig 1).¹⁵ The vertical axis measures some aspect of health care that is considered important to quality. This might be mortality rates, morbidity rates, mammography rates, utilization rates, etc. The horizontal line measures time. The solid line represents the mean of the observed values and the dotted lines represent upper and lower control limits. These limits would define expected or acceptable variations. The value of such charts rest in their ability to demonstrate quickly when observed measurements fall outside expected or desired limits.

Because the standards of quality are statistical rather than empirical they are more objective. This is especially true if they define outcomes rather than process. Early attempts at quality control focused on process factors which were determined by consensus. In those systems there was much room for argument about quality as it was often impossible to determine if the process factors were of value in determining the outcome of care in individual or groups of patients. There is less room for argument if quality is defined by outcome, especially if that outcome is based on scientific data. Thus, a study that determines there is value in maintaining systolic blood pressure below 160 mm Hg in effect develops a standard against which the care of individuals can be measured. There will be some variation but most measurements of systolic blood pressure in an individual or a group of individuals should fall below this upper limit. There is activity now in the field of outcomes research to develop and validate such standards.

One advantage of this method of quality control is that it focuses on systematic factors rather than on finding bad physicians who make bad decisions. Criticism of a peer places physicians in uncomfortable dilemmas. Any quality-control method that mitigates the discomfort should be welcomed. There are reported anecdotes describing successful reductions in variation by using this methodology. The Department of Clinical Epidemiology at the Latter Day Saints Hospital in Salt Lake City used TQM to reduce the rate of post-operative infections from 1.8% to 0.4%.¹⁶ They started by noting that certain physicians had higher rates than others. Then they established that these physicians used different times of administration of pre-operative antibiotic prophylaxis. When these times were changed the infection rates dropped.

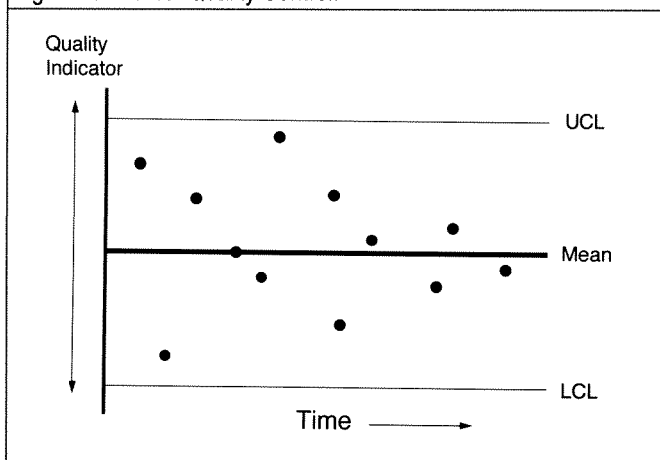
The rationality of TQM should not be used to diminish the requirement for the other activities noted. We must continually remind ourselves that:

Our profession's altruistic responsibility includes a commitment to make the benefits of health care available to everyone.

Peer review is a necessary part of our ethic even when it requires difficult decisions that involve our friends and colleagues. In order to make this process effective, standards of behavior must be clearly enunciated and strictly enforced. Unfortunately, these standards cannot always be objectively defined by a statistical analysis of outcome data. Those that define, for instance, the patient-physician relationship, the limits of accepting gifts from drug companies, the altruistic responsibilities of physicians, etc. can be developed only consensually by professional organizations. Membership should depend on conformance with these standards.

We should make every effort to determine what our patients need and want and direct our efforts to those ends. However, physicians are often in the best position to define futile care and

Fig 1.—Statistical Quality Control.



it is their responsibility to refuse to prescribe such regimens regardless of the social and legal pressures to do so.

It would be exhilarating to re-experience the pride, joy, collegiality and scientific thinking that characterized our profession before it became an industry. Lifelong learning is critical to our profession, so continuing education should be its major priority. Professional organizations, schools of medicine and health care institutions should join to rekindle the fervor for knowledge that once inflamed our profession. It is especially important for these institutions to do so because they have been so influential in causing it to burn fitfully.

Unless there is a commitment to quality it cannot be achieved no matter how much data is collected or analyzed. Making such a commitment involves going beyond the materialism of economics and science into the spirit of our professional souls. It requires idealism, dedication, and sacrifice. If quality is to become a part of our professional ethos, it will be because we are sufficiently idealistic to define excellence, we are dedicated to its achievement, and we constantly challenge ourselves when we have not succeeded in doing so.

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