

The march of improvement – are we keeping up with the march of technology

When MRI scanners were rare, the technology was reserved for those difficult cases where the benefit of the new modality considerable outweighed the cost. Now, in many countries, MRIs have become an essential and frequently used tool within the diagnostic armamentarium. Indeed, MRIs are being carried out as screening tests in many high performance (for high performance, read high value) sports activities, such as mixed martial arts contests, hockey and rugby tournaments, etc. As one who is old enough to remember the advent of the technology and the protective walls (both physical and metaphysical) that were built around this new toy to protect it from over use, the analogy to improvement knowledge comes to mind. Have we lowered the walls around quality improvement enough?

Years ago, Parasuraman *et al.* (1988) described SERVQUAL as a tool for measuring the “quality gap”. The use of this tool has spread slowly and patchily through healthcare. The SWOT analysis tool, so beloved of MBA students and consulting companies, is a building block for organisational analysis that again is used in a hit and miss fashion in healthcare. The tools have spun off more specific and detailed tools. Our first paper by Ajmera *et al.* identifies and explores the use of “technique for order preference by similarity to ideal solutions” as a decision-making aid. I can visualise that it would help to frame any process-related problem more clearly, forcing an organisation to pick the ideal positive solution and the ideal negative solution – there is a benefit to forcing people to identify both ends of spectrum solution so that all avenues of improvement can be considered.

Campos *et al.* further explore patient satisfaction having chosen SERVPERF over SERVQUAL (a single attitudinal scale over an expectation – perception gap analysis); one element of their findings highlights the better perceptions of service from the patients’ point of view when compared to the viewpoint of the healthcare workers. Perhaps this is the saving grace of many healthcare organisations – how is it that our patients think more highly of the service that is offered than we do, and yet we, as providers are slow to change our ways.

The management and oversight of healthcare workers is a concern for national services. Healthcare professionals are privileged to call themselves professionals (one of the key criteria in using the collective term profession is the right and ability to police the craft) and therefore the collective must have structures and procedures in place, stipulated by law or by agreement, to manage behaviours that damage the reputation of the profession. Gallagher and Dhokia have examined the UK’s Optical Council professional disciplinary procedures under the microscope to identify the congruence between the expectations (ophthalmic practice of the highest repute) and the reality (of disciplinary proceedings), as ruled upon by the legal system. It fascinates and delights me, as an Editor, that our journal can be the repository for knowledge of some many disparate areas of healthcare management.

Speaking of disparate topics, I never gave thought of the significance of energy management within the specialism of radiotherapy apart from the basic concepts of dose reduction. Using data envelopment analyses, Simpson *et al.* have built on previous work to bring us information and results for the planning and application of radiotherapy to prostate glands. The application of DEA to the science of radiotherapy is both novel and informative. Its ability to coalesce decision making when dealing with different measures and different modalities should suggest that this tool might have wider application in healthcare.



Another area that I had not given too much thought to was the satisfaction of patients with their breasts. When one thinks of post-breast cancer surgical implants, one is inclined to think of the antecedent pathology and that expression (“I beat cancer” that has become a touch paper for recent discussions on cancer management. However, there are many reasons why patients may require implant surgery and obviously satisfaction with what is a key visible and external signal of femininity is very important. Pahlevan Sharif has documented both the process and the results of a patient self-assessment tool that may act as a roadmap or recipe for others interested in assessing the outcomes for patients undergoing figurative landmark surgeries. In common with other body attributes across both sexes, less than one-third of women are happy with the size of their breasts.

Patient autonomy and the right to choose carer scored significantly less importantly than the responsiveness of the hospital organisation in an assessment by Zarei *et al.* We make no apologies for continuing to publish local and national patient satisfaction studies that point out to the importance of customer care to the wider healthcare industry. We trumpet “patient-centred care” but with the continued volume of submissions tackling this issue worldwide, I fear we are slow to learn the lesson.

The Delphi technique is a tool that crops up rarely in our journal. One would assume that such a valuable tool would get more coverage. Perhaps because it is more resource-intensive than other quality improvement tools, it gets overlooked or bypassed. Njuangang *et al.* describe in elegant detail the application of the Delphi tool in achieving consensus on healthcare infection management and in the process have identified some very interesting gaps in the shared understanding of infection control between facilities management and clinical staff.

This issue of the journal closes out with a manuscript from the veterans association in the USA describing the application of quality improvement tools and methodology in a more effective fashion. Ovretveit *et al.* separate improvement research from implementation research in a Jesuitical treatise in order to combine these two streams in the most productive fashion and maximise outputs. The manuscript does not fall into the traditional straightjacket format and we hope that you will find it interesting to reflect upon.

Just like MRIs, the environment and the substrate criteria for the application of new thinking has alerted. In most cases (but not all), the application of critical thinking and the initiation of quality improvement plans grant us the power of examining the organisation of healthcare in greater detail without deleterious side effects. As quality improvement science gains wider traction and becomes more easily accessed, we can look forward to the greater use of a tool to revolutionise healthcare.

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Reference

- Parasuraman, A., Zeithaml, V.A. and Berry, L.L. (1988), “SERVQUAL: a multiple-item scale for measuring consumer perceptions of service quality”, *Journal of Retailing*, Vol. 64 No. 1, pp. 12-40.