Creating Excellence in Patient Care

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Occupational therapists are working in health care organizations that operate from an efficiency perspective. There is growing criticism that this approach can put quality patient care at risk. This article proposes the excellence perspective as a way to address quality as well as productivity. The excellence perspective is one that occupational therapists can use as a guide to program innovation. It is a perspective that fits with the occupational therapist's concern for quality patient care and the administration's concern for productivity. This article examines the excellence perspective and describes its use in business and its potential for health care. A case study that exemplifies excellence in patient care is presented.

The Efficiency Perspective and Health Care Management

The efficiency perspective originated in industry with principles introduced by Frederick Winslow Taylor in the early 1900s (Copley, 1923). Taylor declared that "scientific management" would enhance productivity by increasing worker performance and decrease labor costs (Taylor, 1919). A critical feature of scientific management was the creation of a class of managers who were guided primarily by concerns for efficiency and profit (Hoxie, 1916). In response to Taylor's ideas, labor unions argued that if scientific management took hold, the craftsman would lose his autonomy and become little more than an animated tool of management (Montgomery, 1984).

Taylor's ideas did take hold. Indeed, scientific management ideology provides the foundation for the efficiency perspective in management today (Drucker, 1954). A basic assumption of this perspective is that resources are finite and must be carefully controlled in order to achieve productivity. Control of scarce resources such as time, money, and staff is accomplished through a hierarchical organizational structure in which formal authority is delegated to managers who are responsible for monitoring efficiency and profitability (Perrow, 1970).

Although the efficiency perspective has exerted considerable influence in industry and business since 1920, the perspective has taken much longer to permeate health care management. Although there is evidence to show that the doctrine of scientific management was preached to doctors as well as to businessmen (Haber, 1964), there is little data to show that the efficiency perspective was influential in the formative years of American hospitals.
Health care institutions were not identified with the business concern of profitability in the early years of the 20th century. The health care system at that time consisted of either charity or voluntary hospitals whose goals were humanitarian in nature (Starr, 1982). In many instances, doctors had authority over both the administrative and the clinical aspects of hospital care and thus fulfilled the roles of technical expert and manager. This was in contrast to industry where the skilled worker, or “doer,” became separated from the manager, or “thinker” (Reich, 1983). One prominent Chicago physician evidently was mindful of events in industry when he warned his colleagues, “If we wish to escape the thralldom of commercialism, if we wish to avoid the fate of the tool-less workers, we must control the hospital” (Holmes, 1906, p. 320).

Indeed it was a shift in control and purpose that brought the efficiency perspective to health care organizations. By 1970, the humanitarian emphasis had shifted to a concern for the best way to run hospitals as businesses (Drucker, 1973). The health care industry expanded from hospitals into rehabilitation centers, outpatient services, nursing homes, and community programs. Accompanying this expansion was growth in the private insurance industry and in federal insurance programs through Medicare and Medicaid. The physician-manager role eroded and governance became separated from clinical management. Hospital administrators with master’s degrees in business administration took over the business functions of hospitals, guided by the efficiency perspective.

The efficiency perspective has been justified on the grounds that health care in the United States is big business, and therefore health care organizations should be run according to a business model, which emphasizes efficiency. Given modern concerns about rising costs in health care, the need for the efficiency perspective was deemed obvious: This approach enables management to focus on the goals of productivity and cost control.

Differences between business and health care, however, raise questions as to the goodness of fit with the efficiency perspective. One important difference lies in the mission of the organization. In business, profits are the top priority. In health care, quality patient care is the predominant goal. Some for-profit health care facilities do exist, but a large proportion of health care institutions remain nonprofit. Even the nonprofit facilities, however, have begun to shift their emphasis away from quality and toward cost reduction as a result of the cost-containment movement.

This shift in focus has highlighted a growing conflict between practitioner and administrator. Differing professional orientations place the administrator trained from a business perspective on the side of efficiency and the practitioner trained from a humanistic perspective on the side of quality. Whereas the administrator focuses on the efficient use of funds and increased productivity, the health care practitioner desires freedom to act in the full interests of the patient and resources to provide the most advanced treatment (“Balancing Health Care Costs,” 1988).

One way to address this dilemma of efficiency versus quality is to reframe the question: Can an organization achieve quality as well as efficiency? Some management theorists argue that this is possible, if organizations use the excellence perspective.

The Excellence Perspective and Health Care Management
The origins of the excellence perspective can be traced to the work of Mary Parker Follett (Follett, 1924; Fox & Urwick, 1973). Follett articulated her management philosophy in the first part of the 20th century, at the same time that scientific management was gaining popularity. She proposed that businesses would be effective only when they created an environment that stimulated each member to make his or her fullest contribution. Indeed, she argued that the strength of an organization depended on its ability to create a “working unit,” in which shared values and common interests could evolve (Follett, 1987). Follett proposed that the best way to create organizational environments that fostered such working units was through shared decision making and participative governance, a position in direct opposition to the authoritarian approach advocated by Taylor.

Follett’s interest in creating an environment in which people could contribute fully was probably due in part to her own experience as a woman. She was also influenced by the idealistic leanings of several of her instructors at Harvard and by her professional experience as the founder of a group of community centers called the Roxbury League (Cabor, 1934; Crawford, 1971). The prescience of Follett’s vision has recently been acknowledged (Mullins, 1979; Parker, 1984). March (1965) claimed Follett was ahead of her time: Her ideas did not fit in with the management wisdom of her age, an age dominated by the efficiency perspective.

Contemporary management theorists challenge the efficiency perspective. They argue that it has not helped American business, which is suffering from declines in product quality and in productivity (Reich, 1983). They urge that we move away from the concern of efficiency and toward a focus on excellence (Peters & Austin, 1985; Peters & Waterman, 1982). They claim that if one emphasizes excellence as the primary goal, then productivity is not sacrificed but, rather, is enhanced (Walton, 1985).
Studies of successful businesses that exemplify the excellence perspective showed several common elements. (Deal & Kennedy, 1982; Waterman, 1987). A key element is the definition of a vision that can guide the direction and activities of an organization. This vision should be shared, that is, the organization’s members must value its mission. Leadership is a critical factor (Kouzes & Posner, 1989). It is the leader with a vision who helps shape the organization. Leaders create an environment that fosters collaboration, one that encourages and recognizes the contributions of all members. Case studies show that organizations committed to a shared goal, with leaders who direct the organization’s resources toward that goal, create an environment that achieves quality and productivity (Posner, Kouzes, & Schmidt, 1985).

Since the first writings on this management perspective were published, much interest has been expressed, as has some criticism. Questions arise as to how an organization creates a vision, which is a vague concept at best. How does an organization convince its members to work toward a shared goal? How does one become the kind of leader who can shape an environment that enables members to achieve excellence and productivity? Recent writings by organizational theorists who support this perspective have attempted to answer these questions (Bradford & Cohen, 1984).

For example, Kouzes and Posner (1989) used data from their research based on 1,372 questionnaires and interviews to describe how leaders bring forth the best in themselves and others. The authors discussed the concept of vision, which they said is not mysterious and which can be defined as mission, goal, purpose, or simply the desire to make something happen that will contribute to quality. Kouzes and Posner described the ways that effective leaders create an environment in which members want to achieve excellence: (a) they enable others to see the possibilities a vision holds; (b) they are willing to take risks and experiment with new ideas; (c) they enable others to act and therefore to feel strong, capable, and committed; (d) they lead by example, through actions that support their words; and (e) they encourage others through genuine acts of caring. The authors’ book is replete with descriptions of acts of leadership that contributed to excellence in performance. Examples are cited from both the public sector and private industry.

Deal, Kennedy, and Spiegel (1983) addressed the specific application of the excellence perspective to health care institutions. They asserted that although this perspective is not abundant in health care, some organizations do exemplify excellence. As examples, they described a prestigious urban teaching hospital and a community rehabilitation facility. Although these organizations differ in size (large versus small), mission (acute care versus long-term care), and financial status (nonprofit versus for profit), they share certain elements. Deal et al. found each organization was committed to being the best. For one, this meant the best teaching hospital; for the other, the best rehabilitation facility. This vision was shared by all members and shaped by leaders who committed the necessary resources to achieve this goal. Individual contributions were encouraged and recognized. Within the rehabilitation facility, the occupational therapy department was well respected for its contribution to excellence. Its members were encouraged to contribute and, in fact, developed several patient care programs. The director of occupational therapy had recently been promoted to vice president, at that level she anticipated having a greater opportunity to further her vision of excellence in patient care (D. Robinson, personal communication, October 30, 1982).

Case Study

The Asian and Pacific American Psychiatric Inpatient Program at San Francisco General Hospital in San Francisco, California, opened in 1980. It later served as the model for the development of four other inpatient programs to serve Latinos, Blacks, women, and patients with AIDS-related psychiatric illnesses. These five programs, designed to provide culturally sensitive psychiatric care to minority and ethnic patients, were recently awarded a certificate of significant achievement by the American Psychiatric Association (American Psychiatric Association, 1987).

It all began when Francis Lu, MD, participated in a 1979 National Institute for Mental Health conference on ethnic and minority curriculum development. Out of that conference grew his idea about how to provide the best culturally sensitive care to ethnic and minority patients. Lu envisioned an Asian-focus unit in which patients of that ethnic background would come together with professionals of the same background. He believed that acutely disturbed patients could benefit from services provided by professionals who spoke the same language and understood cultural values and beliefs. This view is supported by experts who argue that successful treatment can only occur when the professional comes to understand the patient’s story, that is, the way a person views himself or herself in the world (Coles, 1989; Taylor, 1989).

Dr. Lu laid the groundwork for this idea through discussions with the hospital’s administration. The department of psychiatry at San Francisco General Hospital is a joint undertaking of the city and county of San Francisco and the University of California, San Francisco. Lu persuaded the administration that his
idea would assist the hospital to better address the needs of San Francisco's diverse population. He proposed that a core group of mental health professionals who shared a similar vision could provide more effective diagnosis and treatment. He argued that for the same cost as traditional treatment, higher quality care would be achieved. No special grants or funding were requested; however, Lu did gain administrative support for the concept of a focus unit as well as a commitment to provide funds for recruitment. Leaders in the Asian community were approached, and they expressed their support for the idea. According to the 1980 census, 21.3 percent of San Francisco's residents are Asian American.

The unit began with two professionals of Asian origin, Lu and one nurse. The staff grew to consist of a program director, a senior attending physician, nurses, social workers, and an occupational therapist—all of Asian descent. Those who came to work on the unit did so because they shared the vision of the Asian-focus patient care unit. The unit offered professionals the opportunity to contribute their knowledge of Asian languages and culture. Once the vision was established, the professionals shaped the unit's direction and goals. The goals were (a) to provide culturally sensitive psychiatric care, (b) to provide multidisciplinary training opportunities, and (c) to develop a body of research to improve both patient care and education.

The way patient treatment was conducted was determined by the developing unit's vision and goals. The staff employed treatment approaches most likely to provide excellent patient care that was culturally sensitive. An ethnomedical approach to diagnosis and treatment was viewed as more consistent with the unit's goal than the traditional biomedical model. This ethnomedical approach not only focuses on diagnosis and precipitating incident but explores information regarding previous life and stresses in the home country; the escape experience and refugee events; and language, cultural, financial, and racial problems encountered in the United States. The staff also explores beliefs the patient might hold about illness, for example, the belief that disease is caused by an excess or deficiency of yin and yang. This approach provides treatment based on an understanding of the patient's perceived symptoms and difficulties (Lee, 1985).

The milieu is designed to make patients comfortable. Rice and tea are routinely served with meals. Ethnic newspapers, books, and music tapes are available. Family members are allowed to bring home-cooked food during their visits. Great importance is placed on family involvement and linkages with the community once the person is discharged. Evelyn Lee, EdD, became program director in 1982. Lu described Dr. Lee as a charismatic and caring leader who has energetically directed the unit toward its mission to provide psychotic and severely depressed Asian American patients with an environment that understands their pain and their cultural background (F. Lu, personal communication, November 30, 1989).

Lisa Lai, OTR, was hired in 1982 as the unit's occupational therapist. Lai has relied on general principles of occupational therapy coupled with creativity and her knowledge of Asian language and culture. Occupational therapy treatment uses occupation that is both meaningful and purposeful; Lai uses an approach to treatment that takes into account both patients' functional needs and their values and beliefs. For example, the cooking group features recipes from various Asian and Pacific countries. Support for treatment that addresses both the meaning and the purpose of occupation has been a growing theme in the professional literature (Yoder, Nelson, & Smith, 1989). Lai asserts that treatment that combines professional expertise with a sensitivity to the language and values of patients can result in major changes in patients' status and responsiveness to treatment (L. Lai, personal communication, November 30, 1989).

In summary, the Asian-focus unit exemplifies many of the characteristics of the excellence perspective. It began with an idea, a vision, that would join others in the pursuit of excellence in patient care. This vision represents the shared values and beliefs of the professionals within the unit. Its leaders epitomize the leadership qualities of the excellence perspective: They have enabled others to see the possibilities of their vision, they have experimented with new ideas, and they have encouraged professionals within the unit to make individual contributions. They lead through example and encourage through caring. Development of the Asian focus unit was hard work; it took several years to achieve the cohesion it has now. Its evolution required patience, a commitment of resources from the administration, and energy and understanding from the professionals within the unit. Recruitment has been and remains an issue. The unit must attract and retain competent professionals with an Asian background and language capability who share the same sense of mission. Although the program has gained national recognition for its innovative approach, there is a feeling expressed by some within the facility that the program promotes a segregated approach to treatment, one that separates patients as well as staff. This belief assumes that the focus units maintain a separate mission from the rest of the organization. Another viewpoint, however, is that the focus units simply offer one way to achieve the overall mission of the hospital, which is to provide quality patient care for the residents of San Francisco. Further research is planned to document the effec-
tiveness of the focus unit in patient treatment (Lee & Lu, 1989).

Discussion

One might ask, If the excellence approach leads to higher quality patient care, why is it not used by more health care organizations? The answer, in part, is that people act in ways that are most comfortable. As this paper has shown, the efficiency perspective is predominant in health care. Efficiency has become the primary goal; quality patient care is a secondary goal. Common wisdom dictates that if one focuses on efficiency, one gets productivity and reasonable patient care. Excellence in patient care has been presumed to be something that could only be achieved at a financial risk. Research has contributed to disproving this assumption, but common wisdom dies hard. We must also examine the nature of leadership in health care organizations. Administrators tend to be conservative, particularly in a climate that is so heavily focused on cost containment and short-term financial performance. The majority of leaders using the excellence perspective are from organizational cultures noted for being more innovative, such as high technology. Finally, there can be little energy for innovation in an environment where the vision is survival. Only when one replaces that vision with one of excellence can energy be freed for making changes that can contribute to quality patient care as well as to productivity.

Implications for Occupational Therapy

As this case study has shown, health care professionals were the leaders in developing a program to achieve quality patient care. Because many administrators are preoccupied with finances, it will probably fall to health professionals to continue to lead the focus on excellence. Occupational therapists can contribute to this effort by developing ideas to increase the quality services within our domain.

As the profession of occupational therapy plans for its future, one vision emerges that of the multifaceted occupational therapist, a person who is a competent clinician, a supporter of and contributor to research, and a strong manager-leader (Directions for the Future, 1990). This vision says we can no longer afford to have occupational therapists who are knowledgeable only about patient evaluation and treatment. Instead, we need people who are able to articulate the profession's contribution and introduce new ideas that can lead practice. This requires leadership ability and management knowledge. Occupational therapists can use the excellence perspective as a guide to program innovation. It is a perspective that fits with the occupational therapist's concern for quality patient care and the administration's concern for productivity. ▲

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References


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