History of Quality in Health Care

Quality in health care can be traced all the way back to Hippocrates in the 5th century B.C.E.

**Hippocrates (5th Century B.C.E.)**

Known as the *father of the Hippocratic Oath*, Hippocrates made the phrase *first, do no harm* famous as the basic premise of that oath. The phrase referred to the obligation of physicians to not harm the patients in any way, either by acts of commission or omission (Dlugacz, Restifo, & Greenwood, 2004).

An act of commission might include anything done intentionally that ends up harming the patient. For example, the physician might perform surgery on the wrong arm. An act of omission is any act that is not executed that ends up harming the patient, such as failing to administer a prescription drug (Pozgar, 2007).

Because physicians in Hippocrates’ time were considered to be the managers of care, they can also be referred to as *managers of quality* as well. These quality managers help set the stage for the evolution of quality as people know it today (Dlugacz, Restifo, & Greenwood, 2004).

**Florence Nightingale**

Florence Nightingale was a nurse who is often referred to as the *originator of quality management programs*. She was one of the first health care providers to use statistics to analyze a problem and apply the results to solving the problem (Dlugacz, Restifo, & Greenwood, 2004).

Nightingale used statistical analysis to study the problem of infection in patients and why infection was spread so rapidly in hospitals. Through her analysis, she found that infection was spread through simple mistakes such as a physician not washing his or her hands in between patients. This failure to sanitize allowed the infections to spread from patient to patient. Nightingale recognized this and began to implement simple hand washing protocols to cut the spread of the infection. Her application of statistical analysis to health care quality issues showed that quality was the responsibility of everyone in a health care facility and not just the responsibility of physicians as Hippocrates suggested (Dlugacz, Restifo, & Greenwood, 2004).

**Ernest A. Codman**

Dr. Ernest Codman took quality assurance a step further as he defined the notion of quality care in terms of outcomes measurement. He believed that it was not enough to prevent harm or treat a patient to the best of the health care provider’s ability. Codman
felt that the status of the patient after their treatment should be followed in an effort to determine the success or failure of the treatment. The results of this follow-up could then be used to either develop protocol to treat conditions or examine why it failed and look for ways to improve it (Dlugacz, Restifo, & Greenwood, 2004).

**Avedias Donabedian**

Donabedian, a physician, defined the concept of quality in terms of a three-pronged approach. He felt that quality was based on structure, process, and outcomes. Without each piece of the puzzle, the concept of quality was not complete because each part was dependent upon the other two parts (Dlugacz, Restifo, & Greenwood, 2004).

He defined each further. *Structure* referred to the physical properties of the health care facility and all of the supplies, equipment, and so forth that goes with it. The process component is the actual treatment or services rendered to the patient. Last, the outcomes component is referred to as the *outcome of the actual treatment* (U.S. Department of Health & Human Services, n.d.).

**Walter Shewhart and W. Edwards Deming**

Shewhart and Deming contributed to the quality improvement movement with the addition of the PDCA Model. PDCA is the Plan Do Check Act model of quality assurance that identifies quality issues, develops plans to improve the quality concerns, implements the plans, and has a method to evaluate the effectiveness of the plans (Dlugacz, Restifo, & Greenwood, 2004).

The PDCA model employs a strategic management approach to quality improvement because it follows the problem from its discovery to the evaluation of plans put in place to solve the problem.

**References**

