

## Clinical Management and Common Sense

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In order to respond to the new challenges of medical care, it may be necessary to change the organization of health care services. It would undoubtedly be easier to commence from simple, agile, and flexible structures. However, this is not the case of Spanish hospitals which, although they have attained a scientific stature comparable to that of other countries, have a complex, rigid, and self-serving vertical organization. At present, many groups of the medical professionals are looking for new organizational formulas that will enable them to provide better care and feel more closely identified with their work.

Indeed, it is significant that scientific journals provide page space for these topics. Why has the REVISTA ESPAÑOLA DE CARDIOLOGÍA decided to accept articles on clinical management? Perhaps we have become convinced that quality of care is something more than an appropriate diagnostic and therapeutic process. As Donabedian affirmed: «There are several definitions of quality, or variants of a single definition, and...each definition or variant is legitimate in terms of its appropriate concept». In any case, the definition goes beyond the technical treatment of disease and includes points like amount of care, cost, benefits and risks, interpersonal attention, accessibility, continuity and coordination, patient satisfaction, etc.<sup>1</sup> The use of scientific journals as a forum for discussing professional concerns is not a novel phenomenon in other developed countries, and concern for the rise in health care costs (and, consequently, the social responsibility that any clinical decision involves) and the interest of physicians in playing a leading role in the management of scientific knowledge in daily practice are shared by us all. More than twenty years ago, we could read interesting debates on this topic in North American and British journals. An example is this strong

affirmation: «The cost of health care is being treated to a great extent as if it were an economic problem, but it is not. In order to find a solution, it must be treated as an ethical problem».<sup>2</sup>

The present issue of the Journal offers an article by Rodríguez Padial et al<sup>3</sup> on the effect that certain changes in the management of a cardiology department had on the care that patients receive, quantified as a combination of indicators. In earlier journal articles, we have become acquainted with the projects of the Complejo Hospitalario Juan Canalejo of A Coruña<sup>4</sup> and the Hospital Clínic of Barcelona,<sup>5</sup> which were also commented in an editorial by Vallés Belsué.<sup>6</sup> In all three of these cases, management innovations were justified by the need to enhance the efficiency of available resources. They also had a common goal: to centralize patient care.

Nevertheless, whereas the Complejo Hospitalario Juan Canalejo and Hospital Clínic set out to transform the existing organization, the Hospital Virgen de la Salud of Toledo attempted to optimize the operation of a «traditional» department. In our judgment, this could be an excellent practical demonstration of the importance of cultural changes with respect to structural modifications, although it is evident that these changes are not mutually exclusive. Indeed, in the study by Rodríguez Padial et al, it is noteworthy that the fundamental element of their strategy was «the determination of most of the department staff to improve things». This factor is difficult to characterize objectively in the Methods section of a scientific article, but it is of capital importance and possibly essential to any advance in clinical management, easily surpassing any other organizational reality in importance.

### Historical background

The evolution of our health care system towards greater efficiency, a view of the patient as a core element for organization, and enhanced involvement by professionals has laid the foundations for what we now call «clinical management», which rests firmly on these three pillars.

In the 1980s a method of hospital management based on mere «administration» was replaced another method

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that really tried to «manage». It was then that managers first began to be selected. Managers did not always come from the health care sector nor were they necessarily physicians. An attempt was even made to «professionalize» them (which was unsuccessful then and continues to be unsuccessful). A methodology, called the «new hospital management model»,<sup>7</sup> was introduced. This methodology, reflecting the need to manage our hospitals, established goals for care and economic objectives, creating a minimum unified information infrastructure throughout the network, and systematically introduced quality control measures and the «humanization» of care.

The mythification of «management», first as an industrial model and later as a service company, caused us to view the formulas proposed in other countries with curiosity, and even envy. The Thatcherian *Working for Patients* program (which proposed to establish an internal health care market), and the debates that took place among members of the North American medical corporation on the ethics of resource use and the role of physicians as businesspeople were required reading. For a series of reasons that were not always explicit, among others, the introduction in 1987 of a certain structure and organization of public hospitals, which is still active, Spanish physicians were progressively distanced from institutional objectives. It was eventually demonstrated that without their participation, or «complicity», results in terms of true efficiency could not be improved. Parting from a conception of hospitals as knowledge-based organizations, the first proposals were formulated to achieve this objective.

The so-called «co-operative agreement»,<sup>8</sup> proposed by the Spanish Ministry of Health in 1992, was but an embryo of what we would now call a «clinical management unit» (CMU). In the words used then, it was an institutional pact with a group of professionals with the following elements:

1. Explicit economic incentives linked to the attainment of objectives, such as increasing levels of efficiency.
2. A guarantee of the quality of care, aided by information systems for evaluating the process and results.
3. Co-responsibility of professionals for the management of resources, which inevitably entailed their self-organization.

Health care executives proposed the election of a person to head the group, with decision-making capacity and authority over all members, assuming that it would not be compatible with the destructuring produced by «...the independent vertical development of division executives (medical, nursing, and management)». The preparation of diagnostic and therapeutic protocols by consensus, with the participation of professional and scientific organizations, was also proposed. Likewise, it

was suggested that membership in a team be voluntary. Briefly, there was a determined intention to overcome a hospital organization that was inefficient and failed to motivate physicians. Nevertheless, we had to wait until 1998 for minor regulations to appear that would lend legal support to new units.

In the origin of this evolution in the perspectives of politicians was concern for the increase in health care expenses, which claimed a progressively larger part of the Gross National Product (GNP) from year to year. Mainly, there was fear that this growth would become uncontrolled, given its independence from any specific policy. In addition, there was pressure from government budget offices, which, apparently oblivious to the fundamental fact in the health care economy that physicians are agents of both the supply and demand of services, obstructed the implementation of any management changes that would enhance their independence. Given their deeply rooted distrust of physicians, their only proposal was to curtail budgets, which led to shifts in budget outlays and eventually tarnished the reputation of health care and those who managed it.

However, clinical management should not be contemplated solely, or even principally, as a solution to increased health care costs. Among other reasons, this is because health care expenses in Spain are still relatively small compared to other European countries, even when compared only to national health systems. Professor Navarro<sup>9</sup> claims that there are two very important indicators for defining the degree of political commitment of leaders to the public health sector: health care expenditures as a percentage of GNP and employment in the national health system as a percentage of the adult population. In Spain, both indicators are well below the mean of the European Union. In addition, 30% of our public health care expenditures corresponds to pharmaceutical expenses. The establishment of CMUs in hospitals does not seem to be able to curtail this cost significantly. Increased efficiency is more likely to be achieved by an increase in activity than by a reduction in costs.

Clinical management not only responds historically to the universal concern for more efficient health care services, but also to three other facts: uneven access to health care, dissatisfaction of professionals, and the new role of consumers in these services.

1. Different styles of clinical practice, even within what is based on scientific evidence, entail different costs, promote an unequal access of users to the system, and result in different levels of quality.

2. Physicians do not feel satisfied with the role they have been assigned in hospitals organized according to the model that has been effect. The organization by departments fragments the care of a given patient within the context of a specific process. Adequate coordination often depends more on the determination of each specialist than on operational logic or scientific evidence.

Leadership of units, in the absence of a true professional specialty that makes it possible to separate executive functions from questions of professional recognition, depends more on the age or time of service of candidates than on true leadership capacity. There is no system of incentives —positive or negative— to reward interest doing a good job. Initiative is not encouraged, nor is autonomy allowed, within the context of good practice and institutional objectives.

3. The new model of the user of our hospital services is a patient who is increasingly more informed and demanding, and wishes to participate actively in his or her own treatment and the decisions that it involves. This model requires an internally coherent organization and a better balanced, symmetrical, and less paternalist relation with professionals. Our users want to know, and have the right to know, what we are going to do, when, how, and what risks will be involved...This relationship is complicated by the greater possibility that patients have access to information, which is not always complete and truthful, before coming to our office. «The revolution of knowledge appears as both a cause and effect of change...This revolution is not free of risks, since access to more information does not mean access to the best information or understanding of the information by different users.»<sup>10</sup>

## Characteristics of Clinical Management Units

As defined in different proposals of the responsible authorities and documents issued by professional meetings:

1. CMUs are integrated by physicians (functionally unifying existing departments or segregating some department components) and nursing personnel who work in the activities of the «portfolio of services». Affiliation with the CMU is voluntary.

2. To constitute CMUs, their activity should be significant within the context of the activities of the center: usually about 10% of overall activity.

3. The organization of the CMU is patient-centered.

4. Agreements are reached directly with the management of the center on:

- the portfolio of services and quantifiable objectives;
- preparation of clinical guidelines, and
- budget, balance sheet, and incentives.

5. CMUs use self-evaluation measures and periodic external audits.

6. Management is independent, the person in charge can sign contracts for employees and services and the acquisition of goods.

It is difficult to find legal and legislative support for this last item, which has become the greatest obstacle to the generalized spread of CMUs. Another obstacle, in practice, is the limitation of incentives, either because the budget and compensation model is too rigid or be-

cause of fear of pressure from other groups. In addition, CMUs need a reliable system of information that responds to the needs of clinical management, which is very different from proposals by some managers that CMUs adapt to the information systems existing in hospitals, which are designed more to assess indicators of pure efficiency than of quality.

If we were really strict and only recognized the CMUs that met all the conditions described above, there would be very few CMUs in Spain. The immense majority would be found in centers governed by a special statute due to their historical origin as privately endowed institutions.

## Obstacles

The development of CMUs is subject to threats and of varying importance from different quarters, like most new ideas, particularly those that call into question the established order of things. There is a risk that «clinical management» will become a jargon term for a cult of initiates, a new terminology that is incomprehensible for those who are actually involved, a meta-language that tends to perpetuate a caste of «managers» and «experts» of all sorts. The emphasis on «clinical» management should not be lessened, management is, indeed, «clinical» and must be an instrument in the hands of practitioners. Otherwise, it again distances the physician involved in medical care from the new organizational forms. If the loop between managers and practicing physicians is broken, we will just have to begin again.

The study and establishment of CMUs, like other innovations in hospitals (computerization, purchase management, «outsourcing» of services, etc.), is fertile ground for consultants. These specialists often do no more than make an attractive presentation of information obtained from clinicians and offer a combination of proposals that often coincide suspiciously with the opinions heard during the interviews held in the course of studying the problem. Expensive courses proliferate and are often taught by staff who lack hospital experience, but still feel qualified to explain, with equal measures of confidence and inexperience, this or any other topic that currently concerns the health care system.

Nonetheless, the main strengths and weaknesses of CMUs lie in their members. A department with poor professional qualifications and lacking in motivation cannot generate an excellent CMU. CMUs do not produce miracles. For that reason, it is important to be realistic when considering organizational changes. Otherwise, we could find ourselves in the paradoxical situation of subjecting the hospital to a complex, possible convulsive, process, only to find that we have replaced an obsolete structure with a useless one. Hospitals generally maintain an unstable balance that allows them to continue to function every day, although in a way that is unsatisfactory for staff and not very efficient. Disrupting this ba-

lance without any guarantee of securing the consensus of a «sufficient critical mass» of employees could be an irresponsible theoretical exercise. The replacement of one organizational chart with another organizational chart does not constitute an aim in itself. On the contrary, such an exercise might be what Alan Maynard calls «re-disorganization» (paraphrasing Caius Petronius: «...we tend to respond to any new situation by reorganizing ourselves... which is a wonderful method for creating the illusion of progress, but what really takes place is confusion, inefficiency, and demoralization»).

Are professionals prepared to assume responsibility for managing the resources that we work with? Our position on the matter is similar to that found in the U.S. more than twenty years ago. In 1978, Einthoven stated that «physicians...receive no training in medical economics. Most of them have no idea of what hospital costs are in reality...or of the secondary costs of patient care». A 1986 survey revealed that 6 out of 28 schools of medicine in the United Kingdom had no program on health care economics, and three-fourths of the other schools dedicated no more than 4 hours per course to the topic. In Spain, despite specific dispositions in the directives governing study plans, which were approved in 1990, most students of medicine do not receive specific and sufficient training for the administration of patient-care budgets.

The progressive and gradual implantation of CMUs through cultural and organizational changes, with an operative plan previously designed from a participatory, would be a reasonable way to minimize these risks.

### **Above all else: common sense**

Faced with attempts, that are not at all gratuitous, to complicate what is simple and emphasize the obvious, it is necessary to demystify clinical management and any other paradigm that replaces it. Clinical management is like everything else in medicine: the practice of common sense tutored by scientific evidence.

The article by Rodríguez Padial et al confirms that. Significant results can be obtained simply by organizing for patients. It does not seem logical that the diagnostic and therapeutic approach to a patient with acute coronary syndrome, for example, depends on whether the patient enters the hospital from the emergency room, cardiology, a coronary unit (which may be part of an intensive care service), internal medicine ward, hemodynamics laboratory, or cardiac surgery beds. All this occurs because of the existence of an outdated organic structure that only serves to maintain the fiction of levels of power, but has no functional content or utility for patients.

If we make a small collective effort to think about patients, about the path they take from the first appearance of symptoms until the work up is complete and treatment is applied, if we link the personnel and tools that

may be needed in the course of this process, and make an effort to apply clinical guidelines from each access point, we will be designing the functional unit that is required. But we should contemplate these processes without any previous assumptions, situating them in what John Rawls called «their original position», without any foregone conclusions about what our final position in the organization should be when the proposed changes are carried out. Resistance to change, due either to distrust of a model whose execution has not been fully outlined, or to fear of losing status unjustified by professional leadership, is at the heart of many frustrated projects.

CMUs are not the only way to exercise clinical management. This fundamental concept can be developed, with more limitations, in a «traditional» department, precisely because cultural and functional changes are more important than structural changes. The Cardiology Department of Toledo, which is located in a hospital that kept its previous organization intact, is a good example, judging from the results reported.

Finally, we must improve patient care, professional satisfaction, and efficiency, in this order, or clinical management will merely be a theoretical and vain exercise.

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