Influential Article Review - Evaluating Health Care Organizations and their Ability to Innovate

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This paper examines healthcare innovation. We present insights from a highly influential paper. Here are the highlights from this paper: The health care sector shows a disjunction between the well-understood necessity for change and the capacity to realize it. Conventional management strategies and traditional means of influencing professionals often fail to deliver projected outcomes. We address this issue from a different angle. An organization's capacity for change is determined by the combination of power distribution, value system and change readiness, which should be analyzed not as formal qualities but as aspects of the organization as a social system, disclosing a reality beneath the surface of mission statements, quality policy and management models. We describe a method to analyse the identity of an organization as a social system with respect to its innovation potential. This identity shows in the rules of discourse determining what is valid communication and which are the sources of impact of arguments in a communicative interaction leading to decisions. We present two case studies in which groups of physicians argue in favor of respectively against the availability of physician-assisted death (PAD) for terminal patients.For our overseas readers, we then present the insights from this paper in Spanish, French, Portuguese, and German.

Keywords: Health care innovation, Innovation profile, Quality management, Systems theory, Patient participation, Shared decision making, Discourse analysis

SUMMARY

- The physician is powerless against the immutable principles of the medical profession itself. The role of the physician is «sharply, firmly and immutably distinct» from answering pleas for a humane death. In this threefold repetition of the rejection of a possible compromise, any perspective of change is closed for all eternity.
- E. Wesley Ely. Aristotle's Nicomachean Ethics provides the foundation for the decision that life must be prolonged to its natural end. This is a manifestation of «natural law which is universal and based on the rational nature of humans».
- An alternative discursive strategy for complexity reduction in order to reach end-of-life decisions is demonstrated by Quill et al. in their «viewpoint» in the JAMA.

- The authors of this viewpoint, Quill, Back and Susan D. Block are medical professionals and involved in the world of palliative care, cancer research and oncology. They argue why physician-assisted death should be made legally available. The answers to the three research questions is:
- Equal status in discourse as precondition for impact of arguments. No doubt about it: with Quill et al., the ultimate decision to administer a merciful death also rests with the physician as warranted by law. However, the decision concerning a physician's assistance in ending a terminally ill patient's life is reached on the basis of an explicit and structured inquiry in which the physician questions the patient on his or her feelings, fears, experiences and desires regarding the impending death. Within this frame of «question and answer», the patient's influence on the physician's decision is formally guaranteed, thereby distributing «agency» as evenly as possible within applicable legal conditions.
- But the decision is not reached by just physicians and patients. Additional arguments can be provided by «family and friends» on the patient's side and by «trusted colleagues» on behalf of the physician. Quill et al. plead for an «open system with second opinions and consultations», thereby maximizing the inclusiveness of the social system reaching a decision.
- As to governance: in dealing with «hastening death», the authors plead for a legalized context in which patients and physicians should not have to «act in secrecy» and can «experience benefits» provided by an open legal process, thereby fulfilling the strongest requirement for governance: regulation by law.
- The impact of arguments is derived from the values to which they refer. Quill et al. state their position right from the start: «both the living experience of a person with a serious illness as well as commonly recognized ethical principles provide guidance in answering the question concerning the justifiability of physician assisted death». This means that the patient's perspective dominates the exchange of arguments . The physician's set of values should stand back against those of the patient—physicians should respond to the patient's concerns and fears «regardless of their own stance».
- The same goes for the nature of the values referred to. The values with the strongest impact in the decision making process are those referring to the patient's «right to bodily integrity» and his/her desire to «have control over their own bodies, their own lives…».
- Values like these are by their very nature non-quantifiable—which means that their impact cannot be counted by numbers. It will be the support of interest groups for the arguments as well as the emotional passion and the rhetorical force with which they are presented which determine the impact of arguments in discourse leading to a decision pro or contra legalizing PAD.

HIGHLY INFLUENTIAL ARTICLE

We used the following article as a basis of our evaluation:

Kievit, P. J., Oomes, J., Schoorl, M., & Bartels, P. (2018). The missing link: Toward an assessment of innovation capacity in health care organizations. International Journal of Quality Innovation, 4(1), 1–18.

This is the link to the publisher's website:
https://jqualityinnovation.springeropen.com/articles/10.1186/s40887-018-0023-3

INTRODUCTION

In health care organizations, structure and process innovation are considered to be key drivers for the improvement of both efficiency and experienced quality of care [2, 3]. In everyday practice, however, innovation projects frequently fail to meet their targets and to deliver sustainable outcomes [4].

This failure points to misunderstandings about the conditions for innovation and sustained quality improvement in health care organizations.

According to Scott [5], organizations can be seen as either rational, productive systems aiming at optimizing input-output ratios or as natural, adaptive social systems that evolve via spontaneous, indeterminate processes, "trying to survive in their environment". This dual nature of organizations as instruments to reach a specific goal and as living environments for social interaction has deep roots in the literature on organization studies as shown by Lincoln and Kalleberg [6], Orru et al. [7], Scott et al. [8], Hogg and Terry [9], Scott and Davis [10] and Capra and Luisi [11].

Innovation theory has tried to reconcile these two concepts of the organization and to merge them into mixed models in which proven best practices are implemented by means of social engineering aimed at individual attitude—illustrated by "Maier's law" $E = Q \times A$ (the effectiveness (E) of an intervention is equal to the quality (Q) of the solution multiplied by the acceptance (A) of the idea) [12]. This approach, combining the formal and informal structure of organizations [13], has found its way into most paradigms for quality improvement in health organizations such as the EFQM, Continuous Quality Improvement, Total Quality Management, Six Sigma, LEAN, FADE and PDCA [14]. But even an open and all-encompassing innovation paradigm like the Malcolm Baldrige Health Care Criteria for Performance Excellence (HCPE) which combines interventions in organization design, strategy, systems and human capital to create long-term effectiveness (in terms of process design combined with clinical outcome) does not outperform non-HCPE hospitals on this parameter [15]. HCPE hospitals however do score substantially better on experienced quality of care. Obviously, "emphasizing a broadly communicated mission, a supportive learning culture, universal measurement and benchmarking and systematic process improvement" [16] result in greater awareness of patient's needs and interests, but the causality behind this correlation remains unclear.

In addition to these generalized approaches, Lee [17] and Lee and Kim [18], for instance, refer to the multifactorial nature of quality in health service, depending on the perspective of the parties involved. They present a survey of models in which "the perceptions of a variety of stakeholders including patients, physicians, nurses and others to create a more comprehensive view of health service quality" are leading.

But despite all efforts to implement standardized models for quality improvement, the health care sector suffers from a persistent immunity to change as pointed out by Berwick [19] and confirmed in subsequent studies by, for instance, Greenhalgh et al. [20] and Grol and Wensing [21]. There appears to be a disjunction between the generally well-understood necessity for change and the intrinsic capacity to realize it. This so-called quality chasm was defined by the Institute of Medicine as a "disability of health care delivery systems to translate knowledge into practice" [22]. Underlying all concepts of model-management and stage-gate innovation, there seems to be a hidden dynamics in health care organizations, either stimulating or obstructing the effects of interventions aimed at quality improvement.

The purpose of this paper is to analyse this hidden dynamics and to develop an approach to assess the capacity for innovation and sustainable change in healthcare organizations. We look at them through the analytic lens of the theory of social systems and take their compound nature into account. In this way, we aim to construct "the missing link between innovation process design and innovation potential at the organization level" [23] in order to enhance the success rate of innovation projects aimed at quality improvement. These are the "conditions and factors facilitating and inhibiting innovations in healthcare" as outlined by Länsisalmi et al. [24], knowledge of which is essential if innovation is to be successfully implemented, adopted and assimilated. Our research question is how can the potential for change of a healthcare organization be assessed in order to select an appropriate innovation and the best means to ensure implementation? This question addresses the preconditions for sustainable quality improvement. Clarifying it is vital to decide which innovation is appropriate and feasible in a particular situation and which is the best way to implement and adopt it.

CONCLUSION

Quality improvement of healthcare and health care delivery through structure and process innovation can only be successful—yielding sustainable outcomes at acceptable costs—under the condition that both the nature of the intervention and the chosen method of implementation are compliant with the potential of an organization for innovation and change. The difficulty is how to assess this potential. As multiple reviews have shown, an organization's formal properties as rational, productive systems or the individual characteristics of its members are poor predictors of successful innovation. It is the nature of legitimacy, the set of shared values and the perception of evolution which determine the innovation culture of an organization. In the healthcare sector, those three determinants pose extra challenges as they tend to differ for the different groups of stakeholders working together within the same organizational setting and policy agenda.

The analysis of two (mini)-systems has shown how two groups of similar professionals—all physicians and well embedded in the professional institutional environment—operate with different discursive strategies in the complex issue of end of life decisions, thereby reaching different outcomes: a plea for or against a legally embedded right to physician-assisted death in the case of terminally ill patients. An analysis of an organization's innovation potential by means of mapping its discursive strategies can reduce the risk of setting unattainable goals by adjusting the selection of innovations and the design of implementation processes to the identity of the organization which is expected to adopt them.

In our examples, it remains to be seen, whether the innovation profile of the two social systems shown in the PAD discussion persists in other—but similar—situations. In other words, are the observed discursive strategies related to the issue at stake (PAD) or are they truly a marker of a system's innovation profile and hence a predictor of future behaviour? In order to decide the issue, further tests and analysis are required to confirm or adjust the initial hypothesis.

APPENDIX

TABLE 1
THE INNOVATION PROFILE

Arguments: sources of impact		
I legitimacy	**II value**	**III change readiness**
Leadership	Provenance	Tradition as authority
Inclusiveness	Currency	Concept of evolution
Governance	Quantity	Self-assessment

TABLE 2
EXAMPLE 1 "TEMPLATE"

Arguments: sources of impact		
I legitimacy	**II value**	**III change readiness**
Leadership	Provenance	Tradition as authority
Decisions lie exclusively with physician	Physician's values supersede patient's	Reference to founding father of medicine Hippocrates
Inclusiveness	Currency	Concept of evolution

Patient's status as participant depends on physician	Moral values based on deontological ethics	Principles of medicine are immutable
Governance	Quantity	Image of self
Decisions are made unilaterally based on professional status	Non applicable	Physician as upholder of superior a-topical standards

TABLE 3
EXAMPLE 2 "VIEWPOINT"

Arguments: sources of impact		
I legitimacy	**II value**	**III change readiness**
Leadership	Provenance	Tradition as authority
Decision making is shared between physician and patient	Patient's values prevail over physician's	No external source of authority
Inclusiveness	Currency	Concept of evolution
Besides patient, family/friends and colleagues participate	Non numerical: autonomy, integrity, quality of life	Non-applicable
Governance	Quantity	Image of self
Decisions are reached in an objective and transparent way	Non-applicable	Change driven by patient's needs and best interest

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TRANSLATED VERSION: SPANISH

Below is a rough translation of the insights presented above. This was done to give a general understanding of the ideas presented in the paper. Please excuse any grammatical mistakes and do not hold the original authors responsible for these mistakes.

VERSION TRADUCIDA: ESPAÑOL

A continuación se muestra una traducción aproximada de las ideas presentadas anteriormente. Esto se hizo para dar una comprensión general de las ideas presentadas en el documento. Por favor, disculpe cualquier error gramatical y no responsabilite a los autores originales de estos errores.

INTRODUCCIÓN

En las organizaciones de atención de la salud, la estructura y la innovación de procesos se consideran factores clave para la mejora de la eficiencia y la calidad de la atención experimentada [2, 3]. En la práctica cotidiana, sin embargo, los proyectos de innovación con frecuencia no cumplen sus objetivos y logran resultados sostenibles [4].

Este fracaso apunta a malentendidos sobre las condiciones para la innovación y la mejora sostenida de la calidad en las organizaciones de atención de la salud.

Según Scott [5], las organizaciones pueden ser vistas como sistemas racionales y productivos con el objetivo de optimizar las relaciones entrada-salida o como sistemas sociales naturales y adaptables que evolucionan a través de procesos espontáneos e indeterminados, "tratando de sobrevivir en su entorno". Esta doble naturaleza de las organizaciones como instrumentos para alcanzar una meta específica y como entornos de vida para la interacción social tiene profundas raíces en la literatura sobre estudios de organización como lo muestran Lincoln y Kalleberg [6], Orru et al. [7], Scott et al. [8], Hogg y Terry [9], Scott Davis [10] y Capra y Luisi [11].

La teoría de la innovación ha tratado de conciliar estos dos conceptos de la organización y fusionarlos en modelos mixtos en los que se implementan las mejores prácticas probadas mediante ingeniería social dirigida a la actitud individual, ilustrada por la "ley de Maier" E - Q × A (la eficacia (E) de una intervención es igual a la calidad (Q) de la solución multiplicada por la aceptación (A) de la idea) [12]. Este enfoque, que combina la estructura formal e informal de las organizaciones [13], ha encontrado su camino en la mayoría de los paradigmas para la mejora de la calidad en organizaciones de salud como EFQM, Mejora Continua de la Calidad, Gestión Total de la Calidad, Six Sigma, LEAN, FADE y PDCA [14]. Pero incluso un paradigma de innovación abierto y global como el Malcolm Baldrige Health Care Criteria for Performance Excellence (HCPE) que combina intervenciones en diseño de organización, estrategia, sistemas y capital humano para crear eficacia a largo plazo (en términos de diseño de procesos combinado con resultados clínicos) no supera a los hospitales no HCPE en este parámetro [15]. Sin embargo, los hospitales HCPE puntúen sustancialmente mejor en la calidad de la atención experimentada. Obviamente, "enfatizar una misión ampliamente comunicada, una cultura de aprendizaje de apoyo, medición universal y benchmarking y mejora sistemática de los procesos" [16] dan como resultado una mayor conciencia de las necesidades e intereses del paciente, pero la causalidad detrás de esta correlación sigue sin estar clara.

Además de estos enfoques generalizados, Lee [17] y Lee y Kim [18], por ejemplo, se refieren a la naturaleza multifactorial de la calidad en el servicio de salud, dependiendo de la perspectiva de las partes involucradas. Presentan una encuesta de modelos en los que "las percepciones de una variedad de partes

interesadas, incluidos pacientes, médicos, enfermeras y otros, para crear una visión más completa de la calidad de los servicios de salud" son líderes.

Sin embargo, a pesar de todos los esfuerzos por implementar modelos estandarizados de mejora de la calidad, el sector de la atención de la salud sufre una inmunidad persistente al cambio, como señaló Berwick [19] y se confirma en estudios posteriores, por ejemplo, Greenhalgh et al. [20] y Grol y Wensing [21]. Parece haber una disyunción entre la necesidad generalmente bien entendida de cambio y la capacidad intrínseca de realizarlo. Este llamado abismo de calidad fue definido por el Instituto de Medicina como una "discapacidad de los sistemas de prestación de servicios de salud para traducir el conocimiento en la práctica" [22]. Detrás de todos los conceptos de gestión de modelos e innovación de etapas, parece haber una dinámica oculta en las organizaciones de atención de la salud, ya sea estimulando u obstruyendo los efectos de las intervenciones destinadas a mejorar la calidad.

El objetivo de este documento es analizar esta dinámica oculta y desarrollar un enfoque para evaluar la capacidad de innovación y el cambio sostenible en las organizaciones sanitarias. Los miramos a través de la lente analítica de la teoría de los sistemas sociales y tenemos en cuenta su naturaleza compuesta. De esta manera, nuestro objetivo es construir "el eslabón perdido entre el diseño de procesos de innovación y el potencial de innovación a nivel de organización" [23] con el fin de mejorar la tasa de éxito de los proyectos de innovación destinados a la mejora de la calidad. Estas son las "condiciones y factores que facilitan e inhiben las innovaciones en la atención sanitaria", tal como se describe en la empresa L-nnsisalmi et al. [24], cuyo conocimiento es esencial para que la innovación se aplique, adopte y asimile con éxito. Nuestra pregunta de investigación es ¿cómo se puede evaluar el potencial de cambio de una organización de atención médica con el fin de seleccionar una innovación adecuada y los mejores medios para garantizar la implementación? Esta pregunta aborda las condiciones previas para la mejora sostenible de la calidad. Aclararlo es vital decidir qué innovación es adecuada y factible en una situación particular y cuál es la mejor manera de aplicarla y adoptarla.

CONCLUSIÓN

La mejora de la calidad de la atención sanitaria y de la prestación de atención médica a través de la innovación en estructuras y procesos sólo puede tener éxito, lo que produce resultados sostenibles a costos aceptables, con la condición de que tanto la naturaleza de la intervención como el método de implementación elegido cumplan con el potencial de una organización para la innovación y el cambio. La dificultad es cómo evaluar este potencial. Como múltiples revisiones han demostrado, las propiedades formales de una organización como sistema racional, productivo o las características individuales de sus miembros son malos predictores de la innovación exitosa. Es la naturaleza de la legitimidad, el conjunto de valores compartidos y la percepción de la evolución lo que determina la cultura de innovación de una organización. En el sector de la salud, estos tres determinantes plantean desafíos adicionales, ya que tienden a diferir para los diferentes grupos de partes interesadas que trabajan juntos dentro del mismo entorno organizativo y agenda política.

El análisis de dos (mini)sistemas ha demostrado cómo dos grupos de profesionales similares —todos médicos y bien integrados en el entorno institucional profesional— operan con diferentes estrategias discursivas en la compleja cuestión de las decisiones al final de la vida, alcanzando así resultados diferentes: un alegato a favor o en contra de un derecho legalmente integrado a la muerte asistida por un médico en el caso de los pacientes con enfermedades terminales. Un análisis del potencial de innovación de una organización mediante el mapeo de sus estrategias discursivas puede reducir el riesgo de establecer objetivos inalcanzables ajustando la selección de innovaciones y el diseño de los procesos de implementación a la identidad de la organización que se espera que las adopte.

En nuestros ejemplos, queda por ver si el perfil de innovación de los dos sistemas sociales mostrados en la discusión del PAD persiste en otras situaciones, pero similares. En otras palabras, ¿están relacionadas con la cuestión en juego (PAD) las estrategias discursivas observadas o son realmente un indicador del perfil de innovación de un sistema y, por lo tanto, un predictor del comportamiento futuro? Para decidir el problema, se requieren más pruebas y análisis para confirmar o ajustar la hipótesis inicial.

TRANSLATED VERSION: FRENCH

Below is a rough translation of the insights presented above. This was done to give a general understanding of the ideas presented in the paper. Please excuse any grammatical mistakes and do not hold the original authors responsible for these mistakes.

VERSION TRADUITE: FRANÇAIS

Voici une traduction approximative des idées présentées ci-dessus. Cela a été fait pour donner une compréhension générale des idées présentées dans le document. Veuillez excuser toutes les erreurs grammaticales et ne pas tenir les auteurs originaux responsables de ces erreurs.

INTRODUCTION

Dans les organismes de soins de santé, l'innovation en matière de structure et de processus est considérée comme un facteur clé de l'amélioration de l'efficacité et de la qualité des soins expérimentés [2, 3]. Dans la pratique quotidienne, cependant, les projets d'innovation ne parviennent souvent pas à atteindre leurs objectifs et à obtenir des résultats durables [4].

Cet échec fait état de malentendus quant aux conditions d'innovation et d'amélioration durable de la qualité dans les organismes de soins de santé.

Selon Scott [5], les organisations peuvent être considérées soit comme des systèmes rationnels et productifs visant à optimiser les ratios entrée-sortie, soit comme des systèmes sociaux naturels et adaptatifs qui évoluent par des processus spontanés et indéterminés, « essayant de survivre dans leur environnement ». Cette double nature des organisations comme instruments pour atteindre un objectif spécifique et en tant que milieux de vie pour l'interaction sociale a des racines profondes dans la littérature sur les études organisationnelles comme le montre Lincoln et Kalleberg [6], Orru et coll. [7], Scott et coll. [8], Hogg et Terry [9], Scott et Davis [10] et Capra et Luisi [11].

La théorie de l'innovation a tenté de concilier ces deux concepts de l'organisation et de les fusionner en modèles mixtes dans lesquels les meilleures pratiques éprouvées sont mises en œuvre au moyen d'une ingénierie sociale visant l'attitude individuelle , illustrée par la « loi de Maier » $E = Q \times A$ (l'efficacité (E) d'une intervention est égale à la qualité (Q) de la solution multipliée par l'acceptation (A) de l'idée) [12]. Cette approche, combinant la structure formelle et informelle des organisations [13], a trouvé son chemin dans la plupart des paradigmes pour l'amélioration de la qualité dans les organisations de santé telles que l'efqm, l'amélioration de la qualité continue, la gestion de la qualité totale, Six Sigma, LEAN, FADE et PDCA [14]. Mais même un paradigme d'innovation ouvert et global comme le Malcolm Baldrige Health Care Criterias for Performance Excellence (HCPE) qui combine des interventions dans la conception de l'organisation, la stratégie, les systèmes et le capital humain pour créer une efficacité à long terme (en termes de conception de processus combiné avec les résultats cliniques) ne surpasse pas les hôpitaux non-HCPE sur ce paramètre [15]. Les hôpitaux du HCPE obtiennent toutefois des résultats nettement meilleurs en ce qui a sur la qualité des soins expérimentés. De toute évidence, « mettre l'accent sur une mission largement communiquée, une culture d'apprentissage de soutien, une mesure et un benchmarking universels et une amélioration systématique des processus » [16] donnent lieu à une plus grande prise de conscience des besoins et des intérêts des patients, mais la causalité derrière cette corrélation demeure floue.

En plus de ces approches généralisées, Lee [17] et Lee et Kim [18], par exemple, se réfèrent à la nature multifactorielle de la qualité des services de santé, selon le point de vue des parties concernées. Ils présentent une enquête sur les modèles dans lesquels « les perceptions d'une variété d'intervenants, y compris les patients, les médecins, les infirmières et d'autres, afin de créer une vision plus complète de la qualité des services de santé » sont à l'avant-garde.

Mais malgré tous les efforts déployés pour mettre en œuvre des modèles normalisés d'amélioration de la qualité, le secteur des soins de santé souffre d'une immunité persistante au changement, comme l'a

souligné Berwick [19] et confirmé dans des études ultérieures par, par exemple, Greenhalgh et coll. [20] et Grol et Wensing [21]. Il semble y avoir une disjonction entre la nécessité généralement bien comprise du changement et la capacité intrinsèque de le réaliser. Ce soi-disant gouffre de qualité a été défini par l'Institut de médecine comme un « handicap des systèmes de prestation de soins de santé pour traduire les connaissances en pratique » [22]. Sous-jacent à tous les concepts de gestion des modèles et d'innovation par étapes, il semble y avoir une dynamique cachée dans les organisations de soins de santé, soit stimulante, soit entravant les effets des interventions visant à améliorer la qualité.

Le but de ce document est d'analyser cette dynamique cachée et de développer une approche pour évaluer la capacité d'innovation et de changement durable dans les organisations de soins de santé. Nous les examinons à travers la lentille analytique de la théorie des systèmes sociaux et prenons en compte leur nature composée. De cette façon, nous visons à construire « le chaînon manquant entre la conception de processus d'innovation et le potentiel d'innovation au niveau de l'organisation » [23] afin d'améliorer le taux de réussite des projets d'innovation visant à améliorer la qualité. Il s'agit des « onditions et facteurs facilitant et inhibant les innovations dans le domaine des soins de sant » comme l'ont souligné Länsisalmi et coll. [24], dont la connaissance est essentielle pour que l'innovation soit mise en œuvre, adoptée et assimilée avec succès. Notre question de recherche est de savoir comment évaluer le potentiel de changement d'une organisation de soins de santé afin de choisir une innovation appropriée et les meilleurs moyens d'assurer la mise en œuvre? Cette question répond aux conditions préalables à une amélioration durable de la qualité. Il est essentiel de préciser quelle innovation est appropriée et réalisable dans une situation particulière et quelle est la meilleure façon de la mettre en œuvre et de l'adopter.

CONCLUSION

L'amélioration de la qualité des soins de santé et de la prestation des soins de santé par l'innovation en matière de structure et de processus ne peut être efficace — ce qui donne des résultats durables à des coûts acceptables — à condition que la nature de l'intervention et la méthode de mise en œuvre choisie soient conformes au potentiel d'une organisation d'innovation et de changement. La difficulté est de savoir comment évaluer ce potentiel. Comme plusieurs examens l'ont montré, les propriétés formelles d'une organisation en tant que système rationnel et productif ou les caractéristiques individuelles de ses membres sont de mauvais prédicteurs d'innovation réussie. C'est la nature de la légitimité, l'ensemble des valeurs partagées et la perception de l'évolution qui déterminent la culture de l'innovation d'une organisation. Dans le secteur des soins de santé, ces trois déterminants posent des défis supplémentaires, car ils ont tendance à différer pour les différents groupes d'intervenants qui travaillent ensemble dans le cadre d'un même cadre organisationnel et d'un même programme stratégique.

L'analyse de deux (mini)-systèmes a montré comment deux groupes de professionnels similaires — tous des médecins et bien intégrés dans l'environnement institutionnel professionnel — fonctionnent avec différentes stratégies discursives dans la question complexe des décisions de fin de vie, atteignant ainsi des résultats différents : un plaidoyer pour ou contre un droit juridiquement intégré à la mort assistée par un médecin dans le cas des patients en phase terminale. Une analyse du potentiel d'innovation d'une organisation au moyen de la cartographie de ses stratégies discursives peut réduire le risque de fixer des objectifs inaccessibles en ajustant la sélection des innovations et la conception des processus de mise en œuvre à l'identité de l'organisation qui devrait les adopter.

Dans nos exemples, il reste à voir si le profil d'innovation des deux systèmes sociaux présentés dans la discussion pad persiste dans d'autres situations, mais similaires. En d'autres termes, les stratégies discursives observées sont-elles liées à la question en jeu (PAD) ou sont-elles vraiment un marqueur du profil d'innovation d'un système et donc un prédicteur du comportement futur? Pour trancher la question, d'autres tests et analyses sont nécessaires pour confirmer ou ajuster l'hypothèse initiale.

TRANSLATED VERSION: GERMAN

Below is a rough translation of the insights presented above. This was done to give a general understanding of the ideas presented in the paper. Please excuse any grammatical mistakes and do not hold the original authors responsible for these mistakes.

ÜBERSETZTE VERSION: DEUTSCH

Hier ist eine ungefähre Übersetzung der oben vorgestellten Ideen. Dies wurde getan, um ein allgemeines Verständnis der in dem Dokument vorgestellten Ideen zu vermitteln. Bitte entschuldigen Sie alle grammatikalischen Fehler und machen Sie die ursprünglichen Autoren nicht für diese Fehler verantwortlich.

EINLEITUNG

In Organisationen im Gesundheitswesen gelten Struktur- und Prozessinnovationen als schlüsselwerte Faktoren für die Verbesserung sowohl der Effizienz als auch der erfahrenen Qualität der Versorgung [2, 3]. In der täglichen Praxis verfehlen Innovationsprojekte jedoch häufig ihre Ziele und liefern nachhaltige Ergebnisse [4].

Dieses Versäumnis deutet auf Missverständnisse über die Bedingungen für Innovation und nachhaltige Qualitätsverbesserungen in Organisationen im Gesundheitswesen hin.

Laut Scott [5] können Organisationen entweder als rationale, produktive Systeme angesehen werden, die auf die Optimierung von Input-Output-Verhältnissen abzielen, oder als natürliche, adaptive soziale Systeme, die sich durch spontane, unbestimmte Prozesse entwickeln und "versuchen, in ihrer Umgebung zu überleben". Diese doppelliche Natur von Organisationen als Instrumente, um ein bestimmtes Ziel zu erreichen und als Lebensumfeld für soziale Interaktion tief verwurzelt in der Literatur über Organisationsstudien, wie von Lincoln und Kalleberg [6], Orru et al. [7], Scott et al. [8], Hogg und Terry [9], Scott und Davis [10] und Capra und Luisi [11] gezeigt.

Die Innovationstheorie hat versucht, diese beiden Organisationskonzepte miteinander in Einklang zu bringen und zu gemischten Modellen zusammenzuführen, in denen bewährte Best Practices mittels Social Engineering umgesetzt werden, das auf individuelle Haltung abzielt – illustriert durch "Maiers Gesetz" $E = Q \times A$ (die Wirksamkeit (E) einer Intervention entspricht der Qualität (Q) der Lösung multipliziert mit der Akzeptanz (A) der Idee) [12]. Dieser Ansatz, der die formale und informelle Struktur von Organisationen kombiniert [13], hat seinen Weg in die meisten Paradigmen zur Qualitätsverbesserung in Gesundheitsorganisationen wie EFQM, Continuous Quality Improvement, Total Quality Management, Six Sigma, LEAN, FADE und PDCA [14] gefunden. Aber selbst ein offenes und allumfassendes Innovationsparadigma wie das Malcolm Baldrige Health Care Criteria for Performance Excellence (HCPE), das Interventionen in Organisationsdesign, Strategie, Systemen und Humankapital kombiniert, um langfristige Effektivität (in Bezug auf Prozessdesign in Verbindung mit klinischem Ergebnis) zu schaffen, übertrifft Nicht-HCPE-Krankenhäuser bei diesem Parameter nicht [15]. HCPE-Krankenhäuser schneiden bei der erfahrenen Qualität der Versorgung jedoch wesentlich besser ab. Offensichtlich führt "die Betonung einer breit kommunizierten Mission, einer unterstützenden Lernkultur, universeller Messung und Benchmarking und systematischer Prozessverbesserung" [16] zu einem größeren Bewusstsein für die Bedürfnisse und Interessen der Patienten, aber die Kausalität hinter dieser Korrelation bleibt unklar.

Zusätzlich zu diesen verallgemeinerten Ansätzen beziehen sich Lee [17] und Lee und Kim [18] beispielsweise auf den multifaktoriellen Charakter der Qualität im Gesundheitswesen, je nach Perspektive der beteiligten Parteien. Sie stellen eine Übersicht über Modelle vor, in denen "die Wahrnehmung einer Vielzahl von Stakeholdern, einschließlich Patienten, Ärzten, Krankenschwestern und anderen, um einen umfassenderen Überblick über die Qualität des Gesundheitswesens zu schaffen", führend sind.

Doch trotz aller Bemühungen, standardisierte Modelle zur Qualitätsverbesserung umzusetzen, leidet der Gesundheitssektor unter einer anhaltenden Immunität gegen Veränderungen, wie Berwick [19] betonte und in späteren Studien beispielsweise von Greenhalgh et al. [20] und Grol und Wensing [21] bestätigt wurde. Es scheint eine Disjunktion zwischen der allgemein wohlverstandenen Notwendigkeit des Wandels

und der intrinsischen Fähigkeit, sie zu verwirklichen, zu geben. Diese sogenannte Qualitätskluft wurde vom Institut für Medizin als "Behinderung der Gesundheitsversorgungssysteme zur Umsetzung von Wissen in die Praxis" definiert [22]. Hinter allen Konzepten des Modellmanagements und der Innovation im Stage-Gate scheint es eine versteckte Dynamik in Gesundheitsorganisationen zu geben, die die Auswirkungen von Interventionen zur Verbesserung der Qualität anregt oder behindert.

Ziel dieses Papiers ist es, diese versteckte Dynamik zu analysieren und einen Ansatz zur Bewertung der Innovationsfähigkeit und des nachhaltigen Wandels in Gesundheitsorganisationen zu entwickeln. Wir betrachten sie durch die analytische Linse der Theorie der Sozialsysteme und berücksichtigen deren zusammengesetzte Natur. Auf diese Weise wollen wir "die fehlende Verbindung zwischen Innovationsprozessdesign und Innovationspotenzial auf Organisationsebene" [23] herstellen, um die Erfolgsquote von Innovationsprojekten zu verbessern, die auf Qualitätsverbesserung abzielen. Dies sind die "Bedingungen und Faktoren, die Innovationen im Gesundheitswesen erleichtern und hemmen", wie länsisalmi et al. [24] dargelegt, deren Kenntnis für die erfolgreiche Umsetzung, Umsetzung und Assimilierung von Innovationen unerlässlich ist. Unsere Forschungsfrage lautet: Wie kann das Veränderungspotenzial einer Gesundheitsorganisation bewertet werden, um eine geeignete Innovation und die besten Mittel zur Umsetzung auszuwählen? Diese Frage befasst sich mit den Voraussetzungen für eine nachhaltige Qualitätsverbesserung. Es muss klargestellt werden, welche Innovation in einer bestimmten Situation angemessen und machbar ist und welche am besten umgesetzt und angenommen werden kann.

SCHLUSSFOLGERUNG

Die Qualitätsverbesserung der Gesundheitsversorgung und der Gesundheitsversorgung durch Struktur- und Prozessinnovationen kann nur unter der Bedingung erfolgreich sein, dass nachhaltige Ergebnisse zu akzeptablen Kosten erzielt werden, und die sanieren, da sowohl die Art der Intervention als auch die gewählte Umsetzungsmethode dem Potenzial einer Organisation für Innovation und Wandel entspricht. Die Schwierigkeit besteht darin, dieses Potenzial einzuschätzen. Wie mehrere Überprüfungen gezeigt haben, sind die formalen Eigenschaften einer Organisation als rationales, produktives System oder die individuellen Eigenschaften ihrer Mitglieder schlechte Prädiktoren erfolgreicher Innovation. Es ist die Natur der Legitimität, die Menge der gemeinsamen Werte und die Wahrnehmung der Evolution, die die Innovationskultur einer Organisation bestimmen. Im Gesundheitswesen stellen diese drei Determinanten zusätzliche Herausforderungen dar, da sie sich für die verschiedenen Gruppen von Interessenträgern, die innerhalb derselben organisatorischen Rahmen- und politischen Agenda zusammenarbeiten, tendenziell unterscheiden.

Die Analyse zweier (Mini-)Systeme hat gezeigt, wie zwei Gruppen ähnlicher Fachleute – alle Ärzte und gut in das professionelle institutionelle Umfeld eingebettet – mit unterschiedlichen diskursiven Strategien in der komplexen Frage der Entscheidungen über das Lebensende arbeiten und damit zu unterschiedlichen Ergebnissen führen: ein Plädoyer für oder gegen ein rechtlich verankertes Recht auf ärztlich assistierten Tod bei todkranken Patienten. Eine Analyse des Innovationspotenzials einer Organisation durch die Kartierung ihrer diskursiven Strategien kann das Risiko verringern, unerreichbare Ziele zu setzen, indem die Auswahl von Innovationen und die Gestaltung von Implementierungsprozessen an die Identität der Organisation angepasst werden, von der erwartet wird, dass sie sie übernimmt.

In unseren Beispielen bleibt abzuwarten, ob das Innovationsprofil der beiden Sozialen Systeme, das in der PAD-Diskussion gezeigt wird, in anderen – aber ähnlichen – Situationen fortbesteht. Mit anderen Worten, beziehen sich die beobachteten diskursiven Strategien auf das auf dem Spiel stehende Thema (PAD) oder sind sie wirklich ein Marker für das Innovationsprofil eines Systems und damit ein Prädiktor für zukünftiges Verhalten? Um das Problem zu entscheiden, sind weitere Tests und Analysen erforderlich, um die Ausgangshypothese zu bestätigen oder anzupassen.

TRANSLATED VERSION: PORTUGUESE

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VERSÃO TRADUZIDA: PORTUGUÊS

Aqui está uma tradução aproximada das ideias acima apresentadas. Isto foi feito para dar uma compreensão geral das ideias apresentadas no documento. Por favor, desculpe todos os erros gramaticais e não responsacule os autores originais responsáveis por estes erros.

INTRODUÇÃO

Nas organizações de saúde, a estrutura e a inovação de processos são consideradas fundamentais para a melhoria da eficiência e da qualidade da assistência [2, 3]. Na prática cotidiana, no entanto, os projetos de inovação frequentemente não conseguem cumprir suas metas e entregar resultados sustentáveis [4].

Essa falha aponta para equívocos sobre as condições de inovação e melhoria sustentada da qualidade nas organizações de saúde.

Segundo scott [5], as organizações podem ser vistas como sistemas racionais e produtivos com o objetivo de otimizar as relações de entrada-saída ou como sistemas sociais naturais e adaptativos que evoluem através de processos espontâneos e indeterminados, "tentando sobreviver em seu ambiente". Essa dupla natureza das organizações como instrumentos para alcançar um objetivo específico e como ambientes de vida para interação social tem raízes profundas na literatura sobre estudos de organização, como mostrado por lincoln e kalleberg [6], orru et al. [7], scott et al. [8], hogg e terry [9], scott e davis [10] e capra e luisi [11].

A teoria da inovação tem tentado conciliar esses dois conceitos da organização e fundi-los em modelos mistos nos quais as melhores práticas comprovadas são implementadas por meio de engenharia social voltada para a atitude individual — ilustrada pela "lei de maier" e = q × a (a eficácia (e) de uma intervenção é igual à qualidade (q) da solução multiplicada pela aceitação (a) da ideia) [12]. Essa abordagem, que combina a estrutura formal e informal das organizações [13], tem encontrado seu caminho na maioria dos paradigmas para a melhoria da qualidade em organizações de saúde como o efqm, melhoria contínua da qualidade, gestão da qualidade total, six sigma, lean, fade e pdca [14]. Mas mesmo um paradigma de inovação aberto e abrangente, como o malcolm baldrige health care criteria for performance excellence (hcpe), que combina intervenções no design da organização, estratégia, sistemas e capital humano para criar eficácia a longo prazo (em termos de projeto de processo combinado com resultado clínico) não supera os hospitais não-hcpe neste parâmetro [15]. Os hospitais do hcpe, no entanto, pontuam substancialmente melhor na qualidade do atendimento experimentado. Obviamente, "enfatizar uma missão amplamente comunicada, uma cultura de aprendizagem solidária, medição universal e benchmarking e melhoria sistemática dos processos" [16] resultam em uma maior consciência das necessidades e interesses do paciente, mas a causalidade por trás dessa correlação permanece incerta.

Além dessas abordagens generalizadas, lee [17] e lee e kim [18], por exemplo, referem-se à natureza multifatorial da qualidade no serviço de saúde, dependendo da perspectiva das partes envolvidas. Eles apresentam um levantamento de modelos nos quais "as percepções de uma variedade de stakeholders, incluindo pacientes, médicos, enfermeiros e outros para criar uma visão mais abrangente da qualidade dos serviços de saúde" estão liderando.

Mas, apesar de todos os esforços para implementar modelos padronizados para melhoria da qualidade, o setor de saúde sofre de uma imunidade persistente à mudança, como apontado por berwick [19] e confirmado em estudos subsequentes por, por exemplo, greenhalgh et al. [20] e grol e wensing [21]. Parece haver uma disjunção entre a necessidade geralmente bem compreendida de mudança e a capacidade intrínseca de realizá-la. Esse chamado abismo de qualidade foi definido pelo instituto de medicina como uma "deficiência dos sistemas de assistência à saúde para traduzir conhecimento em prática" [22]. Subjacente a todos os conceitos de model-management e inovação em etapas, parece haver uma dinâmica

oculta nas organizações de saúde, seja estimulando ou obstruindo os efeitos das intervenções voltadas à melhoria da qualidade.

O objetivo deste artigo é analisar essa dinâmica oculta e desenvolver uma abordagem para avaliar a capacidade de inovação e mudança sustentável nas organizações de saúde. Nós olhamos para eles através da lente analítica da teoria dos sistemas sociais e levamos em conta sua natureza composta. Dessa forma, pretendemos construir "o elo perdido entre o design de processos de inovação e o potencial de inovação no nível da organização" [23] a fim de aumentar a taxa de sucesso dos projetos de inovação visando a melhoria da qualidade. Essas são as "condições e fatores que facilitam e inibem as inovações na saúde" como delineado por länsisalmi et al. [24], conhecimento do qual é essencial para que a inovação seja implementada, adotada e assimilada com sucesso. Nossa pergunta de pesquisa é como o potencial de mudança de uma organização de saúde pode ser avaliado a fim de selecionar uma inovação adequada e os melhores meios para garantir a implementação? Esta questão aborda as pré-condições para uma melhoria sustentável da qualidade. Esclarecer é vital decidir qual inovação é adequada e viável em uma determinada situação e qual é a melhor maneira de implementá-la e adotá-la.

CONCLUSÃO

A melhoria da qualidade da assistência à saúde e da assistência à saúde por meio da estrutura e da inovação de processos só pode ser bem sucedida — gerando resultados sustentáveis a custos aceitáveis — sob a condição de que tanto a natureza da intervenção quanto o método de implementação escolhido estejam em conformidade com o potencial de uma organização para inovação e mudança. A dificuldade é como avaliar esse potencial. Como várias revisões têm mostrado, as propriedades formais de uma organização como sistema racional, produtivo ou as características individuais de seus membros são preditores ruins de inovação bem-sucedida. É a natureza da legitimidade, o conjunto de valores compartilhados e a percepção de evolução que determinam a cultura de inovação de uma organização. No setor de saúde, esses três determinantes representam desafios extras, pois tendem a diferir para os diferentes grupos de stakeholders que trabalham juntos dentro do mesmo cenário organizacional e agenda política.

A análise de dois (mini)sistemas mostrou como dois grupos de profissionais semelhantes — todos médicos e bem incorporados no ambiente institucional profissional — operam com diferentes estratégias discursivas na complexa questão das decisões de fim de vida, atingindo assim diferentes desfechos: um apelo a favor ou contra um direito legalmente incorporado à morte assistida por médico no caso de pacientes em estado terminal. Uma análise do potencial de inovação de uma organização por meio do mapeamento de suas estratégias discursivas pode reduzir o risco de estabelecer metas inatingíveis, ajustando a seleção de inovações e o desenho dos processos de implementação à identidade da organização que deverá adotá-las.

Em nossos exemplos, resta saber se o perfil de inovação dos dois sistemas sociais mostrados na discussão do pad persiste em outras situações — mas semelhantes—. Em outras palavras, as estratégias discursivas observadas estão relacionadas ao problema em jogo (pad) ou são realmente um marcador do perfil de inovação de um sistema e, portanto, um preditor de comportamento futuro? Para decidir a questão, são necessários novos testes e análises para confirmar ou ajustar a hipótese inicial.