What's wrong with our hospitals?

Lionel L Wilson

EVENTS occurring from 1999 to 2003 at Campbelltown and Camden hospitals within the South Western Sydney Area Health Service received extensive coverage in the media during the first half of 2004 and led to significant government intervention. It has been claimed that some 17 deaths could have been avoided. Other accusations of less than appropriate care by both nurses and doctors have also been made. A group of nurses complained about mismanagement and patient neglect, and alleged that management failed to address their concerns. Medical staff claimed serious under-funding of the two hospitals were reasons for these events. The media and political debate that erupted was highly emotive and further muddied and confused the issues.

This article draws on these events to explore the issues of quality and risk management generally in Australian hospitals. Gaps in current approaches and attitudes particularly prevalent in NSW are analysed and suggestions made as to how these gaps should be eliminated.

Definitions

In discussions of quality in health care the semantics often cloud the important issues. For the sake of clarity and to clearly indicate what I mean in this article the following definitions of some commonly used terms are included:

Quality: Quality in health care demands a multi-definitional approach including technical quality, interpersonal quality, cost and value trade-offs.

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Quality management (QM): Refers to the organisational and management systems necessary to ensure patient safety and avoid patient harm. These systems are complex and require resources, know-how and skills to implement them (Wilson & Goldschmidt 1995).

Quality assurance: Quality assurance is about making sure that what was done and achieved is what should have been done and achieved.

Risk management (RM): Risk management should only be concerned with minimising financial loss. In the hospital environment of today the biggest clinical risk of financial loss is malpractice litigation directed at both hospital and doctors. While quality and risk management for clinical services have somewhat differing objectives, the systems and techniques for each are similar.

Issues of quality and risk in hospitals

An effective QM and RM program at any of the hospitals rocked by scandal would not only have alerted management and medical staff that something was going wrong, it would have entailed careful and detailed documentation to support or refute the accusations that were made. It could have saved considerable resources and avoided much anxiety and depressed morale.

Although Australia has been struggling to introduce effective systems for managing quality in health care since the late 1970s there are still some basic misconceptions, particularly among doctors. The first misconception is that by using educational techniques with which they are very familiar and comfortable, quality will automatically occur. Thus it is widely assumed that specialists with higher qualifications will guarantee quality. However, poor quality care in our hospitals is rarely due to 'not knowing', but rather to not doing. Failing to take blood pressure or

omitting to test the urine, to use very simple examples, are not due to lack of knowledge but to failure to act for a wide range of reasons.

The second misconception is that when poor quality outcomes become obvious the injection of more money into the hospital or the system is all that is needed. Both these misconceptions are appearing in relation to Campbelltown and Camden Hospitals. I argue that if high quality outcomes are expected and even demanded, quality must be managed — a concept that is still relatively new in health care.

During the course of one of the current inquiries, one medical witness claimed that "we are committed to providing a high quality health service". However, there was no indication of how this high quality would be identified or measured or even how it would be achieved; nor was there any indication as to how and by whom this new 'quality' program was to be managed or how it would be funded.

Failure of QM and RM is not solely about resources

Judging from anecdotal accounts and media reports there seems to be little doubt that resources at the two hospitals were inadequate. However, correcting these deficiencies will not guarantee quality of care or prevent similar quality problems recurring. In Australia, and indeed around the world, the reality is that those hospitals with some of the worst examples of poor quality of care are those with large resources and sometimes large medical staffs. The King Edward Memorial Hospital in Perth and the Bristol Royal Infirmary in the UK come immediately to mind, but there have been many instances in NSW. Within recent times there were three deaths due to blood transfusion in three of Sydney's major hospitals. One major teaching hospital was in the Coroner's Court in recent times with three deaths due to medication errors. In very recent times, a pair of surgical scissors was left in a patient's abdomen following surgery at another hospital. These are major teaching hospitals, one of them a highly regarded private hospital. So simply increasing the range and number of medical specialists and providing better equipment do not of themselves prevent quality and safety problems.

However, an adequately funded, robust and properly documented quality management program can provide the hospital and its staff with the objective evidence necessary to successfully argue for increased resources. Claims for more resources based on doctors' anecdotal evidence usually find little favour with governments or administrators and are often dismissed as little more than 'shroud waving'.

Yet the one issue which has received little or no mention in the publicity over the problems at Campbelltown and Camden Hospitals is the funding and resources necessary for them to operate an effective quality and risk management program.

Making judgements about quality of care

It is very easy to make accusations about the performance of individual health professionals, doctors in particular, but it is much more difficult to provide the evidence necessary to support or refute such accusations. The provision of sound, documented evidence of quality or lack of it is one of the main outcomes of an effective quality management program. It is possible for our hospitals to provide the necessary evidence, although few do so. The absence of this evidence means that accusations of poor quality care can be seen as mischievous and unfair, particularly if they are accompanied by the full range of bias, prejudice and emotional reactions of which we are all capable.

Handling complaints

The handling of complaints (whether from patients or other staff) against medical practitioners in a hospital setting involves a different order of complexity from handling a complaint against an individual doctor in a non-institutional setting. To what degree is the problem due to an organisational/system failure and how much is

due to the incompetence, negligence or behaviour of the practitioner alone? This has been a major issue in evidence taken by the Walker Inquiry. There is no doubt that doctors have an individual duty of accountability additional to their roles as members of hospital staff.

In the event of a complaint against doctors being lodged with the HCCC, effective credentialling procedures within a QM and RM program would have provided the information necessary to support or refute the complaint. The expense and stress experienced by Camden and Campbelltown could perhaps have been largely avoided or, at least, reduced.

Unfortunately, it is still all too common for complaints by patients in hospitals to be mismanaged and so create a real risk that the complainant eventually will become a very angry and aggrieved litigant.

The dilemma facing doctors and others is that whether or not the HCCC is an appropriate mechanism to deal with issues of hospital quality and safety, it is difficult to see any alternative in the absence of robust and effective hospital QM and RM programs. The Interim Report of the Walker Inquiry has clearly demonstrated that given the legal framework of the HCCC, once a complaint is lodged with that body the process of finding individuals at fault becomes inevitable (Walker 2004).

Avoidable deaths

It is hardly surprising that allegedly avoidable deaths attract so much media attention and result in official inquiries, in the absence of sound evidence that would establish whether such deaths were avoidable or not. By contrast, there is still less than adequate official response from either governments or hospitals to the Quality in Australian Health Care study published in 1995, which describes an estimated 18 000 deaths and significant incidence of disability associated with adverse events (Wilson et al. 1995).

It seems that we have to have whistleblowers and scandal before safety and quality receive high level attention.

It is my conviction that the events at Campbelltown and Camden hospitals centring on quality and risk are merely the tip of an iceberg and represent the situation in many hospitals in Australia.

The missing pieces of the jigsaw

Quality managers

Many hospitals assert that they do have an effective quality management program. My experience is that existing programs are usually not sufficiently robust and in many cases are little more than tokenism.

Skilled, qualified quality managers are essential to adequately implement and manage effective quality management systems in hospitals. The manufacturing industry has recognised this for a long time. A quality manager must be very senior, must know how to manage and must have specialised knowledge about quality and risk management. Doctors and nurses employed in clinical roles do not have the time, the skills or the resources to manage these programs (Wilson 2000).

Managing quality is a workface task

Quality and risk management in hospitals cannot be effectively conducted by departments of health or area health authorities. It is a workface activity. Several state governments and the federal government have made various attempts to deal with quality and safety issues by top down approaches, usually in the form of committees. None of these initiatives has made much impact at the workface. Quite recently, NSW has promoted a Clinical Excellence Commission with quite an elaborate organisational structure under it. In my view, this most recent effort in NSW is unlikely to do much better.

One of the reasons for lack of progress is the failure to distinguish between the two separate and distinct levels of quality in health care — quality at the system level and quality at the workface level. A central agency such as a department of health or area health service has responsibility for quality at the health system

level. At this level the agency is responsible for quality issues in relation to access, availability of service, community perceptions and satisfaction, costs, and the availability of data for monitoring purposes.

By contrast, workface level quality is concerned with the performance of individual providers such as a hospital, clinic or clinician. The performance of these providers is one of the major factors determining quality at this level. At this level, measuring and assessing performance via quality management influences and supports the delivery of quality of care in practice. Attempting to *improve* quality at an individual hospital by activity at the level of an area health service or department of health will inevitably fail.

Despite claims, most QM programs fail

There seems to be general acceptance that some elements such as incident and adverse events monitoring, complaints monitoring and infection control are essential parts of a comprehensive QM program. Nevertheless, there are many obvious examples of failure in so many of our hospitals. In spite of claims made about their programs, few if any hospitals have a robust, formal and effective program that can demonstrate real improvement and the reduction of litigation risk. For example, clinical meetings such as grand rounds and the like are important educational tools but will not assure quality of care.

There are, however, three components of QM that either don't exist at all in our hospitals or are so badly handled that urgent action is required. They are:

- Credentialling of medical staff
- Adequate documentation in the medical record
- Integration, organisation and problem resolution.

Credentialling of medical staff

A credentialling program could have saved the medical staff at hospitals rocked by scandal a great deal of angst by identifying in a timely way whether a particular doctor lacked knowledge, judgement, skill or care.

Credentialling (or delineation of clinical privileges) is a formal process, quite separate from the appointment process, whereby medical staff are able to assure the governing body about what any doctor, including a doctor in training, is permitted to do. Thus the medical staff become fully accountable for what they are doing. Absolute observance of the terms of reference of the Credentialling Committee and a formally structured process are paramount (Wilson 1997; Wilson & Fulton 2000). The Tito Report and published material in the US, UK and Australia strongly support detailed, robust credentialling (Weagley 1996; Commonwealth Department of Human Services and Health 1994).

If credentialling is to be effective, it must be conducted annually and must be procedure specific. While many Australian hospitals conduct credentialling programs, it is our experience that few, if any, do so at the level where it becomes an effective quality and risk management tool.

Conducted properly, credentialling is a complex undertaking. It must not only be credible but be fair and free from bias or apparent bias. This demands a significant program that must be planned and managed (Wilson & Goldschmidt 1995, pp. 545-59; 564-71].

To be effective and to prevent the possibility of a successful legal action against medical staff or the hospital as a result of the credentialling program, there must be adherence to certain basic rules and proper process. There must be:

- A properly constituted Credentials Committee with terms of reference
- Carefully prepared minutes
- Absolute confidentiality
- Observance of the principles of natural justice
- Standard processes for all medical staff
- Endorsement of all recommendations by the board
- Notification to each doctor of procedure-specific decisions.

Good medical records

The medical record is a key element in any QM or RM program. It is an essential tool if claims of mismanagement are to be substantiated or refuted.

Nothing causes doctors and hospitals more medicolegal angst than inadequacies in the medical record. Every case settled out of court because inadequate documentation precludes an effective defence contributes to upward pressure on doctors' indemnity premiums. Accurate and complete documentation is as important for nurses as it is for doctors. Anecdotal accounts confirm that the quality of medical records in Australia varies from adequate to grossly deficient. This variation occurs within the same hospital and from hospital to hospital. In one recent case, only two doctors made a record of the procedure in which they participated with others. Neither was able to interpret for the court with any certainty what he had written!

A recent analysis by the Australian Council on Healthcare Standards (ACHS) of survey results confirms that most records surveyed did not fully meet the required standard; and that "Visiting Medical Officers/doctors are not adequately filling in or utilising the current record documentation" (personal communication, Heather McDonald, Executive Manager Customer Services, ACHS, 2004). Mr Brett Walker, in transcripts of evidence before the Special Commission of Inquiry, noted that: "This Inquiry . . . observes that a great deal of public money has been, in my view, wasted by reason of the inability or refusal of practitioners — alas mostly doctors, not nurses — to prepare records in a way that those following in the care of patients, and certainly those following in the scrutiny of their conduct would find straightforward to use" (Walker 2004).

Integration, cohesion and problem resolution

In addition to an absence of credentialling of medical staff and the inadequacies of the medical record, many hospitals conduct QM and RM activities as isolated and self-contained projects. But if quality and risk are to be successfully managed, all these activities must:

- Be integrated and coordinated into one cohesive program;
- Be conducted, coordinated and managed in the hospital;
- Make results and conclusions from these activities available in a timely fashion primarily for the clinical staff of the hospital and not primarily for a central government authority;
- Be associated with an effective mechanism for problem resolution and change management at the hospital. It's not much use detecting a problem if the culture and attitudes mean it can't be fixed.

Where does responsibility lie?

Hospital board and management

Hospitals are corporate entities and as such it is the Board and Management, not doctors and nurses, that have prime responsibility for quality and risk programs. This responsibility requires boards and management to ensure that effective quality and risk management programs are in place, that they are properly funded and that they are working. Quality improvement must embrace the concept of measuring and demonstrating that improvement. Boards must also be prepared to engage properly qualified quality managers.

Medical and nursing staff

To lay the prime responsibility on Board and Management does not absolve from exposure to discipline doctors against whom a complaint has been made, where it can be demonstrated that they lacked knowledge, judgement, skill or care. Such disciplinary action may go as far as the Medical Board.

No effective QM and RM program is likely to be successful in the absence of significant input from medical and nursing staff. The medical staff in particular are the primary clinical decision-makers in the hospital. Any program without this medical input degenerates into an exercise in

time-wasting. Failure of such programs also leaves the medical staff powerless to deal with the occasional colleague whose standard of care or behaviour they find unacceptable.

The medical profession's concern with its independence and its suspicion and often hostility towards management have widened the gap between the clinical roles of doctors and the input from management that is so essential if QM and RM programs are to be properly funded and managed.

Government and Department of Health

The basic reason why hospitals do not have effective Quality and Risk Management programs is that there are no 'drivers' in the system. Development and implementation of such drivers (incentives and sanctions) is the prime role of government and should be directed at hospital Boards and Management, not doctors and nurses. Governments and departments of health cannot micromanage hospitals, especially in relation to quality and risk.

Conclusion

In the absence of sound, objective documented evidence it is impossible to defend hospitals or their medical staff from accusations that they were wanting in terms of knowledge, judgement, skill or care.

Unfortunately, well trained doctors and nurses with good intentions are no longer enough. Now is perhaps the time for all hospitals to review their own situation and circumstances to avoid becoming the next '*cause celebre*' in the media.

Disclaimer

The author has no personal knowledge of any of the individuals or the events at these two hospitals. He had occasion to spend a day talking to nursing and medical staff at Campbelltown Hospital some six years ago.

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