

Commentary on the King Edward Inquiry: lessons we fail to learn

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The Douglas Inquiry has clearly illustrated systematic deficiencies in the delivery and regulation of Obstetric and Gynaecological services. Such problems are not unique to the KEMH. Irrespective of the specialty, seven million dollars of careful analysis at any Australian tertiary hospital would have yielded the same conclusions. What lies at the core of the problem are grossly deficient industry standards for quality, safety and efficiency.

It would be wrong to view the King Edward Inquiry as a wake up call. The Quality in Australian Health Care Study (QAHCS) clearly sounded the alarm with regard to the magnitude of avoidable adverse events. The need for transparent outcome review was reiterated in the publicity surrounding Bristol. What new lessons have we learned? The most telling is the simple truth that, 7 years after publication of the QAHCS, very little has changed.

If accident statistics and the QAHCS are to be believed, the risk of death in hospital due to an error or accident is 50 times greater than a year driving on Australian roads, and perhaps 10 000 times greater than a commercial flight. Apples and oranges of course, but the message does not lie in the precision of these figures. Rather, it is in our response to risk. The airline industry operates in an environment characterised by clearly defined protocols, effective incident analysis and external regulation. Road rules, law enforcement and education campaigns reinforce the message of road safety. What of hospital practice?

The need for quality improvement in health care is clearly recognised. Despite this, the philosophy of clinical governance has not translated to effective work place reform. What are we doing wrong? Current risk management strategies rely on one of several approaches:

- Mandatory reporting of index ('Sentinel') events, or clinical indicators
- Voluntary (+/- anonymous) reporting of errors or adverse events
- Random retrospective case note review, screening for adverse outcomes
- Para-clinical outcome audit, such as infection monitoring.

From the above, it is clear that clinical governance has very little to do with clinicians. Para-clinical governance would be more apt. Our present approach risks legitimising Departments of Quality, Safety and Efficiency. This is as much a nonsense as having a Department of Favourable Public Opinion. We have not learnt the obvious lesson that safety, quality, efficiency and community trust cannot be achieved on behalf of clinicians. Rather, these are a direct outcome of the interaction of patients, clinicians and the hospital environment.

The KEMH Inquiry does not teach us that clinicians are uncaring, uninterested or obstructive. Administrators, regulators, insurers, clinicians and allied health professionals all want better outcomes. The missing ingredient is a practical strategy to move safety and quality into the arena of daily clinical practice. Without clear direction, terms like collaboration, communication, openness and accountability are little more than platitudes. It seems remarkable that neither current nor emerging strategies have emphasised three obvious necessities, as follows.

1. The process of care should be clearly defined, as should the tools that support this activity.

Clinicians determine what treatment is delivered. By contrast, the mechanism by which care is provided are typically determined by individual departments or para-clinical groups. It is unusual for clinicians to meet with nursing and allied health colleagues in order to purposefully define or review this activity. As a result, the overall process of care is often poorly defined.

The lack of integration and refinement in health care is illustrated by the tools that support elective surgery. Hospital consent forms do not describe either the intended treatment or relevant risks. Patient education is addressed by a plethora of separate generic forms and brochures. Intended hospital management is poorly defined - clinical pathways remain the exception rather than the rule. In such an environment, it is hardly surprising that management errors are endemic, and adverse events are common.

2. The outcome of every episode of care should be recorded

Most outcomes relevant to safety, quality and efficiency are known at the time of discharge, together with the clinical context in which these occurred. This includes clinical outcomes, errors, adverse events and inefficiencies. This knowledge is largely ignored. In place of coordinated and prospective data collection, we have systems that are almost entirely reliant on retrospective review.

Inefficiency is compounded by poor coordination. For example, DRG coding, adverse occurrence screening, clinical indicator monitoring, incident reporting, para-clinical and clinical audit are all independent activities. As a result, outcome assessment is sporadic, ineffective and/or labor intensive. Currently, the greatest investment of time and effort is squandered in attempting to recapture this same information from poorly documented medical records.

An obvious response would be to ensure that the outcome of every episode of care is recorded prospectively at discharge. We have yet to see any commitment to coordinated, comprehensive outcome assessment.

3. Outcomes should be regularly reviewed by the clinical team

There is a cultural reluctance on the part of clinicians to accept transparent outcome review. In part, this reflects concern that to do so might encourage litigation, threaten professional re-certification or prejudice the views of indemnity insurers and referring practitioners.

In reality, most avoidable adverse outcomes relate to the mechanism by which intended care is delivered, rather than errors of judgement or clinical performance. These outcomes are of relevance to the entire clinical team. At present, errors are perpetuated by the failure of clinicians and clinical teams to acknowledge, record and collectively review the outcomes of patient care.

In an important sense, clinicians in Australia stand at the crossroads. Sustainable effective reform is urgently needed. Will we clinicians continue to devolve responsibility for quality, safety and efficiency? If so, there should be no objection to the inevitable accompaniment of imposed external regulation and practice constraint. How, for example, should an insurer view a surgeon who cannot define their usual management or outcomes? In this void, experience might reasonably become the surrogate for competence. Future clinicians may well find their practice defined by the procedures for which they are granted indemnity insurance.

The answer must lie in effective self-regulation. Reliance on various councils committees, and para-clinical groups has been tried and has failed. The challenge for regulators, administrators and clinicians is to resist the easy option of pouring even greater resources into programs that offer more of the same. If clinicians are to assume a significant role in governance, this activity must be supported. Refinements in clinical process, data collection and outcome review will require a significant funding commitment. As with the QAHCS, the Douglas Inquiry makes an eloquent business case.

In the end, the economic and personal cost of hospital error is borne by the community. An informed public should view hospital outcomes with disquiet. 1995 saw \$658M earmarked for five years of quality improvement. This expenditure may have silenced a community demand. Regrettably, it has contributed little towards meeting an urgent community need. In 2003, no fundamental reform has been achieved where it is most needed - at the coalface of daily clinical practice.