Why aren't clinicians caring about carepaths? A commentary

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One of the most thought-provoking aspects of the paper by Pearson and Macintosh (2001) is the simple observation that the management practice described is in any way noteworthy. After all, it amounts to little more than a description of care, some measurement of outcome, and the incorporation of basic software. If this is exceptional, what is going on elsewhere? A public brought up on American medical dramas and media medi-hype might reasonably assume that this was already the norm. Sadly, it is not.

Before looking at the Cairns experience, I would therefore like to consider why defined care has yet to be widely accepted.

Pathways: can it be so hard?

The lack of definition, process, audit and accountability in the delivery of health care is astonishing. The only thing more remarkable is the fact that the present situation continues to be tolerated. The relevant adjectives in describing acute care medical management are autocratic, arbitrary and assumed. That is, clinicians generally dictate hospital management, and do so without reference to any specific predefined clinical plan. The appropriateness of management is usually taken for granted, both by clinicians and those around them.

Examples such as Cairns are exceptions that prove the rule. The clear indictment of current medical practice in terms of errors of care, avoidable deaths and financial cost has yet to make a significant impact on medical psyche. The status quo is sustained in the face of extensive literature supporting clinical pathways as effective tools for risk management, communication and documentation.

This is not to say that clinicians are (necessarily) bloody-minded, or even that this approach is premeditated. A reluctance to embrace defined care reflects the more subtle nuances of medical culture. In my observation, there are three simple and several rather more complex barriers to the widespread adoption of clinical paths.

The simple barriers

Anyone who has discussed pathways with clinicians will be familiar with these objections. They are simple in that each reflects a misunderstanding of the intent of pathways.

1. Patients are unique

The tenet of individual care for individual patients is held to be self-evident. This is clearly appropriate, and recognises the interaction of places, patients, personalities, physicians and pathologies. A myocardial infarction may or may not be complicated by cardiogenic shock. A renal stone in an airline pilot might warrant particular management. Most of these considerations relate to the *selection* of appropriate treatment. The principle of defined care still applies, but the tool here relates to evidence-based practice, or practice guidelines.

By contrast, clinical pathways are most relevant to the *structure* of care. That is, having decided on a particular management, pathways help to ensure that this care is delivered in an optimal manner. The issue of quality and safety in healthcare is not that decisions are inappropriate, but rather that the processes by which they are supported are frankly unsafe. The rigidity of pathways is urban myth. Pathways support clinical management.

2. Teams need leaders

Tertiary education in nursing and allied health has accelerated recognition of clinical teams. These respect the validity of opinion and contribution from these groups in clinical management. Despite this, clinicians assume final responsibility. That is, the activity of component members ultimately requires clinician approval. Progress in para-clinical autonomy is limited to determining the optimal delivery of care that is requested, either expressly (eg, dietetics) or implicitly (as in daily nursing care).

Ultimately, the construction of a clinical pathway does not alter this relationship. Importantly however, pathways reinforce team constructs by facilitating communication and allowing members to participate in the process of re-appraising care.

3. My own practice is optimal

If management is transparent, so too are differences. As pathways are meant to incorporate best practice, how should clinicians determine whose version of the truth to use? In reality of course, this is rarely an issue. There is precious little objective (let alone level 1) data on any matter related to the process of care. For a profession advocating evidence based medicine, this has several interesting implications:

- clinical paths provide transparent definitions of care
- transparent definitions allow comparison
- comparative studies provide the basis for determining optimal care.

The purpose of a pathway is not to restrict freedom. If clinicians wish to maintain individual differences, they should all be supported. In the end, the most appropriate option will emerge.

The complicated barriers

Two important issues arise from an understanding of clinical paths, and the consequence of implementation.

4. Defined care can be costed

The lack of funding and specific resources relative to need is a defining characteristic of healthcare. Although the activity of clinicians is critical in determining health expenditure, they typically have little role in the allocation of resources.

An explicitly defined clinical pathway provides a definition of labour and disposables. As such, it is relatively easy to estimate a cost. The true cost of care is irrelevant. From a clinician perspective, the only useful figure is a *costed clinical care index*. This is simply the cost of all the clinical resources required to deliver optimal care as defined by the pathway.

If labour and disposable costs are standardised, this allows resource requirements to be compared across pathways, centres and clinicians. One concern is that this figure will ultimately be used to justify further resource restriction. Would healthcare purchasers give preference to the cheapest providers?

In reality this is unlikely to be the case, if only because pathway costs are based on intention to treat rather than outcome. The opposite is equally pertinent – that is, a costed path provides a transparent definition of the minimum resources needed to provide optimal care. Costed paths justify resource consumption.

In addition, some clinicians express the view that resource management and patient advocacy are irreconcilable roles. Although appealing in its simplicity, this philosophy is untenable.

As Hindle and Degeling (2000) emphasise, clinical decisions are resource decisions. For example, clinicians are not responsible for patients who are denied access to hospital because of waiting list constraints. Nevertheless,

they are responsible to them. At the very least, clinicians have an obligation to ensure that the management they dictate is delivered with optimal efficiency. Efficiency in this context can only be determined by defining process, resource and clinical outcomes.

5. Pathway development is difficult, pathway management even more so

In theory it is not difficult to write pathways. Typically a nurse is recruited to do the up-front work – liaising with clinicians, achieving broad consensus, developing templates, refining content, and so on. The temptation for all involved is to quit (with a sigh of relief) once the inpatient management pages are complete. This is a mistake. The value of clinical pathways lies in their capacity to facilitate integration, communication, documentation and risk management. For example, the five basic elements of a clinical path for an elective surgical procedure would include a comprehensive patient brochure, specific consent, inpatient management pages, outcome data collection and costing.

Those who have tried will recognise that it is extremely time-consuming to write comprehensive pathways that fulfil these requirements. Many hospitals are presently littered with inpatient management paths, or have achieved only a smattering of comprehensive examples that cover high volume interventions. Between purchasers and clinicians, we seem incapable of learning that pathway development only sounds easy.

Even once this is achieved, pathway utilisation falls a fair way short of pathway management. The difference lies in commitment to audit. Data collection itself is a meaningless activity. Audit means audit cycle. There are several significant hurdles to achieving this. I would like to highlight four:

- lack of universal variance codes
- constraints on clinicians' time
- lack of appropriate software
- concern regarding the implication of audit data for re-certification.

The failure of health care purchasers to grasp the importance of outcome measurement is apparent from the lack of any relevant coding system. Procedures are coded by ICD or the MBS schedule, and pathology by ICD. These facilitate data collection and comparison. What universal coding system defines an excess length of stay because the family refused to take granny home today? Scant attention has been paid to understanding the process of care. National codes for variance reporting are an obvious and urgent need.

Pathways define an expected process and outcome. This allows audit through exception (variance) reporting, where variance is defined as anything impacting significantly on the process, the patient or the price. Collection of variance data at the time of discharge is easy. In comparison, data entry and reporting is labour-intensive. Medical staffs, both in public and private facilities, do not have time to sustain this commitment. At a consultant level, a good deal of essential activity is already provided without payment. The need for an AMA review of safe working hours underscores the burden of service time on junior medical staff. Audit activity that is unfunded and unsupported is simply unwelcome. If the activity is worthwhile, it is worth funding.

One critical lack is appropriate audit software. Several obvious points are worth reiterating. Stand-alone programs are worse than a waste of time. The duplication of data entry simply squanders precious resources. Data should be collected prospectively and at source. That is, operative data should be entered in theatre, and discharge information from the ward. Outlier data can be captured using hand-held devices to collect and upload information. The audit should be intranet (or preferably internet) enabled. Restricting access to a single PC greatly reduces audit utility. In addition, the presentation of data is important. Clinicians need to see relevant data presented in a clear and concise manner. It is a pointless collecting outcome data in isolation. Information is only meaningful in a context. For example, surgical outcomes need to be indexed against age, ASA score and relevant co-morbidities.

A recent concern has been the implication of outcome data collection on accreditation. Clinical colleges have mandated some audit activity as a prerequisite for re-certification. At present this requirement is minimal – for example, surgeons need only review an aspect of their practice. As much as anything, the present lack of rigor reflects a paucity of interest.

Pathways could potentially allow much greater scrutiny through routine outcome assessment for every episode of care. Audit implies peer review, but who should be privy to this information? In my view, clinicians should

embrace (and purchasers should fund) more comprehensive outcome review by the clinical colleges. If we are to learn anything from the crisis of confidence currently being played out in the UK, it is the virtue of preserving public trust. Self-regulation is certainly the most appropriate and acceptable option.

Conclusion

In the context of chronic underfunding, bed and resource constraints, patients undoubtedly need an advocate. Clinicians should appropriately assume this role. Certainly no one else has the unique insight into both the needs of individual patients, and relative clinical priorities.

In this same environment medical practice itself will undoubtedly come under greater scrutiny. Consumerism, public calls for greater accountability, economic self-interest by healthcare providers, and re-certification requirements will add to this pressure. Who will our advocate be?

The new millennium might bring with it a new slogan – physician steel thyself. We should be mindful that we cannot defend what we cannot define. A practice characterised by the three A's is vulnerable. At the very least, clinicians should be able to define their optimal management, and defend resource requirement and outcomes. Yes, it is hard, but the future of professional autonomy may well hang in the balance. It is time for a sea change.

The Cairns Report

Belinda Pearson and David Macintosh must be congratulated on the experience they report. The success of implementation in Cairns rests on their capacity to secure three major goals – namely funding, clinical consensus and IT support. Their obvious enthusiasm, persistence and clear recognition of relevant goals is inspiring.

By contrast, it is disappointing to hear of subsequent funding difficulty. Clinicians need to shoulder at least some of responsibility for funding constraints. Historically many para-clinical departments have emerged to fill a void created as clinicians devolved 'non-clinical' responsibilities. Quality assurance is a case in point. Meaningful QA outcomes will only be achieved by pursuing the Cairns approach. Diversion of funds to QA units, whose output is generally of little value, simply underscores the previous lack of clinician interest. The result is a self-perpetuating cycle. QA units absorb the funds. In the absence of any resources, clinicians are unable to contribute usefully. In the absence of clinician input, purchasers continue to fund largely irrelevant QA units. Clinicians need to be proactive.

I do not feel I can add to the process they describe. Nevertheless, a few points are worth considering. In developing pathways and audits, there is a tendency for large pendulum swings. That is, there is progress from a state of no activity or resources to one that becomes extremely comprehensive but labour-intensive. I recently observed an audit that had been established to meet the needs of a single surgical unit. Although the data were comprehensive and complete, the time required for database management was in the order of 0.4 FTE. Even given efficiencies of scale, it seems unlikely that this could be extended to service other units. The Cairns team is correct in emphasising integration with existing systems, and the capacity for expansion.

Given the IT support they describe, I am surprised to read the authors' reservation that withdrawal of funding (presumably loss of the carepath administrator) may result in departments not being able to 'even use the current carepaths'. At least as far as the inpatient management is concerned, time efficiency is one justification for pathway management. However it is established locally, labour efficiency must be paramount in design specification.

One thing IT has successfully achieved is a reinvention of the cargo cult mentality. This includes a sense that we don't need to worry about pathways or audit until the program arrives on the desk, complete with glossy brochure and four-digit dollar tag. Ultimately, the success of paths and audit requires, but does not solely depend on, IT support. The critical element is time spent by clinicians examining relevant data. A review of medical outcomes with colleagues needs to be complemented by time spent formally reviewing process outcomes with other members of the clinical team. I did not get a clear sense of the extent to which the latter occurred. In my experience, generating clinician interest in ongoing review is difficult.

The IT success was matched by the rapidity with which paths were introduced. It is pleasing to see a commitment to extending these across consent and preadmission. I am uncertain as to how successful they were able to integrate other elements. Patients are often left sifting through a showbag of paraphernalia that can include admission instructions, patient charters, ward information, hospital brochures, physiotherapy instructions, discharge advice, and follow-up appointments. It is little wonder things go awry.

Pathways should spell the death of generic documentation, and Cairns has taken this one step further, individualising the paths for each patient. Although not discussed in this paper, the greatest hurdle in progression to paperless documentation is free text documentation. As anyone who has struggled through volumes 1-5 will agree, the paperless medical record cannot come too soon. In emphasising documentation by exception, pathways will facilitate this transition.

What Cairns has shown so well is that broad pathway implementation and integration is possible. Go to it.

References

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