MODULE 5

CLIENT-CENTERED HEALTH CARE: AN ESSENTIAL ELEMENT OF QUALITY

(1 day – 7 academic hours)

Topic Overview: Health care managers often forget that it is the patient (or client), and not the doctor, who determines health. A doctor may prescribe a medication, but a patient may chose not to take it. A doctor can only treat a patient who seeks care. Many patients will self-treat or chose alternative treatments that are cheaper or seen to be equally effective. Only when patients' wishes and needs are known and respected by providers and managers will they be able to influence a patient's behavior and, consequently, their health. This is particularly important for family planning in Ukraine, where patient-controlled methods rather than doctor-controlled methods are generally more accepted. (Throughout this module, the terms "patient" and "client" can be used interchangeably; however, keep in mind that the term "client" carries with it the notion that a doctor provides a patient with a service, which must appeal to the client and about which he/she can freely express an opinion.)

Objectives of the Module:

1. Participants should understand that health care and especially reproductive health care must be oriented to meet the needs of the patient and not the provider. This includes convenience, respect, good communication and care that is adjusted based on patient feedback.
2. Participants understand the importance of giving patients accurate, easily understandable information, so patients can make correct decisions about their own care.
3. Participants improve their communication skills in their work with patients.
4. Participants develop skills that will enable them to introduce innovations in hospitals for patients' convenience.

STRUCTURE OF THE MODULE:

Lecture 1: *(2 academic hours)*
Client-Centered Health Care: An Essential Element of Quality
(R. Criswell)

Case 1: *(2 academic hours)*
Recognizing Domestic Violence
(Y. Onyshko)

Lecture 2: *(1 academic hour)*
Quality Management in Health Care
(V. Krasnov)

Case 2: *(2 academic hours)*
Quality Maternal and Child Care
(V. Krasnov)

Lecture 1

CLIENT-CENTERED CARE

By Rachel Criswell

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CLIENT-CENTERED CARE: AN ESSENTIAL ELEMENT OF QUALITY

2

What is quality health care?

3

From a medical professional's point of view…

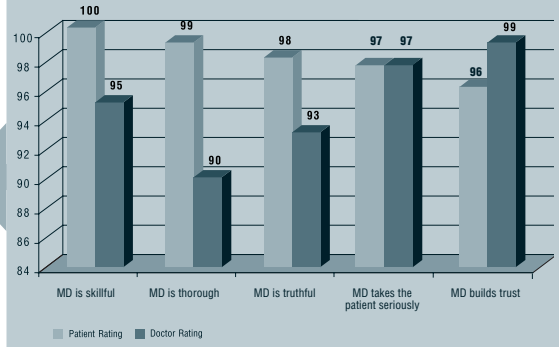
…Quality health care is making sure that sick people get healthy and that healthy people stay well.

4

But what do patients see as quality health care?

5

What Doctors and Patients Agree About*



*Slide courtesy of Tom Delbanco's presentation Patient (and Employee) Centeredness, 2006.

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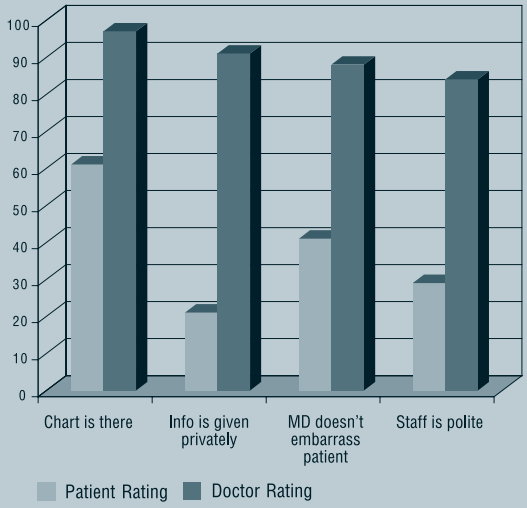
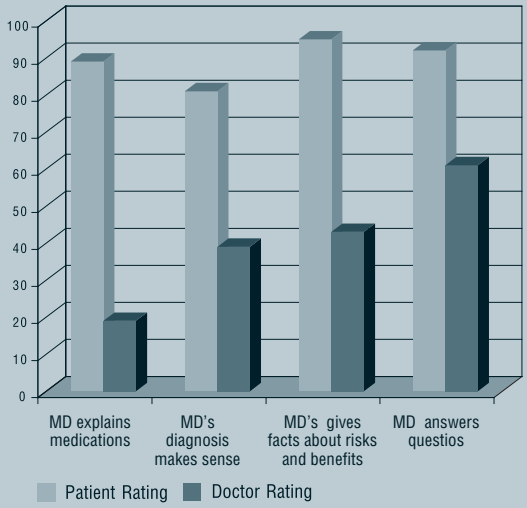
What Doctors and Patients Disagree About*



*Slide courtesy of Tom Delbanco's presentation Patient (and Employee) Centeredness, Harvard Medical School, 2006.

7

What Doctors and Patients Disagree About*



*Slide courtesy of Tom Delbanco's presentation Patient (and Employee) Centeredness, Harvard Medical School, 2006.

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The Ultimate Goal is GOOD HEALTH

- This requires an investment on both sides, from both medical professionals and patients
- Patients often take their cue from doctors and medical professionals
- This aside, health behaviors and compliance are dependent on the patient not the doctor
- A doctor may prescribe a medication, but the patient may still choose not to take it

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Patient → Client

- The doctor is providing a service
- That service has to appeal to the person receiving it
- The patient/client can choose to use or not use the service
- The patient/client will be more likely to use it, if he/she has a role in determining the service

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Rights of the Client in Family Planning*

(International Planned Parenthood Federation)

1. *Information:* To learn about the benefits and availability of family planning.
2. *Access:* To obtain services regardless of sex, creed, color, marital status, or location.
3. *Choice:* To decide freely whether to practice family planning and which method to use.
4. *Safety:* To be able to practice safe and effective family planning.
5. *Privacy:* To have a private environment for counseling or services.
6. *Confidentiality:* To be assured that any personal information will remain confidential.
7. *Dignity:* To be treated with courtesy, consideration, and attentiveness.
8. *Comfort:* To feel comfortable when receiving services.
9. *Continuity:* To receive contraceptive services and supplies for as long as needed.
10. *Opinion:* To express views on the services offered.

*From Mitchell, Marc and Arlette Campbell White. The Tools for Adapting to Change. World Bank Institute, Sept 1999, 14.

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Client-centeredness allows doctors to achieve the goal of good health

- Client will only participate in their health care if they play a *role in deciding* it and if *it appeals to them*
  - A woman who comes to a family planning clinic with a method of contraception in mind that she then receives is more likely to use contraception than a woman who is prescribed a method that she had no role in choosing

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How can doctors and health care professionals make sure that the client's needs are met?

- LISTEN
- EDUCATE
- Build TRUST
- Ensure CONVENIENCE

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LISTEN

- LISTEN to what the client's concerns are: they may not be the same as the doctor's concerns
- Client-doctor pact:
  - What does the client need to do to stay healthy?
  - What options can the doctor provide to meet these needs?
  - Which of these options fits with the client's lifestyle, characteristics, values, and goals?
- If the client promises to adhere to healthy lifestyle choices and take the medication as prescribed, the doctor, in turn, will provide the client with accurate information and good care from a trusted professional

EDUCATE

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- Clients are most receptive when they know what is happening and can make *informed decisions* about their own care
- Clients need to know about all of their *choices*
- Information needs to be distributed *when clients are psychologically ready to hear it*, not in stressful environments such as the hospital
- Population-based information campaigns can help educate the public

But what about TIME?

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- *The problem*: doctors have little time with each client as it is– there is no time to listen and educate!
- *The solution:* midlevel medical professionals (family doctors, midwives, nurses) can be trained in counseling and can be another group making an effort to *listen* and *educate*
- This does not mean that doctors do not need to engage in client-centered care, but it does relieve some of their burden

Building TRUST

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- Clients need to be able to count on their doctors to be *honest* and provide all of the *necessary information* about illnesses and treatment
- Clients need to be able to return to their health care provider in the event that something goes wrong for *follow-up treatment*
- Clients need to be able to count on their doctor to maintain *confidentiality*

Ensure CONVENIENCE

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- The maximum amount of information, prevention, and treatment as possible must be available in one place at one time and from the same team
- Effective referral system must be in place
- Doctors and other health care professionals must ensure that the prescribed treatment or prevention takes the client's lifestyle, characteristics, values, and goals into consideration

Case Study: Family Planning and Client-Centered Care (1)

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- LISTENING: Understand the contraceptive needs of the client
  - Do they already have children or want them?
  - Are they comfortable with hormones?
  - Do they have control over contraceptive choices or is that something determined by their partner?
  - Are STIs and HIV something to consider?
- EDUCATING: Provide complete, objective, and evidence-based information– benefits and risks– about all methods of contraception

Case Study: family planning and client-centered care (2)

- Building TRUST:
  - Provide a non-judgmental environment
  - Ensure that the client feels comfortable returning for more information if the method is not optimal
  - Support the client in his or her contraceptive decision
- Ensure CONVENIENCE:
  - Have FP information, methods, and prescriptions available at the same facility
  - Nurture working relations (and geographic proximity) between Women's Consultations, Family Planning Centers, dermatovenerologists, and hospital gynecological departments

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How can health care managers motivate medical professionals to make client-centeredness a priority?

- Support the "team model" of care— doctors work with midlevel medical professionals and other specialists to ensure that the client receives the best possible care
- Training for all medical professionals in counseling skills and population-based health programs
- Monitor and evaluate based on quality of care and client-centered care indicators

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Case Study: Improving Quality of Care in Kyrgyzstan: Exit Interviews and the Role of Clients' Perceptions (1)

- At several family clinics in Kyrgyzstan, clients reported very low levels of quality in the care they received during exit interviews. Their reasons?
  - The facilities were dark
  - There was little privacy
  - There was no cloakroom
  - Providers had bad attitudes
  - It was cold in the facilities
  - There was nowhere to sit while waiting to see the doctor
- How can a facility improve these aspects of care?

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Case Study: Improving Quality of Care in Kyrgyzstan: Exit Interviews and the Role of Clients' Perceptions (2)

- Staff at these facilities addressed these concerns by:
  - Creating separate examination rooms
  - Improving lighting
  - Buying potted plants and flowers
  - Painting the examining rooms
  - Hanging curtains
  - Providing soap and towels for clients
  - Borrowing chairs from other facilities so that clients would have somewhere to sit while waiting
  - Attaching a string to the main door of the facility so that less cold air would be let in
- After these changes, clients' perception of quality increased 119%!

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Monitoring for Client-Centeredness

- Exit interviews
- Provider observations and supportive supervision
- Quality of care indicators
- Facility self-assessment

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Provider Observations and Supportive Supervision

- Conducting post-training sessions
- Supporting trained providers in implementing new skills, answering questions, and addressing doubts
- Assessing the quality of the trainings (and need for further development) based on how much of the information was retained and used by the provider
- Measuring aspects of care that indicators cannot (quality and completeness of counseling, medical histories, etc.)

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Case Study: Provider Observations and the Together for Health Project

- Clinical trainings addressed collection of medical histories, contraceptive counseling, STI risk assessment, and prescription or provision of the selected method
- Provider observations were conducted within a few months after trainings, for both trained and untrained providers
- Found that TfH-trained providers employed a more public health-oriented, client-centered approach, "including information about possible complications of abortion and messages about the safety and affordability of modern FP methods to encourage clients to make healthy decisions"*

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*Tymoshevska, Viktoriya, et al. The Impact of Clinical Training on Health Providers' Family Planning and Reproductive Health Practices. Kyiv: Together for Health, 2008.

Quality of care indicators

- Traditional indicators, while important measures of a population's health, do not always measure the *quality* of care that clients receive or how satisfied clients are.
- Easily measured, non-traditional indicators must be developed that show a client's choices and satisfaction

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Case Study: Maternal Care in Central Asia

- The ZdravPlus II Project aimed to increase client-centered quality care in maternity hospitals in Central Asia
- Since the traditional indicators of maternal health require long-term tracking and do not necessarily indicate quality, the project developed new, easily-measured indicators for each facility
- Example:
  - Percentage of pregnant women who attended at least one birth preparation class
  - Percentage of pregnant women who gave birth in the presence of a family member or friend
  - Percentage of women who received a method of contraception post-partum

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The Principles of Client-Centered Care

- Listen
- Educate
- Trust
- Convenience

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Comments to slides

Slide 5. From *Using patient reports to improve medical care: A preliminary report from 10 hospitals* (Paul D. Cleary, Susan Edgman-Levitan, Janice D. Walker, Margaret Gerteis, and Thomas L. Delbanco); the Picker/ Commonwealth Program for Patient-Centered Care: Patient reports showed that patients and doctors had different priorities about health care, once the very basic health care needs were met.

Both patients and doctors want health care services to be skillful, thorough and honest.

Slide 6. Doctors are much more concerned about the formalities of health care, whereas patients really notice how they are treated.

"It takes ten years for a patient to understand how he or she is being treated medically, but it takes ten seconds for a patient to understand how he or she is being treated personally."

Slide 7. Good health requires a commitment from both sides—doctors and patients.

Medical professionals are paid to provide good health care services, but why should the patient care?

Good health depends on the patient—only he/she can comply with the behaviors and treatment the doctor prescribes.

Slide 9. From patient to client: This distinction is made because the doctor provides a service and the service needs to appeal to the person who is receiving it.

Slide 10. The International Planned Parenthood Federation (IPPF) established the Rights of the Client in Family Planning, to encourage clients to be actively involved in choosing a family planning method and receiving family planning services. The innovative aspect of this list is that it frames quality health care as a human right, rather than a privilege. These rights can be applied to any area of care. Once these basic rights are met, the client can bring his or her full commitment to the task of improving health.

Slide 11. Client-centeredness allows doctors to do their job better because it involves the client in establishing and maintaining good health.

Slide 13. LISTENING:

This seems simple, but it is the most basic part of health care and often gets overlooked. Listening to the client's concerns makes a client feel cared for and is a huge part of providing good care.

Slide 14. EDUCATING:

Clients need to have enough information to make choices about their care

Doctors need to be aware of when and where it is best for clients to receive this information. It may not always be when they are in the hospital.

Slide 15. Dealing with the time issue:

Doctors often face the obstacle of time. The responsibility of education and listening should be distributed equally among all medical professionals involved. Nurses, midwives, family doctors, GPs, etc. can all listen, educate and provide counseling services.

Slide 16. TRUST:

Honesty—clients deserve to know the full details of their condition and treatment.

Clients need to know that they can return to their health care professional for follow-up care or clarification.

Confidentiality—doctors must assure their clients that their information and records will be kept private.

Slide 17. CONVENIENCE:

Clients are more likely to fulfill their end of the health pact if it is easy to do so. They need to be able to fill prescriptions, receive information and easily access referral services, whenever possible in a single facility.

Slide 19. Health care managers and client-centered care:

- A "team model" of care—this overcomes the obstacle of time and ensures that there are many professionals, who are aware of and can meet the client's needs. Confidentiality is not compromised, even with many professionals involved.
- Training and retraining in client-centered care, such as counseling skills and a population-oriented approach for medical professionals.

Slide 20. Other techniques are detailed in the following slides, but it is important to touch upon facility self-assessment with an eye towards improvement:

This step is especially important during the later stages of quality improvement, when staff and managers are already aware of the areas for improvement and the effects of quality improvement measures. Involving staff promotes an employee-centered approach, which will also benefit the overall quality of care.

Slide 21, 22 Exit interviews with clients will channel their perceptions of quality and will often reveal non-medical aspects that impact heavily on these perceptions.

In Kyrgyzstan, where the USAID-funded *ZdravPlus* Project conducted a Quality of Care initiative in reproductive health, client exit interviews indicated that the appearance of the examination and waiting rooms and the attitudes of the staff were very important in affecting their perception of quality. Many of the facilities originally scored very low in terms of client perceptions of quality, but after some basic, non-medical changes were made, such as hanging curtains in examination rooms to ensure privacy, providing chairs for clients to sit down while waiting, keeping the door shut to maintain heat in the building and decorating with potted plants, the clients' perception of quality increased by 119%.

Slide 24. Provider observations and supportive supervision need to be supportive and not punitive.

Slide 25. The USAID-funded *Together for Health* (TfH) project conducted clinical training for health care providers to improve knowledge and attitudes toward modern family planning with a cross-cutting emphasis on client-centered care, choice and counseling. To assess the effect of these trainings, TfH conducted follow-up provider observations and supportive supervision. These visits found that the clinical trainings had a positive effect on the counseling skills of health care professionals, the frequency with which they took complete medical histories, and the mix of contraceptives that they provided to their clients. In addition, these visits gave the providers an opportunity to ask follow-up questions to TfH trainers after they had had a chance to put quality of care principles into practice.

Slide 26. New indicators that measure quality of care on a short-term basis must be developed.

Slide 27. A case study was conducted of the USAD-funded *ZdravPlus II* project and the quality of care indictors used to measure improvements in maternity care in Central Asia. To monitor quality, they conducted baseline and biannual follow-up monitoring every six months of special quality of care indicators, including:

- Percentage of pregnant women who attended at least one birth preparation class before delivery;
- Percentage of pregnant women who gave birth with the support of a family member or friend;
- Percentage of women who received a method of contraception postpartum.

Case 1

RECOGNIZING DOMESTIC VIOLENCE

By Y. Onyshko

Tetyana sat crying in the outpatient clinic, near the emergency care unit. She had been beaten by her husband. Although not the first time, this time he had used a stick. Tetyana had tried to defend herself as best she could. She had escaped to her neighbor's house. The neighbor was the one who had taken her to the clinic when the pain in Tetyana's arm had become too intense.

The door of the doctor's office opened and an elderly woman, a nurse, stepped out. She called, "Next!"

Inside the office, Tetyana was greeting by a young doctor about her age. His name was Petro Mykolayovich.

"What's wrong?" he asked.

"I was beaten by my husband," replied Tetyana, still crying as she told her story.

The doctor listened to Tetyana's story in silence, examined her and took her to the Radiology Department where an X-ray was taken of her arm. The doctor and the radiologist, Vasiliy Antonovich, diagnosed a fracture in the elbow. Vasiliy Antonovich, an elderly man, said to his colleague, "This woman's last name seems familiar. I think I have examined her before." Looking through his records, he found several more X-rays taken of Tetyana over the past several years. Vasiliy Antonovich explained to his younger colleague that "such traumatic case histories are typical either for people who work in extreme occupations or are victims of domestic violence."

"We'll see what we can do," said Petro Mykolayovich curtly. He returned to his office, where Tetyana was waiting. In silence, he prepared the plaster cast for her arm. Then, he asked her softly, "Do you want your husband to go to jail?"

"Oh, no, by no means," answered Tetyana defensively. "I just don't want him to beat me again. I'm scared to go home. He was so angry when I left and I'm afraid he'll be angrier if he sees me again with a broken arm."

"Well," replied Petro Mykolayovich, "I will write in your case history that you broke your arm by falling down the stairs."

"But that's not true!" said Tetyana sternly.

"Well, who needs truth? This is a family affair. I don't want to get involved and I don't believe in airing one's dirty laundry in public," Said Petro Mykolayovich.

"This is terrible! You men are all the same!" said Tetyana in exasperation. She was crying again, but this time not from pain but from despair.

Petro Mykolayovich was moved by Tetyana's tears. He knew that he could not let her leave in that state. He had no desire to dig deeper into this mess because it was not his place to become involved; however, he was a human being with feelings as well as a doctor.

"Let me see what I can do," he said gruffly to Tetyana as she sobbed. He found his way back to Vasiliy Antonovich's office and said to him, "You were right. The patient told me that she was beaten by her husband. However, I don't know what I should do in a case like this."

"Unfortunately, I don't know a lot about this problem either," replied Vasiliy Antonovich, "However, I think the case should be documented as a result of domestic violence. That may be

relevant for a trial if the patient ever decides to take her husband to court. Meanwhile, she should probably talk to the police." A court trial? Police? Petro Mykolayovich winced. He had so much work to do, how could he possibly get involved in all of this?

"It seems to me that we should inform Yuriy Pavlovich, the hospital's head doctor, about the situation so he can make a decision," said Petro Mykolayovich.

"Okay, that's what we'll do," agreed Vasiliy Antonovich.

The doctors stopped to speak with Tetyana again and asked her to wait while they spoke to Yuriy Pavlovich. Tetyana looked frightened but nodded when they said they would be back shortly.

After listening to his colleagues, Yuriy Pavlovich thought and said, "I agree with you that this is a terrible story, but why should we deal with it? Yes, there is a special procedure for documenting trauma resulting from domestic violence and other crimes. It's regulated by a joint order of the Ministry for Internal Affairs and the Ministry of Health. It is order number 307/105 of May 10th, 1993, 'On the procedure for health care institutions and local district health care authorities to register cases of citizens who have sustained physical injuries of criminal origin with police stations.'[1] To be in compliance with the order, I would need to do a lot of paperwork, documenting the injuries, the patient's visit and the police investigation."

Yuriy Pavlovich continued, "In addition, a special record would need to be made so that the patient could be referred to the appropriate health care institution. If we do this, we will certainly be visited later on by police officers and officials from the public prosecutor's office and possibly even be summoned to court as witnesses. Can you imagine what we will have to face? On top of this, it's even questionable whether or not this accident can be considered a trauma of criminal origin. We have no evidence, which means that there is a possibility that the woman is simply slandering her husband. If so, the injury wouldn't even be of criminal origin, but of domestic trauma. Wouldn't it be better if we just came to an agreement with the patient that she fell down the stairs? As far as we are concerned, we've done our part. We've already provided the woman with the medical care she needed. And as for the future, that's not our business."

The doctors did not know how to send Tetyana home after she had waited for them with the hope of receiving help. Although they were both intimidated by Yuriy Pavlovich, Vasiliy Antonovich spoke up.

"Yuriy Pavlovich, my wife is works with Social Services and she recently attended a meeting held by the Oblast Department of Health on the prevention of domestic violence and ways to help victims. She said they discussed different aspects of interdepartmental cooperation to effectively carry out the Law of Ukraine "On Prevention of Domestic Violence." Clearly, we must give this woman medical attention, but we can't stop there. We're lucky in this case, since the patient told us her injuries were the result of domestic violence. Often that is not the case because most women are too scared. It takes a keen eye to spot the signs of domestic violence when the victim is trying to cover them up. There must be a way we can help this woman or at least refer her to the correct authorities."

Petro Mykolayovich groaned inwardly at his colleague's words. Of course it was a nice thought to help this woman, but as the old Ukrainian saying goes, "Shoemakers should make shoes and doctors should heal." Petro Mykolayovich felt he had done his job and he was now wasting precious time in which he could be seeing other patients. He tried to exchange a look with the head doctor to show him that he disagreed with Vasiliy Antonovich, but Yuriy Pavlovich just sighed and said, "You gentlemen do whatever you want. I don't want to get involved, and I don't want this hospital involved in an investigation."

[1] See Appendix 1 of this module for more information.

When they got back to his office, Vasiliy Antonovich reached into his desk, pulled out a brochure and a book, and handed them to Petro Mykolayovich. "Here," he said, "My wife gave these to me after her training. It's a copy of *The Resource Handbook for Helping a Victim of Domestic Violence* and a brochure for an NGO that helps women overcome a life of domestic violence.[2] The NGO is called *Hope.* The phone number is listed in the brochure." He looked at Petro Mykolayovich, "I know you'll do the right thing."

Petro Mykolayovich took the book and the brochure and returned to his office. He did not want to get involved, but he now felt responsible for Tetyana. When he returned, he found her still crying.

"What are you going to do to my husband?" she asked. "He can't go to jail, he'll just get more angry and beat me again. And I have nowhere to go! I don't have a job! How will I be able to support myself or my son if he is in jail? I just need some help… If only there was someone I could talk to or somewhere I could go for a little while…"

Petro looked at the information in his hand and he looked at the sobbing woman in his office. Everyone had different agendas and they all seemed to be different. What was his role in all this? To whom could he turn for help? Who was he responsible to?

DISCUSSION QUESTIONS:

1. Assess the actions of all the players in this case. Which of their actions do you consider right? Which of their actions would you consider wrong? Why?
2. What are the priorities of each of the players in this case? Identify the motivating factors and ultimate goals that are most important to each.
3. Try to imagine yourself in Tetyana's place and assess all of the player's actions once again. Which actions were the most appropriate from the victim's point of view? What was lacking?
4. Which approach would you consider most compliant with the principles of client-centered care? What principles of client-centered care were missing from each approach?
5. What would you do in Petro Mykolayovich's place?
6. In your opinion, how much are patients' needs taken into consideration by the present-day health care system in Ukraine? How popular is the client-centered approach in Ukraine's health care facilities? Provide some examples – both positive and negative – from your own experience.
7. What sort of points would you include if you were drawing up a Patient Bill of Rights?

Supplemental Readings:

Cleary, Paul, et al. *Using patient reports to improve medical care: A preliminary report from 10 hospitals.* Quality Management in Health Care 2(1), 1993: 31-38.

Delbanco, Tom. *Listening and Breaking Down the Walls.* Literature and Medicine 21, no 2 (Fall 2002): 191-200.

Delbanco, Tom, et al. *Healthcare in a land called PeoplePower*: nothing about me without me. Health Expectations 4 (2001): 144-150.

[2] See Appendix 1 of this module for some basic information contained in the *Resource Handbook for Helping a Victim of Domestic Violence*.

Appendix 1

INFORMATION FROM THE RESOURCE HANDBOOK FOR HELPING VICTIMS OF DOMESTIC VIOLENCE

A heath care provider should know that incidents of domestic violence come under the following legislative domains:

- When a medical trauma results from a crime, as evidenced by a serious injury, for example traumas caused by a knife, firearms, beatings, etc.
- When no signs of a crime are found.

There is a special procedure for documenting traumas of criminal origin, regulated by a joint order of the Ministry for Internal Affairs and the Ministry of Health, number 307/105 dated May 10, 1993,'On the procedure for health care institutions and local district health care authorities to register cases of citizens who have sustained physical injuries of criminal origin with police stations.' This order states that the heads of hospitals, preventive clinics, general clinics and emergency care centers should immediately inform the appropriate government agencies of all cases in which individuals seek medical care for injuries resulting from firearms, knives and other weapons, if there is a reason to believe that the injury was the result of criminal activity. All necessary information is recorded in a special register at the health care facility. The information required includes:

– The date and time of the victim's visit;
– The victim's full name, occupation, position and office phone number;
– The victim's address and home phone number;
– The circumstances of the accident (date, time, place, other information);
– The last name and address of the person who allegedly inflicted physical injuries on the victim;
– The date and time that the police were informed of the incident and the name of the person who told the police;
– The name of the person on duty who received the message;
– The type of injury and body part injured;
– A note about where the victim was referred.

However, most cases of injury resulting from domestic violence are not registered as traumas of criminal origin. Very often the victims of the violence and the people who take them to the hospital or clinic do not mention the real cause of the injuries. In these cases, it is difficult for the doctor to follow the necessary procedures, especially when the victims are children. Children rarely go to the doctor for an injury. If they are accompanied by their parents, their reports on the causes of the injury may be unreliable.

With this in mind, health providers should be aware of the following:

Data obtained as a result of physical examination

Sometimes victims of domestic violence try to hide the signs of a beating under long sleeves or a high collar. They may also try to hide bruises under glasses or thick make-up. That is why a doctor, should try to do an unclothed physical examination.

The doctor should examine the patient's entire body to detect sensitive spots as well as visible trauma. Trauma resulting from domestic violence is generally inflicted in "a central location"

on the patient's body, that is along the patient's "central axis" (for example, the patient may show trauma on the face, neck, chest, breast, abdomen or genitals.) Also typical are multiple injuries on different parts of the body and injuries obtained while the patient was trying to defend him or herself. This means that he or she is likely to have sustained injuries on the elbows, head and back.

Health care providers need to take into consideration that certain types of trauma do happen by accident. If there is a bruise shaped liked a particular object–a belt buckle, a shoe sole, a stick–it is a clear sign that the trauma was inflicted deliberately. Accidental bumps on the head usually occur on the forehead or the upper back of the neck, but bumps on the side or crown of the head are generally deliberately inflicted. Accidental bruises on the legs are usually located on the outer leg, while bruises on the inner arm and leg are more likely the result of domestic violence. Narrow long bruises and scratches located on the patient's back as well as on the back of the legs and buttocks are most probably the result of a beating.

Multiple traumas at different stages of healing are usually evidence of ongoing physical abuse, especially when the victim is a child.

Additional sources of information

Two valuable sources of information when working with a victim of domestic violence are 1) the full case history and 2) the medical chart. If a patient has gone to the emergency room on multiple occasions, the doctor should recognize that he/she may be a victim of domestic violence rather than just accident-prone.

In general, additional laboratory tests are not useful in such cases. The only exception is an X-ray, which may reveal old bone fractures.

The necessity of thorough documentation

Precise documentation in the case history and medical chart is very important in cases of domestic violence, since these documents may be used as evidence if the case comes under further investigation by law enforcement agencies, social services or other organizations.

If legal action does occur, medical documentation may be demanded by the investigation, court or special agencies. Thorough and detailed medical documentation is of primary importance in preventing repeated acts of violence. They may be considered proof of violence and can play a decisive role in a trial. Medical documentation is often considered more credible than testimony from witnesses. Below are the most critical elements of a patient's case history and medical chart.

Case history: Note the victim's story as he/she tells it, using quotations when necessary. If the victim was threatened verbally, record the threats word for word. If you know the instrument of the violence, note that as well, using phrases like "the patient says she was beaten by her husband, who hit her on the head with his fists." If the victim mentions the aggressor's name, record that in the documentation; for example, "she says her father-in-law hit her in the back several times (3-4 times) with a stick."

Describe all the essential **physical findings**. If possible, include a picture of the body to illustrate your records. This is important in case of any trauma, especially sensitive spots where there are no visible bruises. When severe trauma or sexual assault is diagnosed, keep all material evidence. Torn or bloodied clothes can be sealed in an envelope or a bag.

If the patient refuses to confirm violence, but you suspect that violence occurred, mention that in the patient's case history, for example, "the patient says she fell down the stairs; yet her trauma appears to be caused by a direct blow in the eye socket."

After the victim has been provided with the appropriate medical care, he or she should be referred to specialized government agencies that care for victims of domestic violence:

– If no psychological trauma is evident, the victim should be referred to the crisis center at the Oblast Service for Youth and Families or to a public organization that runs equivalent services, where victims can receive psychological, social and legal aid as well as rehabilitation;
– If psychological trauma is evident, the victim should be referred to the Center for Medical and Social Rehabilitation for Victims of Family Violence where he or she can be treated for psychological stress and receive psychological, social and legal aid;
– The doctor can also recommend that the victim speak with a law enforcement agency. An adult can speak with a policeman, while a child can go to the Criminal Police for Under-Age Citizens accompanied by a parent, guardian, trustee or teacher.

TEACHING NOTES:

Teaching Objective:

Participants should recognize the difference between treating a patient as a medical case and treating him/her using the principles of client-centered care, which take into account a patient's needs, values and circumstances.

Doctors can provide substantial assistance for victims of domestic violence, ranging from simply providing medical treatment to testifying at a trial; and from referring the victim to other services to reporting the crime to police. However, the key to this case study is for participants to look at the different goals of each player and to recognize that the goals that matter most are Tetyana's. When the doctors are meeting to discuss the situation and what to do, her voice is noticeably absent. The instructor should present the case in such a way that the participants are divided among the three doctors' points of view. Then the instructor can bring up the issue of client-centeredness and the fact that that none of the doctors in the case raised Tetyana's specific needs and concerns.

This case is particularly good for demonstrating how to be client-centered, since there are many possible levels of involvement for the doctor, and the victim is likely to have complicated and conflicting needs and emotions. The issue of domestic violence is a sensitive one, and every participant is bound to have an opinion as to the "proper" course of action. It will be difficult for participants (just as it is difficult for doctors) to separate their own moral views and beliefs from what the patient wants—and focus on Tetyana's needs. Once participants are aware of the need for a client-centered approach in this case, they should list the needs as expressed by Tetyana:

– She does not want her husband to go to jail because she is afraid it will make him angrier;
– She is afraid that her husband will beat her again;
– She has a child that she needs to take care of;
– She has no means of supporting herself;
– She needs a place to go to get away from her husband.

The participants need to be able to read into these comments, to see how they can meet Tetyana's needs. In this case, it seems like Tetyana does not want to go straight to the police, but she does need an anonymous, free place to stay for a while with her child, where she is away from her husband. Tetyana is worried that her husband will be angrier and more violent if he is put in jail, even if it's for a short time; but she may still want to consider taking legal action which could mean that he would be in jail for a longer period of time. Instead of referring her to the police, the doctor might be able to refer Tetyana to someone who can provide her with legal information and advice.

Participants might also be encouraged to brainstorm questions to ask Tetyana to clarify her needs, since her story is not fully developed in the case. Once Petro Mykolayovich has an idea of the services he could provide, he needs to ask and listen to find out which ones he needs to provide and in what order.

Lecture 2

QUALITY MANAGEMENT IN HEALTH CARE

By Vladimir Krasnov

1

QUALITY MANAGEMENT IN HEALTH CARE

2

DOCTORS' AWARENESS AROUND THE WORLD

- In 2002, there were **100,000 documented deaths** due to medical errors in the United States. This exceeds the number of deaths due to AIDS, breast cancer and car accidents combined. **Damages totaled $17-29 billion.**
- In Great Britain, almost **850,000** cases of unnecessary medical interventions are recorded annually. Half of these could be prevented. **Yearly damages total $3 billion.**
- In Canada, **one in 13** hospital patients falls victim to medical error, and there are **1.1 million** bed-days resulting from complications arising from incorrect treatment.

3

REASONS FOR POOR QUALITY MEDICAL CARE

- Increases in the cost and complexity of treatment;
- An aging population;
- Increases in chronic diseases;
- Poor management of patient flow;
- Poorly qualified personnel;
- Increased volume of health care information;
- Lack of technology, such as computers, in health care facilities.

4

THE SOLUTION

BUILDING A MODERN SYSTEM OF QUALITY HEALTH CARE USING PROVEN METHODS OF PLANNING AND PROVIDING HIGH STANDARDS OF CARE

5

DEFINITIONS

- The quality of services is their ability to meet the needs and expectations of various clients

  "Total Quality Management" (TQM)
- Quality—the extent to which essential elements of services and client preferences are identified and implemented and the degree to which a client perceives these elements to be satisfactory

  Murdick, 1990
- In general, quality is understood to be a set of characteristics that meet specific needs

  Encyclopedic dictionary

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LEVELS OF QUALITY

Level 1 – Compliance with standards

Level 2 – Compliance with use: the product should not only meet quality standards, but also the standards of that particular market

Level 3 – Compliance with real market standards: meeting the expectations of consumers through high quality and low price

Level 4 – Recognition of underlying and lesser known needs as well as the needs of certain clients

7

People blame 20% of problems on poor quality and 80% on poor management and systems problems

E. Deming

8

DEFINITIONS

Quality of Medical Care (QMC) provided is a combination of meeting the patient's (or the population's) needs, his/her expectations and complying with modern levels of medical science and technology

Glossary – Medical Care Quality, Russia – USA, 1999

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ISO 9001

STANDARDS FOR QUALITY MANAGEMENT

TYPES OF CLIENTS

ISO 9001: 2000 specifies the standards of quality management, so that organizations can meet the demands of clients and governments

- Doctor
- Patient
- Corporate client
  - Individual
  - Group or community
  - State

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If you want to make money, think about money.

If you want to earn a lot of money, think about yourself.

If you want to make a lot of money, think about other people.

Henry Ford

10

PRINCIPLES TO ACHIEVE QUALITY

1. Target the client
   - Understand the needs of current clients
   - Understand the needs of future clients
   - Understand the importance of client satisfaction
   - Strive to exceed clients' expectations
2. Leadership
   - Establish goals and directions for the organization
   - Foster the appropriate environment within the organization
3. Staff development
   - Develop the skills necessary
   - Use those skills to their maximum potential
4. Process approach
   - Think of resource management as a process
   - Effective achievement of desired results
5. System approach
   - Define it
   - Understand it
   - Manage interrelated processes to efficiently and effectively achieve the goals
6. Regular improvement
   - Consider improvement as a permanent goal
7. Information-based decisions
   - Logically analyze data and information
8. Mutually beneficial relationships with suppliers
   - Create value through mutually beneficial and interdependent relationships

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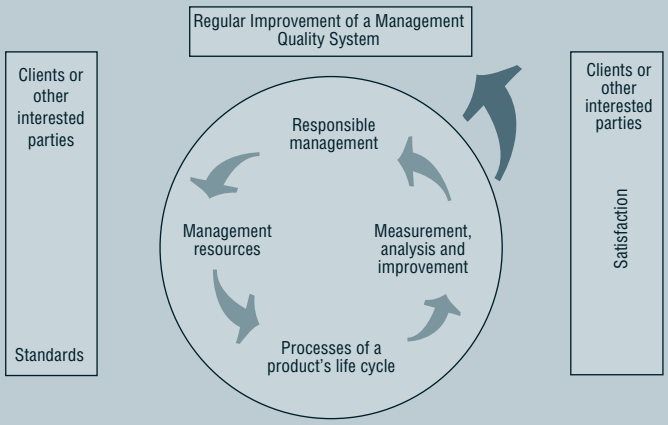
MODEL OF A QUALITY MANAGEMENT SYSTEM BASED ON THE PROCESS APPROACH

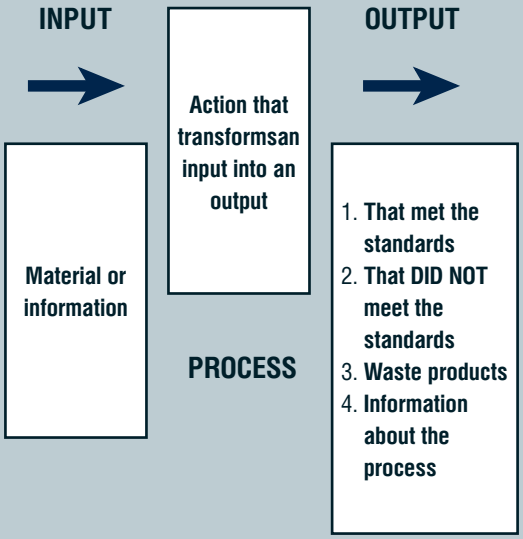


14

THE FOUR STAGES OF QUALITY IMROVEMENT

Definition	Identify improvements
Analysis	Understand the problem
Design a plan of action	Develop hypotheses and a strategy to make changes that will lead to improvement of quality
Review and implement	Test the strategy. Based on the test, decide whether to implement the strategy and, if so, what modifications to make.

THE PROCESS APPROACH



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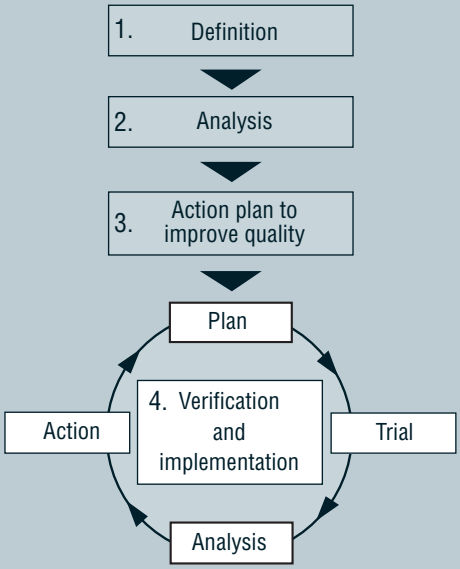
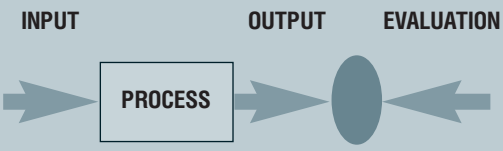
15

THE FOUR STAGES OF QUALITY IMROVEMENT



PROCESS OBJECTIVES



1. EVALUATE (MEASURE) THE EXTENT TO WHICH THE OUTPUT MET EXPECTATIONS.
2. ALTER THE INPUT TO MEET THE DESIRED OUTPUT AND EXPECTATION.

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Module 5

MANAGEMENT PROCESSES

- Types of Processes
- Goals of Processes
- Intermediate Processes
- Responsibility
- Process Structure
- Process Entrances & Exits
- Realization & Management
- Measures & Indicators
- Control & Evaluation
- Improvement

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DOCUMENTATION

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MANAGEMENT OF NONCOMPLIANCE

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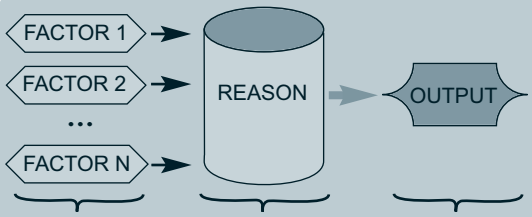

Preventive action

Corrective action
An action taken to address the causes of noncompliance, or the causes of the problem, and prevent its reoccurrence in the future. (ISO 9001)

Correction
An action to remove or correct inconsistencies in a product or low standards (ISO 9001)

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NONCOMPLIANCE

Paragraph 8.3 Irregularity in Management Services

1. Identify the product that is not in compliance
2. Make corrections through responsible management and document the process
3. For the product:
   - Prevent further noncompliance
   - Bring it into compliance
   - Assure future growth
4. Document the noncompliance, any inconsistencies and actions taken with respect to the product
5. After correcting the problem, check the product
6. If the problem(s) arose after the product was supplied, take corrective action

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CORRECTIVE ACTIONS

Paragraph 8.5.2

1. Analyze the noncompliance or nonconformity
2. Analyze the complaint
3. Identify the causes of the problem(s)
4. Identify ways to prevent a reoccurence
5. Take action to correct the problem(s)
6. Record the results
7. Analyze the results

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PREVENTIVE ACTION

Paragraph 8.5.2

24

1. Identify potential noncompliance
2. Identify causes of potential noncompliance
3. Assess the likelihood of future noncompliance
4. Identify steps to prevent noncompliance
5. Take action(s) against noncompliance
6. Record the results of the action(s)
7. Analyze the results of the action(s) and determine if they were effective

TAKING CORRECTIVE ACTION

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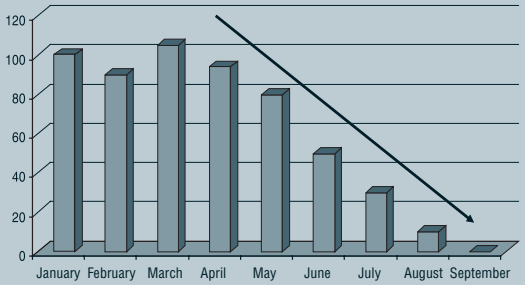

Complete implementation of corrective actions

MONITORING

26

The systematic assessment of success, measured against target indicators; the identification of reasons for deviation; the revision or clarification of standards when necessary; the evaluation of efficacy; the planning and implementation of continuous quality control

DESIGNING QUALITY INDICATORS

Questions:

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1. What do we want to receive information about?
2. Which indicators will provide the most accurate measurement?
3. How can we most clearly define the indicator?
4. How can the indicator be calculated?
5. What sources of information can provide the necessary data?
6. What data needs to be analyzed?
7. How can we obtain the necessary data?
8. How can analysis of the indicator be used to improve the quality of care?

IMPLEMENTATION OF QUALITY INDICATORS IN CLINICAL PRACTICE

Types of Quality Indicators:

- Infrastructure indicators;
- Indicators of Clinical Processes;
- Results indicators.

Infrastructure Indicators:

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- Conditions for providing medical care;
- The availability and use of financing and financial assets;
- The level and use of equipment;
- The number and qualifications of staff;
- Other resource components.

The ratio of the quality indicator's actual value to the desired target value is called an index of goal achievement.

QUALITY INDICATORS

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Quality indicators are numerical indicators used to assess the structure, process and results of medical care.

A threshold (end) quality indicator value is the desired level of a quality indicator. This is often set as the goal of quality improvement programs and used to assess the frequency of problems, such as complications, readmissions, deaths, etc.

Checkpoints are stages in the process where problems are most likely to occur and where the status of the process can be assessed most effectively.

IMPLEMENTATION OF QUALITY INDICATORS IN CLINICAL PRACTICE

- Indicators of clinical processes
- Quality assessment of myocardial infarction patients in the US *(Medicare, 2000)*

Quality indicator	End level %	Actual level %
Timely prescription of aspirin	100	86
Prescription of aspirin on discharge	100	78
Prescription of 3-blocker on discharge	100	50
Prescription of inhibitors of angiotensine converting factor under low ejection fraction of left ventricle	100	59
Recommendation to give up smoking during hospitalization	100	42

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No problem can be solved on the same level in which was identified.

Albert Einstein

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IMPLEMENTATION OF QUALITY INDICATORS IN CLINICAL PRACTICE

Indicators to measure the results of medical care related to oncology in the United States prior to 2010:

1. Reduce mortality due to malignant neoplasms;
2. Reduce mortality due to lung cancer;
3. Reduce mortality due to breast cancer;
4. Reduce mortality due to cervical cancer;
5. Reduce mortality due to colorectal cancer;
6. Reduce mortality due to prostate cancer;
7. Reduce mortality due to melanoma;
8. Reduce the effects of ultraviolet irradiation and the incidence of skin cancer;
9. Implement measures to prevent malignant neoplasms;
10. Increase the frequency of conducting Pap smears;
11. Increase the frequency of screening for colorectal cancer;
12. Increase the frequency of mammography;
13. Expand cancer registries;
14. Increase the five-year survival of patients with all types of cancer.

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Comments to slides

Slide 2. Technological progress at the end of twentieth century has brought significant changes to the health care sector, making it possible to treat conditions that were previously fatal and enabling doctors to diagnose conditions early enough for effective treatment. However, considering the improvements made in the health care sector, the outcomes of medical care—even in developed nations—are not at a level that might be expected.

The percentage of clients who are dissatisfied with the medical care they receive stands at 38% in Canada, 44% in the USA, 31% in England, 36% in Australia and 48% in New Zealand (Sh. Leatherman, USA, 2005). The use of new, effective and aggressive medical technologies has resulted in an increase in the risk of serious complications and a decrease in patient safety. In the US, 98,000 people die every year as a result of preventable medical errors. Based on research conducted in Canada in 2000, one in 13 patients experiences side effects as a result of hospital treatment, increasing the duration of hospital stays in general to 1.1 million bed days. Even in countries with high health care expenditures, such as the US, where health care accounts for 14% of GDP, and Canada where it accounts for 8.7% of GDP, there are still significant gaps in the quality of medical care.

Slide 3. Problems with the quality of medical care are often due to the increased cost and complexity of care, an aging population, an increase in the proportion of diseases that are chronic, poor management of patient flow, unqualified personnel, an increase in the amount of health care information available, and lagging computerization of health care facilities.

In the US, Canada and the EU, the need to improve the quality of medical care has been recognized as a national priority and the governments of these countries are committed to financing measures to act on this priority.

Slide 4. Improvements in health care services require a combined effort by a country's health care management structure, health care services and social sectors. Also important are adequate health care financing, effective management, improvements in staff training and human resources management, adequate modern equipment for health care facilities, adequate information services in the health care industry and encouraging home medical care and industry development.

In other words, building a modern system of quality health care depends on good management and quality measurement methodologies.

Slide 5. The quality of medical care (QMC) is a function of meeting the patient's needs and expectations, as well as raising health care services to modern international standards.

Slide 13. There are a range of approaches to quality improvement.

Needs for quality improvement vary widely, depending on the type of health care facility involved and the situation. The same quality of care principles are applied from village FAPs to urban hospitals and large systems. However, certain approaches work better under certain circumstances. There is a wide spectrum of approaches to quality improvement, from simple to complex, that have proven useful.
These approaches can be presented along a continuum of complexity. As complexity increases, more time, personnel and resources are required. Four approaches to quality improvement have been defined based on this continuum.

Slide 14. Steps in quality improvement.
All approaches to quality improvement go through four distinct steps.

Slide 15. However, quality improvement is not limited to these four steps. Managers need to continuously look for ways to improve quality, even when it seems that the job has been done. This concept is often called “continuous quality improvement”

Stage No 1: Definition
The goal of the first stage is to define what needs to be improved. It may be a problem that needs to be solved, something that needs to be improved or changes to an entire system.

Stage No 2: Analysis
Having defined the problem or area for improvement, in the analysis phase, you look critically at the information available that can help bring about the desired improvement.

Stage No 3: Design
In the third stage, information is used to identify the concrete changes that will result in improvement. These changes should become the basis for a workable strategy to be implemented in the facility or system.

Stage No 4: Verification and Implementation.
In this final stage, the strategy is tested to determine if it will actually result in improvement. The results from the test should be used to modify the strategy as needed. Managers should be prepared that changes may not bring about immediate results, even if they are effective.

Slide 27. How can you assess whether medical care was provided fully and correctly? This information is necessary to evaluate staff performance, measure the effects of management decisions and plan the way forward.
Over the past 15 years, quality indicators have been developed to do this.
Quality indicators are quantitative indicators used to assess the structure, process and results of medical care.
Quality indicators are generally expressed as percentages.
A threshold value is the target level of a quality indicator; this is often set as the goal of a quality improvement program.
Clinical protocols, systematic reviews, best practices and expert opinions are used to establish the value of a threshold indicator.

The progress of quality improvement programs is measured by checkpoint indicators at clearly defined stages of the program where problems are likely to occur. Due to the problematic nature of these stages, analysis of checkpoint indicators is especially useful at these times. In the health care system, different illnesses progress differently, so checkpoint indicators that only measure the treatment process do not provide a good measure of the quality of care. However, these indicators can point to harmful or ineffective elements of the system.

Slide 28. **Designing quality indicators**

While designing indicators, it is necessary to keep in mind:

1. What exactly do we want to collect information about?
2. What indicators will provide the most accurate measurement?
3. How can we most clearly define an indicator?
4. How can this indicator be calculated?
5. What sources of information can provide the necessary data?
6. What data needs to be analyzed?
7. How can we obtain the necessary data?

8. How can analysis of the indicator be used to improve the quality of care?

Slide 29. Applying quality indicators in clinical practice:

Types of quality indicators:

The following indicators are typically used to evaluate provision of medical care:

- Health facility indicators;
- Health care process indicators;
- Results indicators.

Combining several quality indicators to assess a particular field of medical technology is called a *profile of indicators*.

Profiles of indicators can be used to evaluate QMC, measuring efficacy, safety, timeliness and others elements of quality care. Profiles of indicators can also be used to describe the management of patients with a particular disease.

Indicators of structure:

Indicators of structure evaluate:

- The conditions for providing medical care;
- Adequacy of financing and resource distribution;
- The types of technical equipment and their use;
- The number and qualifications of staff;
- Other resource components.

Indicators of this type can be used at any level of the health care system.

A quality indicator has a target and the values actually achieved. The ratio of the quality indicator's actual value to the target value is called an *index of goal achievement.*

A common integral index can be calculated for a particular quality indicator profile. (The average value is the sum of all the values of the index of goal achievement divided by the number of indices).

For example, to evaluate the quality of the structural elements of medical care, the following integral indicators can be used:

- Integral index of financing;
- Integral index of health care facility equipment.

Indicators of health care processes

These indicators are used to evaluate patient management in certain clinical situations (prevention, diagnosis, treatment and rehabilitation). The number of quality indicators selected for monitoring depends on the complexity of the task at hand. Currently, developed nations regularly monitor management of patients with the illnesses that have a large impact on death rates.

An *integral index of quality*, the mean value of all of the indices of goal achievement in a disease profile, measures the management of patients with certain diseases in health care facilities, a region or a country.

Experts in the United States have extensive experience with projects to improve the quality of medical care using a quality index. A profile of the quality index used by the managers of Medicare—a government-financed health insurance program for the elderly—to assess proper management of patients with myocardial infarction is presented in the table. The table presents the end value and the actual values of the quality index (Medicare, 2000). As shown in the table, patients received inadequate treatment in hospital. It was estimated that improving pharmacotherapy for patients with myocardial infarction in the US could reduce the death rate within a year, to 27.4% and save nearly 3,000 lives a year.

Case 2

QUALITY MATERNAL AND CHILD CARE

By Vladimir Krasnov

One evening, Taras, an obstetrician-gynecologist and the head doctor of the Central District Hospital in Kosiv District, Ivano-Frankivsk Oblast, was thinking about the disappointing results of his tireless two-year-long effort to introduce new ideas into obstetric practice in his hospital. The outcome made him sad. At that morning's meeting of the Oblast Department of Health, Taras had been criticized for too few deliveries in his hospital. He realized that, under new regulations from Ukraine's Ministry of Health, his obstetric department was at risk of being shut down if the number of deliveries went below a certain level.

In spite of this, Taras really believed in the changes he had made in the obstetrics department. His district needed these innovations! Things had gone so well in the beginning. People had been so willing to work, they had put their souls, their enthusiasm and new ideas into practice.

The authorities had tried to shut down the obstetric department two years ago, but Taras had managed to convince them to allow him to restructure the department's services instead. Taras instituted these innovations in line with the new orders on management of labor and new prenatal technologies. Wanting the obstetric department to become a Baby Friendly facility, he introduced family delivery rooms, where a woman could be accompanied by her partner, and rooms where mothers and babies could stay together after the delivery. He allowed relatives to visit the mother and baby and to stay in the same room. Taras had learned the benefits of these innovations while on a business trip abroad. The department's small staff had quickly adapted to the new technologies and understood their necessity, once Taras had trained them.

Even though the restructuring in the obstetric department had somewhat reduced the number of hospital beds, the district's obstetric needs were met. The birth rate in the district had never been higher.

Taras tried to compare the conditions for women in the obstetric department of the Kosiv Central District Hospital with those of the central hospital in the neighboring district. There did not seem to be any real difference. There was no television in the rooms of either hospital; each woman had a bed and a bedside table for personal belongings, purchased by the Oblast Department of Health. In both hospitals, there was a hot shower available to patients, there was a washstand and washbasin in each room, the hospital-prepared food was similar, and patients in both facilities had access to a refrigerator for their own food.

The only difference between the hospitals was in the conditions for infants. In the central hospital of the neighboring district, newborns were separated from their mothers and were brought to them every three and a half hours for breastfeeding. The newborns were looked after by nurses and doctors. No visitors were allowed, although patients' relatives could send packages. In Taras' hospital, each mother shared a room with her baby, the babies were breastfed on demand and the babies were looked after by their mothers. Relatives were allowed to visit and help the mother as needed.

In addition, according to reports from district pediatricians, Kosiv Central District Hospital encouraged mothers to breastfeed their infants for a year or more after birth, while mothers giving birth at the central hospital of the neighboring district faced many problems with breastfeeding. Infant morbidity in Taras' hospital was lower than that of other hospitals. Babies born in Kosiv

Central District Hospital were less likely to fall ill with inflammatory diseases and intestinal disorders in their first year of life than babies born at other hospitals.

In Taras' opinion, his hospital seemed to be functioning well; however, official statistics showed that things were not as perfect as they seemed. Taras looked at the papers lying in front of him with various statistical indicators. "Where did I go wrong?" he thought. "How could this happen to me?"

Since the beginning of the twenty-first century, Ukraine's birth rate has been gradually increasing. So more babies were being born in Kosiv District. However, most of these babies were born not in Kosiv Central District Hospital but in the central hospital of the neighboring district or in the Oblast Maternity Hospital. Women were actually traveling from his district to another hospital to give birth!

Across the oblast, all high risk pregnant women (those with premature deliveries, with underlying medical conditions, etc.) were transported to the Oblast Perinatal Center at the first sign of labor, so they could receive tertiary-level health care services. Women without any complications of pregnancy could choose where they wanted to give birth. Some of these women went to the Oblast Maternity Hospital because they had relatives in the oblast center or they had their own means of transportation. Others gave birth in Taras' hospital, which was easily accessible by minibus. Until recently, bus transportation between the districts was poor; yet, even some women from the most remote parts of the district preferred to give birth in the central hospital of the neighboring district.

"What do my patients see in the other hospital that they don't see here?" Taras thought as he paced around his office. "I thought I had taken everything into consideration and I even explained my ideas!" Immediately after the restructuring of the obstetric department, Taras had written an article for the district newspaper and made a speech at a meeting of district health providers (family doctors, obstetricians and pediatricians, *feldshers**, nurses and others) where he presented official statistics on the quality of the new obstetric services in his hospital. Both in the article and in his speech, Taras tried to show that the indicators in the obstetric department of Kosiv Central District Hospital were no worse than in the central hospital of the neighboring district—and that they might even be better than in the Oblast Perinatal Center where women with complicated pregnancies gave birth.

However, the fact remained that the number of births in the obstetrics department of Taras' hospital had declined, which could result in specialists loosing their skills due to lack of practice. Besides, any further decrease in the number of deliveries could result in closing the obstetric department of the Kosiv Central District Hospital.

DISCUSSION QUESTIONS:

1. What are some possible reasons for the decrease in the number of births at Taras' hospital?
2. What are some possible explanations for women from Kosiv District going to the neighboring district to give birth?
3. Do you think Taras did everything that was needed when he introduced the innovations in his facility? If so, why? If not, what else should he have done?

* A *feldsher* is similar to a physician's assistant.

4. How should Taras assess the success or failure of his hospital? How does the Oblast Department of Health assess the success or failure of the hospital? Are there other assessment mechanisms that are being overlooked?
5. Which voices are represented in this story? What other sources of information could Taras use to help explain his problem?
6. What kinds of changes are needed in Taras' facility?

SUPPLEMENTAL READING:

Seitkazieva, Noorgoul, et al. *Technical Document: Improving the Quality of Reproductive Health Services in Issyk-Kul Oblast, Kyrgyzstan: Report on a Pilot Project. Issyk-Kul* Oblast: ZdravPlus project, March 2002.

TEACHING NOTES:

Teaching Objectives:

1. Participants should learn to understand and respond to the expectations of patients;
2. Participants should understand how to promote new, high quality treatments;
3. Participants should understand the difference between official statistics and patient satisfaction.

The voice that is noticeably absent from this case is that of the patient. While Taras has implemented a series of innovations that are internationally acknowledged as quality improvements, he has not communicated with the population that his hospital serves; therefore, he is unaware of their possibly negative reaction to these changes. In this case, the improvements that Taras made follow international standards and have been shown to improve the health and wellbeing of both mother and infant. However, in this case, as in many areas of Ukraine, the population is critical of new and apparently low-tech changes (see "Additional Information" below).

In order to address both the issues of quality care and patient-centered care, Taras needs to conduct further explanatory and educational programs for the public. He could collect positive accounts from women who gave birth in his facility, speak with the families of pregnant women, disseminate information among family doctors, obstetricians and pediatricians and host educational programs for future parents that would explain the benefits of the new delivery technologies. Over time, such educational campaigns would help the population accept the idea of "low-tech births" and hopefully increase the number of women who choose to deliver in Taras' hospital. In this case, Taras has encountered a common problem that many health care managers and doctors run into: he has done what is "right for the patient" without letting the patient know why it is the best choice.

In terms of the Oblast Department of Health, Taras needs to make a distinction between statistics and patient satisfaction. If the patients who deliver at his hospital are indeed satisfied with the new technologies, then he needs to find a way to collect their testimonies to prove the success of his restructuring. In addition, Taras could consider introducing quality of care indicators that address the more subtle aspects of care in his facility. While the number of deliveries may have decreased, it is possible that fewer women get anesthesia during delivery or that fewer get unnecessary Cesarean sections. Participants could brainstorm a list of quality of care indicators to assess the quality of maternal care delivered at Taras' hospital beyond simply the number

of births that occur there. (This is already addressed to some extent in the case, with regards to the morbidity of infants.)

Once participants have understood the need for a patient voice, the instructor can provide them with the following account:

ADDITIONAL INFORMATION

When visiting a friend in one of the villages of his district, Taras was walking down the street and ran into one of his friends with a colleague. Taras' friend asked the colleague when her daughter was going to have her baby, since he knew that his colleague's daughter was pregnant. The woman reported happily that her daughter had already given birth to a son in the central hospital of the neighboring district. When Taras asked the woman why her daughter had preferred to give birth in the neighboring district, she responded, "In the central hospital of the neighboring district all things are done according to tradition. After the delivery, the woman can rest and regain her strength, so she can produce milk. Until the mother is ready to breastfeed, the baby is fed from a bottle with baby formula. At the hospital in our district, the woman has to take care of her baby as soon as it is born. And to add insult to injury, the woman's husband has to come and witness the labor. In my opinion, there's no way men should see things like that!" The woman added one more comment, "I gave birth to my children the same way my mother did and everything went well. I want the same thing for my daughter. So my husband and I made the decision to send her to the Central Hospital of the neighboring rayon."

GLOSSARY OF TERMS

Audit – a systematic, independent and documented process of obtaining audit evidence and their objective evaluation to determine the extent to which audit criteria are met.

Auditor – a person who has competence to audit.

Measurement process – a set of operations that allows defining the meaning of a value.

Audit conclusion – the result of an audit formulated by the audit group after taking into account all audit data according to the purpose of the audit.

Conformity – fulfillment of the requirement.

Efficiency – the ratio between achieved results and used resources.

Quality assurance – a component of quality management focused on providing confidence that the quality requirements will be met.

Customer satisfaction – customer's perception of the degree at which his/her requirements have been met.

Preventive action – an action performed to eliminate the causes of potential nonconformity or another potentially unwanted situation.

Quality control – a component of quality management focused on fulfilling quality requirements.

Corrective action – an action carried out to eliminate the detected nonconformity or another unwanted situation.

Correction – an action carried out to eliminate the detected nonconformity.

Audit criteria – a set of policies, procedures or requirements used as a reference.

Dependability – a collective term used to describe the readiness characteristics and factors that impact it, characteristics of reliability, sustainability and maintenance.

Nonconformity –non-compliance.

Quality improvement – a component of quality management focused on increasing the ability to meet the quality requirements.

Continual improvement – repeated efforts to increase the opportunity to meet the requirements.

Audit programme – one or more audits planned for a specific time frame and directed towards a specific goal.

Product – the result of a process.

Traceability – being able to trace the prehistory, the use or location of something.

Process – a set of interrelated or interacting activities that transform inputs into outputs.

Effectiveness – the degree of implementation of planned activities and achievement of planned results.

System – a set of interrelated or interacting elements.

Measurement control system – a set of interrelated or interacting elements needed for metrological confirmation and ongoing measurement control.

Management system – a system that allows setting policies and goals and achieving them.

Quality management system – a management system which directs and controls an organization's activity in terms of quality.

Capability – the ability of an organization, system or process to create products that meet the requirements for this product.

Management – coordinated activity that consists in directing and controlling an organization.

Quality management – coordinated activity that consists in directing and controlling an organization in terms of quality.

Quality characteristic – the characteristic of products, processes, or systems based on the requirements.

Quality objectives – what is desired or what is planned to achieve in terms of quality.

Quality – the extent to which a set of features meets the demand.