Organisational change

The clinician, the patient and the organisation: a crucial three sided relationship

Fiona Moss

Understanding and respecting the system of care essential for patient safety

In the UK about 5000 people die each year from hospital acquired infections. That equates to 65 000 people since this journal was launched in 1992. This is an intolerable toll, which at least in part is linked to failure of healthcare professionals to clean their hands. Evidence that hand hygiene is effective in reducing infection is compelling and is available in the medical literature. So, why cannot hospitals institute and insist on the sorts of changes that make their hands between seeing patients. Many healthcare workers do not do this simple thing: there is a chasm between organisational intention and the action of individuals. An organisational rule goes unheeded. People continue to die from hospital acquired infection. It is difficult to imagine people in the airline or oil industries not doing something that was so important for safety. But those organisations would surely have made the rule explicit; have provided training and made sure that the appropriate cleansing agent was always available in places where it was needed.

Descriptions of when things go horribly wrong usually include failures of the system of care, often with an element of care being given outside the usual process or system. Rarely are they stories of failure of intention to care for an individual. The story of Wayne Jowett, a 16 year old recovering from leukaemia who had forgotten to attend chemotherapy. A kind act but, in the end, one that could have exposed patients to risks that result from not respecting organisational guidelines. The education of clinicians needs to be extended to include an understanding of the impact of organisational behaviours on clinical care. Otherwise, focusing on individual needs and blind to the demands of the system of care, clinicians embark on actions that could jeopardise their patients' well being.

Clinical education needs to catch up with this changing world. Clinical autonomy, valued by clinicians, cannot be allowed to expose patients to risks that result from not respecting organisational guidelines. The education of clinicians needs to be extended to include an understanding of the impact of organisational behaviours on clinical care. Berwick et al suggested eight skills for quality improvement (see box) and, more recently, the US Accreditation Council for Graduate Medical Education has proposed a competency based model designed to encourage residents to learn about improvement principles. The six competencies are: patient care; medical knowledge; practice based learning and improvement; interpersonal and communication skills; professionalism and system based practice.
Hospitals, too, could take responsibility organisational guidelines are observed. A break that is needed to encourage ship and organisational commitment will require significant cultural change. These skills should be included with clinicians to make sure that organisational guidelines are respected and adherence to. Insisting on hand hygiene is one area where they are not there to be broken.

This journal has reflected the development of quality and safety improvement for 13 years. Undoubtedly, much more is now known and understood about the extent of problems and some of the underlying causes. Important documents, including the two reports from the US Institute of Medicine, have influenced thinking and shaped the debate about the quality and safety of care worldwide. In the UK we have seen the implementation of clinical governance; the development of National Service Frameworks for a range of conditions and client groups; and the setting up of agencies such as the National Patient Safety Agency and the National Institute of Clinical Excellence. All this seems worlds away from the UK setting up of agencies such as the National Patient Safety Agency and the National Institute of Clinical Excellence. All this seems worlds away from the UK setting up of agencies such as the National Patient Safety Agency and the National Institute of Clinical Excellence. All this seems worlds away from the UK setting up of agencies such as the National Patient Safety Agency and the National Institute of Clinical Excellence. All this seems worlds away from the UK setting up of agencies such as the National Patient Safety Agency and the National Institute of Clinical Excellence.

The improvement horse race: bet on the UK

D M Berwick

The task of building the best healthcare system in the world is well started in the UK

Place your bets. Both the UK and the US are struggling to improve their troubled healthcare systems. Which is more likely to succeed? The two countries are strikingly similar in the problems they face, and equally dissimilar in their plans of action. I am a fan of both but, when bets are placed, my money will be on the UK.

Clinicians coming through such programmes should be better equipped to offer safer care in today’s healthcare environment and, if hospitals provide the appropriate support and environment, will be able to put this training into practice. Most of those currently practising will not have had this training. Insisting on hand hygiene is one area where they are not there to be broken.

The best problem list for either country is probably the one in the landmark 2001 report “Crossing the Quality Chasm” issued by the Institute of Medicine (IOM), a branch of America’s National Academies of Science.1 Summarizing decades of health services research and literally thousands of studies, the Chasm report recommended six “aims for improvement” as targets for the redesign of healthcare systems:

- safety (reducing medical injuries to patients);
- effectiveness (increasing the reliability of evidence based care);
- patient centeredness (giving patients and carers far more voice, control, and competence in self-management);

Quality improvement in the US and UK

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• timeliness (reducing waits and delays throughout the system);
• efficiency (reducing the total cost of care); and
• equity (closing racial and socioeconomic gaps in health status).

Rearranging the first letters, some organizations have taken to calling these the “S-T-E-E-E-P” goals.

Although the IOM’s report addressed only American health care, its findings—and especially the six aims for improvement—pertain well to the UK and the NHS. The ongoing massive UK effort to improve the NHS—launched as the so-called “Modernisation Plan” in 1997—has involved massive new investments (raising the total UK expenditures on health care from its starting place of about 6.5% of the GDP closer to the EU average of about 8.5%; compared with 15% in the US!) and the creation of focused strategic plans—National Service Frameworks—that lay out dozens of new targets and approaches to care improvement for a variety of important clinical areas. The National Service Frameworks speak much the same language as the Chasm report, with a good deal more precision.

The profile of relative importance of the six aims differs somewhat between the two countries. Equity and excessive cost are far more urgent problems in the US, while timeliness ranks at the top of the NHS improvement agenda. Problems in safety, effectiveness, and patient centeredness plague us both. Overall, however, both nations can with confidence focus on the same “STEEEP” list of aims as a worthy agenda.

Why would I bet on success in the UK over the US? The biggest reason is simple: the UK has people in charge of its health care—people with the clear duty and much of the authority to take on the challenge of changing the system as a whole. The US does not. When it comes to health care as a nation, the US is leaderless. An immense resource for progress in improving the NHS—the key resource, in my view—has been the consistent focus of government, emanating from the Prime Minister personally, on raising the bar for NHS performance. The modernisation process sought to establish accountabilities, structures, resources, and schedules in the NHS that no one at all is in a position to establish in the pluralistic, chaotic, leaderless US health care system.

No one is thoroughly happy in the UK with the NHS modernisation program to date; it has stumbled occasionally, as any project of that level of ambition must. But no honest observer can fail to credit the process with immense productive change, headed for real measurable successes in a behemoth system that could easily seem unchangeable. Several objective evaluations—of which the most important is that sponsored by the Nuffield Trust in 2003—find substantial gains underway in access, reliability, safety, and outcomes of NHS care. In the especially important arena of patient safety, the clear headed and courageous leadership of England’s CMO, Sir Liam Donaldson, and the founding of the National Patient Safety Agency as a national resource, may soon catapult England into international prominence in systematically achieving new and unprecedented levels of patient safety.

“Three tough issues lie between the good successes that are almost in hand and the great ones that could be.”

So, I will bet on the Brits. But I would offer even longer odds in their favor if a few large changes were made in the agenda for improvement of the NHS. Three tough issues lie between the good successes that are almost in hand and the great ones that could be.

Unifying improvement work at the health economy level

As an outsider, I would have thought that the globally funded, governmentally sponsored nature of the NHS would lead unerringly to sound development of community wide systems for the care of chronically ill people across the continuum of care. I would have thought that hospitals, community agencies, and primary care trusts—hav ing, in effect, the same “owner” and “employer” (the public) and drawing on the same common pool of taxation—would work together seamlessly to assure flow, efficiency, integrated experiences, and common aims. But this is not the case. To my surprise, and to the UK’s loss, hospitals and primary care trusts at the community level—the so-called “health economy” level—remain too often strangers, uncoordinated, mistrusting each other, convinced of conflicting aims, and thereby failing to achieve the needed flow and coordination of care for patients in desperate need of both. The NHS’s long hospital lengths of stay and the feelings of disenfranchisement of chronically ill patients and carers, are only some of the symptoms of fragmentation.

The NHS will not achieve its full potential—the “STEEEEP” goals will remain out of reach—unless and until the primary care trusts and hospitals at the community level are somehow brought more effectively into a common frame of planning, action, and patient care. Only a few local economies have shown success in this, due usually to nearly heroic leadership and hard work to maintain fragile coalitions. That plan is not robust enough for the nation as a whole. I do not necessarily recommend the rediscovery of the ancient “health authorities” as a vehicle, but some vehicle must be found to unify actions across the continua of care, or fragmentation will remain.

Achieving authentic patient centeredness

To a visiting American, consumerism and world class customer service seem a bit less developed in the UK than in the US. The same is true in health care. Viewed through American eyes, the modul British patient seems willingly more passive, and the modul British clinician habitually more controlling, than is probably best for either. The Chasm report uses the awkward term “patient centeredness” to denote the constellation of qualities of care that can give patients and carers power, knowledge, dignity, self-efficacy skills, respect for their diversity, and freedom of action. This is more than a political agenda (though it has political overtones); much sound clinical research shows that empowered, informed, activated patients tend to have much better outcomes and to use healthcare resources much more effectively than patients made helpless, silent, or passive by a system that takes too much control from them.

The NHS modernisation process still lacks a thorough commitment to patient centeredness of the type contemplated in the IOM vision. Perhaps the apparent lack of control British norms are just fine for Britain, and perhaps the pursuit of patient centeredness does not belong on the NHS agenda. But I doubt that. The next phase of development of a better NHS will go farther and faster, in my view, if stakeholders commit to a new level of control by patients and families of their own information and destinies in health care. It is important to know that British patients will not, in the first instance, demand that. They are trained too well. The question is not if they will ask, but rather if—once offered a new level of control and self-efficacy—they and the clinicians will come to appreciate the advantages of a new relationship that neither would have thought to request.

Linking the improvement of care to changes in professional education

It is as important to build a future as it is to heal the present. In health care the “future” refers to our young
professionals—doctors, nurses, therapists, and managers—who will inherit the NHS when we rest. From the viewpoint of improvement, and in pursuit of the “STEEEP” aims, our young professionals are emerging ill prepared to help. The education of health professionals generally lacks focus on the skills in systems thinking, statistical thinking, measurement, cooperation, group process, teamwork, and pragmatic “real time science,” to name but a few disciplines that provide the foundation for effective citizenship in improvement. The result of missing this knowledge is a workforce that too often seems resistant to change and that lacks sufficient capacity to change the work it does.

So far, as I see it, the processes of change underway in the NHS lack effective connection to consonant changes in the education of young professionals. The omission is costly now, and will be more costly in the future as the workforce continues to be ill prepared to cope with—let alone to lead—a new, evidence based, reliable, patient centered, efficient, and safe system of care. That can easily change in the UK, but only with a totally new level of communication with and involvement of the agencies and leaders who are stewards of the educational systems—the Royal Colleges and others. Very promising changes are now underway in the relationships between the Royal College of Physicians and the leaders of the NHS, and these bode well for the future.

**CONCLUSION**

I do predict success for the UK in its efforts to build what can become the best healthcare system in the world—nothing less. The task is well started. These three adjustments—to organize care far better at the community level, to raise the bar on patient centeredness beyond what British patients may at first ask for, and to welcome and embed into the improvement process an agenda for change in the education of young professionals—will not be easy, but they are important enough to tackle hard and soon.

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studies suggesting a significant impact and others suggesting little.\textsuperscript{11, 12} Evaluation of the impact of guidelines and guidelines programmes will be a significant issue. And, as the technology grows and is exported to more and more countries (including those with less well funded health systems), it is reasonable to ask whether there need be multiple national programmes or, at least, how such programmes might support one another.

The Guidelines International Network seeks to address these issues. The recognised importance of implementation is to be welcomed. The early conference and web developments look like a commendable start to this process. For example, the website contains much valuable material brought together in the same place for the first time and includes some topic areas such as a range of guidelines in a specific area such as asthma or ischaemic heart disease. However, it is unfortunate that the full searchable database of guidelines is available only to fee paying members. There is an undoubted need for a searchable site of quality assured guidelines; keeping that part of the site for members only may undermine the aims of the project. In addition, if the network is to achieve its aims, it will rapidly need to decide how it will assure the quality of the guidelines it decides to incorporate on its website. Those available in the topic based section range from fully developed evidence based guidelines using robust state of the art methods to others that have gone through a far less robust process. This not only leads to differences between the guidelines available on the site for the same clinical areas, but also risks repeating some of the problems that the movement was set up to address.

The widely accepted formal definition of guidelines as crafted by the Institute of Medicine—"systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances"—also throws up some challenges. The concentration to date has been on clinicians and, arguably, guidelines are rather paternalistic. This will be challenged by the increasing emphasis on patient choice and engagement in decision making. Indeed, there may be a significant tension between applying guidelines based on effectiveness and the drive to engage patients in shared decision making. How will guidelines work in this context?

When we look back in 50 years at this stage of the guidelines movement, the last decade will be seen as a pivotal point. Much progress has been achieved in stimulating high quality methods of appraisal and development and in finding ways of promoting guidelines in health systems. But many challenges remain. The Guidelines International Network has a big job ahead.

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Medical decision making

Researching doctors’ decisions

J Dowie

Why bother trying to discover how clinicians make decisions? Would it really make any difference to the quality of care if we knew more about their decision making processes? Is there any basis for the conventional assumption that it would make a significant difference, and in the right direction?

Probably not. During the three decades since the pioneering work of Elstein et al.,1 numerous studies of the decision making behaviour of clinicians—and, indeed, professionals in many fields—have yielded only one relevant finding. Insofar as we can make inferences about how they decide what to do by observing their behaviour or interrogating them, their decisions and decision processes vary enormously. Even when researchers are able to come...
up with generalisations about the diagnostic or therapeutic processes of practitioners, these are often weakly supported and/or highly restricted in their coverage. Above all, they are analytically vague. This is not surprising because, even though some explicitly analytical reasoning is usually reported by practitioners, the expertise applied in professional decision making appears to be substantially intuitive, involving significant amounts of either intuitive pattern recognition or intuitive regression across “multiple fallible indicators”.

The disappointing results from the vast amounts of money and effort put into developing “expert systems” of the production rule (“if-then”) sort have merely confirmed that much of the time experts literally do not know what they are doing. This does not, of course, imply that what they are doing is not appropriate and may indeed be optimal. What it does mean is that even skilled “knowledge engineers” cannot extract the inaccessible elements of expertise for use in either practice guidelines or professional training.

Given the undoubted existence and significance of intuitive expertise, what is the point of attempting to describe the decisional behaviour of doctors? Setting aside the aim of acquiring knowledge for its own sake, which justifies the interest of the academic psychologist, does descriptive theorising and empirical research without an explicit prescriptive standard have any practical use for either practitioner decision making or professional education? Why spend any time on descriptive theorising unless one knows what is the best decision or best decision process, or both? Without a prescriptive basis, the use of descriptive results in improving the quality of care is zero and this is true whether the adopted prescriptive basis is decision analysis, the practice of some person or some group defined as best practice, or any other criterion.

It is, of course, methodologically imperative that the prescriptive basis be defined before any research study. Otherwise one will simply be defining the prescriptive as what happens: this is the way doctors do make decisions, therefore this is the way they should make decisions. Alternatively, one will end up simply pointing out the existence of variation, in itself of no practical use except in so far as it acts as a stimulus to identifying the necessary prescriptive basis.

If one does have an accepted prescriptive basis for quality care, why not just apply it and teach it to the extent either is possible? Forget the descriptive challenge except as an aid in determining the most effective way to identify the obstacles to implementing the prescriptive.

But there is a major difficulty lurking here—one that only an explicitly analytical prescriptive standard, such as that offered by decision analysis, satisfactorily exposes. Many studies of practitioner decision making which seek to evaluate the quality of decisions (either explicitly or implicitly) fail to recognise, or sufficiently emphasise, two things. Firstly, that there can be no such things as a gold standard verdict on management decisions of the sort that is possible on diagnostic judgements. Decisions involve value judgements as well as probability judgements and the prescriptive bases of the two types are very different, if indeed one exists for value judgements. Secondly, that any evaluation of a decision by a prescriptive standard must logically be on an ex ante basis. One cannot sensibly evaluate a decision by its ex post outcome, as is often suggested.

One can certainly set up a prescriptive standard against which to evaluate an ex ante probability judgement offered as to whether this patient has appendicitis or this child has actually been abused. But unless one can also set up a gold standard on the value side of the decision, which will involve establishing the relative value/disutility to be assigned (ex ante) to the false positive and false negative errors always possible under irreducible uncertainty, one cannot evaluate the decision. In order to evaluate the decision one must be able to identify what the best one was in this particular case, and this necessitates identifying the best available probabilities and most appropriate value judgements—in both cases at the moment of decision. Evaluation of decisions is therefore contingent on agreement on the values and preferences regarded as the appropriate ones at that moment. Ethically, these should be those of the owner(s) of the decision—the patient in the private clinical situation or several constituencies in the public health and health services. If there is insufficient agreement on these—and some variation in values may be consistent with the same choice of action—no agreed evaluation of the quality of a decision will be possible.

Why the ex ante basis? Under uncertainty it is possible that the best decision will produce the worst outcome and vice versa. One can obviously establish, by an ex post gold standard procedure, whether this patient actually had appendicitis or whether this child had actually been abused. (The latter example illustrates the difficulty of establishing a carat gold standard verdicts or, in many cases, ones of very few carats.) But while the judgement/ex post outcome observation in this case can be added to the database for future decisions—improving the assessments of the sensitivity and specificity of the professional concerned—it cannot, by definition, change the evidence that was available at the time the original decision was made. It is therefore irrelevant to the evaluation of that decision. (The existence of a treatment effect, as in the ventilation case investigated by Kostopoulou and Wildman, is a serious problem for the development of the evidential database.) Equally irrelevant is the experienced utility or disutility of the actual outcome, as opposed to the anticipated utility or disutility of the possible outcomes at the moment of the decision. Description without prescription is as useless as diagnosis without treatment.

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