Commentary on the King Edward Inquiry: coming soon to a theatre near you

DON HINDLE

Don Hindle is visiting professor in the Medical Faculty, University of New South Wales

The Australian health system is the best in the world. Mistakes happen occasionally, but we quickly find the culprits and deal with them. So says the Prime Minister, and many others who do not want to see the reality. It is indeed full of excellent staff, but its performance could be much better.

Four obvious points occurred to me after reading the excellent paper about KEMH by Jenny McLean and Michael Walsh. First, clinical work process control was bad. Many simple tasks were being handled by clever and mostly responsible people in uncoordinated and often illogical ways.

Second, there were hardly any effective systems that pooled knowledge about what should be done, and encouraged good practice prospectively (by informing and motivating) rather than retrospectively (by external audit and punishment). Nor were there systems that monitored and responded to performance to ensure there was continual improvement.

Third, there was confusion about responsibility, but no shortage of willingness to blame once the problems could not be concealed any more. There was too little money, doctors were being unprofessional, the Boards focus too much on the budget, accreditation needs to be improved, and so on.

Fourth, KEMH was unlucky to be caught out because the attributes of behaviour associated with the poor outcomes are common around Australia. This is a matter of logic: Australian clinicians mostly have shared learning experiences and work practices, and junior clinicians have to accept them or they will achieve slow career progression at best – or will be sent to Coventry at worst (as happened to Stephen Bolsin when he talked about what was wrong at Bristol).

These problems have been identified before, not only through blockbuster audits like Bristol and KEMH, but also in thousands of local perturbations that have been more easily swept under the carpet. In total, the problems are systemic, we have been trying to address them for a long time, and the same old recommendations might not be good enough – even if we update the words and say 'clinical governance' and 'benchmarking' instead of 'professionalism' and 'accreditation'.

The problems are worldwide

I have worked in ten countries in the last three years, and all of them had the same kinds of problems of clinical work process control. An English example concerned over-prescribing of drugs to elderly people with multiple system problems. Everyone seemed to know this was a problem, but it only became a matter of widespread concern when there were complaints about otherwise relatively healthy elderly people being sectioned (committed by court order to a secure institution) and subsequently being found to need such awful treatment because of the drugs they were being prescribed. The excuses could be guessed: GPs said it was hard to communicate with specialists, specialists said they were overworked and it was quicker to prescribe than to talk with patients, nurses said they could not possibly challenge doctors' decisions, funders said their computer systems did not support coordinated care, and so on.

A current Slovenian example involves an oncology department at a major hospital that failed correctly to review pathology results over a period of about five years. Again, the story broke when a few patients and relatives began to compare notes – about having no feedback about the pathology results, and subsequently discovering the presence of cancer through another route. The excuses can be guessed, as can some of the corrective

measures: the chief executive of the hospital has been dismissed, the Medical Chamber is undertaking an enquiry, and so on.

It would be tedious to continue with similar examples of which I have personal knowledge, if only because everyone who has taken the trouble to look has their own stories . It is sufficient to claim that basic weaknesses in clinical work may be the norm in all countries, from Japan to Mongolia and Germany to China.

This might be relevant, because it suggests that any excuse related to resourcing is not supported by the evidence. For example, countries whether rich or poor can afford to explain to patients what is about to be done to them. In fact, there are ways of informing patients that not only improve quality but also reduce cost.

The hypotheses that refer to a lack of trained staff are also questionable. Most of the changes that are urgently needed are technically simple, and could be designed and then subjected to continual improvement by even the most inexperienced of clinical teams. Indeed, there are large quantities of well-written documents that explain how to implement good work processes.

The underlying causes are cultural

The problems of clinical work process control originate in systems that are driven by a collection of largely disparate cultures within hospitals. In the last issue of AHR, I described a process of organisational learning that involved presenting a picture of a part of the health care facility and asking the participants three questions: can you see a problem, can you think of a solution that will improve quality as well as reduce costs, and who is responsible for solving the problem?

Wherever I have facilitated such a process, people were able to recognise problems and define solutions with great speed and accuracy. They addressed the third question in two stages: the first involving attribution of blame (the government, the insurer, the nurses, the doctors, and so on) and the second involving a collective realisation that 'we are all responsible' and 'we are all prisoners'. This last step is a pre-requisite to making good progress.

I think these points are relevant to the KEMH. It seems to me that all parties (governments, hospital CEOs, medical managers, nurses, and so on) should have done something because they all had responsibilities and all of them could have seen the problems simply by sitting and watching – or talking over a beer. It also seems to me that none of them could have been expected to do something because they were all prisoners of processes that exist by virtue of culture, and prisoners of not choosing to see because they are not supposed to see or because there are rewards for becoming blind. The dismissed CEO of the Slovenian hospital is alleged to have said that "… lots of people knew the problem but they, like me, could see nothing but personal harm to declare it."

Lessons from Bristol

All the ideas I quickly summarised above are in the UK Department of Health's final report on Bristol (http://www.bristol-inquiry.org.uk/final_report/). The following is a summary, but the italicised parts are verbatim.

The Department said the story *was not an account of bad people, or of people who did not care*. Nor was it a problem of lack of information. *Bristol was awash with data,* but it was not available to patients, and hardly used by clinicians. More resources would help, but *whatever went wrong at Bristol was not caused by a lack of resources.*

Rather the problems concerned how people worked together. *Many failed to communicate with each other, and to work together effectively.* The problems arose because *systems were not working well*, not because of the conduct of individuals. Relations between professions were poor on occasions, and *all the professionals involved were responsible for this. Communication between parents and some staff was poor. Informing patients and gaining their consent to treatment was regarded as something of a chore by the surgeons.*

The problems did not lie outside the hospital. Rather, to the very great extent, they *were within the hospital, its organisation and culture*. There was a need for a *different mindset*. The *systems and culture were such as to make open discussion and review more difficult. Staff were not encouraged to share their problems or speak openly.* It was made known that *problems were not to be brought to the Chief Executive for resolution*. Problems were therefore *neither adequately identified nor addressed.*

There was a 'club' culture, and there was a lack of leadership and teamwork. Errors were concealed because of fear of blame: *the culture of blame is a major barrier to openness.*

Many actions are needed. There should be *shared learning across professional boundaries, because future health professionals must work in multidisciplinary teams. Safe care depends on many things, including teamwork and good communication.* There must be *a culture of openness and accountability*, and *a culture in which collaborative teamwork is prized.*

There must be standards of clinical care that *incorporate the concept of teamwork and the respective responsibilities of members of the team. They must not be the product of individual professional groups talking to themselves.* Data are needed that are cost-effective. This means reducing duplication and inconsistencies. *Data must be collected as the by-product of clinical care. Informing patients must be regarded as a process and not a one-off event.*

In total, the findings of Bristol were consistent with those of KEMH, and of many other reviews in the last decade or so. It cannot be that findings are poorly disseminated. They are easily accessible to millions of homes and offices around the world through the web.

The main reason must be that people do not want to hear what is actually being said, or to accept that it has any relevance to them. Their weltanschungen are such that they see a different reality – what they see depends mainly on who they are.

Are there practical steps?

There are many steps that can be taken to resolve these fundamental weaknesses. They are easy to see if you recognise that systems problems that are culturally founded need systems responses that address cultures where they are destructive. I will mention one kind of change, merely for illustration.

In technical terms, the idea is simple – and is already routine in a few parts of a few health systems around the world. First, the funder (the government, the insurer, or whatever) states categorically that clinical pathways are useful if well designed and implemented, and therefore they must be well designed and implemented as a condition of licensing or funding or whatever.

Second, a few case types are selected where it is believed there are significant opportunities to improve cost-effectiveness, and illustrative clinical pathways are designed and made available as a starting point for care providers.

Third, the selected pathways are costed and the cost of good care becomes the payment rate. Contracts are written that require the use of pathways, and clinical teams are given support to adapt and then implement them.

Finally, the use of the pathways becomes the basis for internal and external audit. Internal audits, meaning team meetings where variances are discussed and decisions taken about whether the pathway or the care provider got it wrong, are the most important. They are, of course, continuous quality improvement in action. External audits then involve no more than checking that the clinical pathways are being used, that team meetings occur, and that problems are continually being identified and resolved.

Pathways are a good way of dealing with system complexity because they are an integrating idea. They help resolve problems of discordant cultures, because they are a vehicle for promotion of respect and understanding. I recently asked a group of clinicians in the UK whether pathways would have resolved the problems that Bristol had. The unanimous answer was yes. Issues of questionable patient outcomes would mainly have been a matter for the multidisciplinary team (rather than the medical staff committee). Suggestions from the anesthetist would be welcomed. Unexpected adverse outcomes would have been recorded as variances on the clinical pathway as a matter of course, and then been the subject of discussion in the regular team meetings. Reports of problems and their solutions would have been largely in the public domain and clinicians would have been proud to report them.

However, there was an important qualification: nobody believed it would have been possible to introduce pathways in paediatric cardiac surgery at Bristol. As is evidenced by the enquiry, the surgeons believed they had nothing to learn (poor outcomes were the patients' or the funders' fault not theirs), the nurses knew there were problems that could have been alleviated with pathway technology but felt powerless to do anything, junior doctors were concerned but dared not speak out, and so on. Pathways build teamwork, but a sense of team is required before pathways will ever be used.

So pathway-based clinical work process control is technically simple, but it is a culturally difficult idea. In order to succeed in all circumstances, there has to be a systems approach: governments must be demanding it, purchasers must be supporting it by the way they select care providers and negotiate payment rates, nurses and doctors must be willing to change the ways they work together, junior doctors must be prepared to complain if the pathways are not clear or not up to date, the hospital finance committee must be able to deal with a specialty that is over budget without stealing from another department that is under budget, and so on. It requires people to act in ways that go against habit and culture.

However, simply saying it must be done is not sufficient in many clinical settings. It is necessary to go through a process of preparing players to take a new view of what is possible and desirable, and this means having a few people who are skilled in such a process. Inter alia, this means helping players to see the limits of their rationality (to understand why they think the way they do), and to understand cultures that are different from their own (and thereby both respect and deal with the other cultures in a more effective way). This is all manageable, and some clinical teams have already managed it through their own devices. Other teams – perhaps the majority at present – need a little help.

If improvements are to be made in clinical work process control, it would be good to have all the players in the same room for as long as it takes. The process should be one of defining the language that will help, and then talking about what everyone will be committed to do. The language of committees and enquiries and task forces is unlikely to be adequate. The goal is to talk about the real problems and their solutions, and too often the process involves sacred talk that conceals the reality.

I doubt, however, that this will happen in Perth. We will probably see the same kinds of responses that occurred elsewhere, and which had hardly any effect on the system-wide problems. Several people with power have to do the unusual, and there is not yet a counter-culture that will encourage this to happen.

There was a recent case of poor clinical practice by a private medical specialist in Canberra. To cut a long story short, he failed to follow a simple protocol and this led to failure to obtain informed consent and to give information about post-procedure care. The patient went to the internet, found a copy of an appropriate checklist and took it to the consultant's office and suggested he used it in future. The specialist, having been put under threat of litigation, felt obliged to sound interested. But what will happen to his clinical practice when the risk of litigation has disappeared? More important, what effect will this have on the other specialists with similar weaknesses?

I know a few hospitals in Australia that have had sessions on Bristol and KEMH, where there was open and honest discussion of the extent to which the underlying weaknesses were present at home. They are the exceptions, and therefore the kinds of changes that are needed will continue to take place but at a rate that will lead to more poor patient outcomes than the community deserves.