

Commentary on the King Edward Inquiry: every defect a treasure

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Jenny McLean and Michael Walsh have distilled well the key lessons of the events at King Edward Memorial Hospital (KEMH). To some extent KEMH is unique: the only tertiary provider of obstetric services in Perth, the world's most isolated city. It is thus easy to think of the KEMH experience as an isolated one and engage in our own form of shaming and blaming by finger pointing at that hospital and tut-tutting about the failures in governance, failures of individual doctors, failures of Ministers etc. But just as shaming and blaming inside a hospital fails to create the right culture to learn from an adverse event, so too will finger pointing at KEMH distract us from thinking about the lessons for our own organisations and for the system as a whole. KEMH is probably not unique and the weaknesses identified there parallel both the events at the Royal Bristol Infirmary and closer to home, the Royal Melbourne Hospital. All three hospitals exhibited failures of clinical governance to a greater or lesser degree. In all three, a focus on "efficiency" and/or revenue was associated with a de-emphasis on quality of care issues.

The careful reader will note the inverted commas around efficiency in the above paragraph. It is important to note that efficiency is measured by examining the inputs required to produce a unit of output. We generally think about efficiency as improving if fewer inputs produce the same output or the same inputs produce more outputs. But, as in most economic analyses, outputs are usually defined with a *ceteris paribus* assumption, normally that quality is invariate. This means that in economics terms efficiency is not improved if fewer inputs are required because we are producing a product of inferior quality. We may spend less, but efficiency may also have been reduced. Unfortunately, too often management and policy makers measure efficiency crudely and ignore quality effects.

It is easy for Boards and management to focus on financial management and the bottom line of the hospital. This is often a high profile focus of funders, to whom we are all immediately accountable for budget overruns. The media can easily pick up stories about financial crises. Budget overruns can yield instant (or, probably more accurately, relatively quick) gratification. They are amenable to action which makes Boards and managements feel good: tightening belts, freezing staff appointments, making predictions where we will be in six months time and so on. Ensuring that the organisation, in its focus on financial health, does not lose sight of quality and cultural health, is our challenge.

Dealing with quality issues is intrinsically difficult: it involves complex inter-relationships in the organisation; uncomfortable discussions about what needs to change and long time frames. Although conventional wisdom is that one in ten admissions to hospital is associated with an adverse event, this startling high rate does not attract the same media, government or management attention as a budget overrun. There may be the occasional bad egg that attracts management attention and remedial action, but quality problems are usually far more complex than this. Quality problems involve failures in communication between different parts of the organisation, slips occurring in the midst of a pressured work situation, attempting to do too much in too little time with too few resources, etc. Solving a quality problem in a complex organisation may involve introducing new checks and balances, further increasing the complexity of the system and thus contributing to a new round of adverse events.

Some factors that might account for the KEMH management or governance structures failing include multiple organisational changes in the period under review. Is there a state in which this has not happened in recent times? McLean and Walsh also draw attention to the difficulty in obtaining appropriate benchmarking information. Is the KEMH review Robinson Crusoe here? Are we as Boards or managers satisfied with the amount of benchmarking information on quality (rather than efficiency) that we receive?

The KEMH Report should cause us all to open our eyes and to address clinical governance issues with increasing vigour. We need to ensure that our structures and processes are working adequately. Board members must ensure attention is given, at the highest level of the organisation, to safety and quality issues. Boards should ensure the culture of the organisation encourages openness and learning rather than blaming and hiding. The current (Liberal) Prime Minister's injunction is that we should be 'relaxed and comfortable'. However, one of his (Liberal) predecessor's statements may be more apposite: 'life wasn't meant to be easy'. Dealing with quality issues is difficult. Dealing with structural problems is also difficult. The intersection of the two poses a great challenge for those of us involved in clinical governance processes. But it is a challenge of supreme importance to the health system. We must ensure that we learn the lessons from KEMH and improve the whole system's performance on safety and quality.