Money and quality in health care: Muttered medical musings from the back of the class

Time is money, as the saying goes. You get what you pay for is another. This is often used to justify buying something expensive when something cheaper would do quite nicely. Sometimes paying a lot for a service is another way of assuring that the service is of high quality. It seems much easier for the customer to decide whether a purchase is 'worth it' if something concrete is bought. It seems much more difficult to decide when what is bought is an opinion or advice. Perhaps this explains the rise of patients being self informed and discounting their physician's opinion.

What about buying a medical service? Is the quality of the service related to the time spent? The beauty and difficulty of asking a question like this is that the answer seems often to be, 'it depends'. Which leads to the next question, as every progression like this always does: "How does one decide what quality is?" Right away let us agree what quality isn't. It isn't democratic. You don't determine a quality opinion by having three consultations and taking the best two out of three. Maybe the minority opinion is best (not right or wrong). How do you tell; that is the question. Also, you don't decide by finding the opinion you already agree with; then what would be the point of getting any opinions? So let me get it off my chest and have it done with. Our present system, though accessible, seems to place accessibility ahead of quality, because it promotes open access but not the time spent for complexity. The system leaves quality up to the doctor and patient. There are two assumptions here: the doctor will not supply low quality and the patient will not accept low quality. I am also making another assumption: that time spent is related to quality.

Quality is such a morass that it is seldom discussed, but some quality issues are easy. The well-selected surgical patient who is happy with their result is not a quality issue, the unhappy patient might be purely on the issue of selection, not on the basis of surgical performance. The viable flap flush with good circulation speaks for itself because it succeeded. The struggling flap might be an issue but equally might have been wonderfully selected and performed in heroic circumstances, but still fail. Then there is quality from the surgeon's point of view. The surgeon looks at quality from the view of being able to decide how best to achieve quality. This might need operating room accessibility, well-trained interested operating room staff and preoperative investigation. It means excellent surgical assistants, instruments and anesthesia with finesse.

The Physician Charter published in the *Annals RCPSC*, Vol 35, number 7, October 2002 page 400 states: *medical professionalism demands that the objective of all health care systems be the availability of a uniform and adequate standard of care.*

What is adequate anyway? Is it fair, good, good enough, very good or excellent? In who's opinion is it adequate? If it is not adequate, who do you tell? How do you make your case and to whom? What do they do then? What if you think more money

would make it better since you don't like the quality? What if you think quality is in fact related to money? What if you are the only one who thinks money and quality are linked?

I'd like to give a simpler answer. The committee that wrote the statement about adequate care was writing a sermon proposing a high ideal. Sermons derive their suasion from the pulpit, the obviousness of the statement, the sheer impudence of debate and the high mindedness of the issue. Sermons (at least the ones I've attended) seldom give practical advice on how to achieve the goals and virtually never invite debate from the back rows, which is my favorite seat. I admit I have always sat in the back row since here I could make editorial comments about the teacher or sermonizer with minimal chance of being overheard and read exciting books under the desk during the boring bits. (I once read Peyton Place during grade 10 physics – exciting stuff in the fifties). But I digress.

Forget the charter, it's not real. Patients will tell us when they think their care is less than adequate. On the other hand it has to be obvious to them, not so with us, since we tell patients what they should be getting in investigation and when surgery needs to be performed. When surgical delay could result in an inferior result we have a particularly difficult dilemma; the dilemma of telling someone they need something immediately when we know it is not available right now. It is so easy to compromise and seek the middle ground, ie, treatment that is adequate. There is that word again. I'll take a chance and say that no surgeon ever wanted to be adequate – merely adequate. We want to be something better than adequate: good, excellent, better, more skilled – but we avoid adequate like the plague. So whoever wrote that sentence, it could not have been a surgeon. We strive, evolve and change, and therefore are never merely adequate. We sit in the back row and comment. We never let the adequate go unchallenged.

So this question is unanswered because there is no answer. Those who pay will cut until people complain. It will be like a thermostat. The temperature will be lowered until we get tired of wearing sweaters. Then we might have some answer to the question of whether money and quality are related.

John R Taylor

So long from the back row.
John R Taylor