ENTREVISTA

"MAKING A REAL DIFFERENCE: THE CHALLENGE IN IMPROVING QUALITY IN HEALTHCARE"

En esta entrevista realizada en exclusiva, el Dr. Lachman responde sobre sus motivaciones para comenzar a trabajar en la mejora de la calidad en salud respecto de la necesidad de un cambio cultural en lo relativo a la seguridad del paciente, tanto en la formación universitaria como en la atención médica y sobre la importancia de los procesos de estandarización y acreditación como parte de la mejora continua.

Próximamente, podrá acceder a la versión en español a través de nuestro sitio web.

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Which were your motivations to start working on quality in health care? And how did you start working on ISQua?

I have been really involved in quality since I started as a doctor. To illustrate, let me start with two stories of when I was a trainee doctor. When I became a registrar on my first night on call a child died due an adverse event. What had happened was that a doctor in the Emergency Room had inadvertently given the baby Potassium Chloride and not Sodium Chloride. I was the doctor present when the child died four hours later. The doctor and the nurse were charged with manslaughter and lost their jobs. So, I did not know then that this was an issue of human factors which was the reason for the mistake.

Another story is of a baby in the Intensive Care. I had inserted over forty drains in that baby who was four month, and when I went on holiday, the baby died the next day. And then I realized on reflection, that perhaps we had over treated the baby, maybe we should have been more realistic. I give you these two stories because I believe that in healthcare everyone has a story and people go into quality of care for subconscious reasons as well as apparent reasons.

In 1994 I was asked to go to the UK to reorganise a hospital in a rural area, as a nurse had murdered four babies. And that was the start of my journey of solving problems and I tended to follow the problems. I then went to another large hospital in London and within six months of becoming head of department, I ended up addressing one of the biggest child protection cases in the UK, where a child had been murdered by her aunt; but she had been seen in multiple hospitals and then the problem was misdiagnosed. I then became head of obstetrics and over time there were deep seated safety issues we had to address, as there were a series of maternal deaths. We now can say it was due to the culture, with a lack of standardization, lack of accountability, lack of responsibility. This was in 1990-2000, a time before quality and safety were big issues, and we did not have any theories of patient safety. Now I can say we understand the issues involved.

In 2005 I went to IHI [Institute for Healthcare Improvement] as a fellow for a year, and I was trained in quality and safety —my first formal training in the new sciences of improvement and safety. Then I went back to London and I was a head of quality and safety at Great Ormond Street Hospital for ten years.

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Maybe this leads to the next question: what do you think will be the fundamental challenges for quality healthcare in the future?

You need both sides to change; you need a theory and a method. But the sociological and the psychological part of me says that it's about the people. The fundamental ingredient is what people believe. I think problem in quality and safety is that the approach has been more transactional change. For example, if you want to prevent central line infection, the transaction is the care bundle, the transformation is changing human behaviour. And for to do that one needs to understand the origins of medicine. For example I have read [Michel] Foucault's *The Birth of the Clinic* and this helped me to understand the construct of medicine and the way doctors think.

"Do you trust or not"?

The Birth of the Clinic was quite interesting to me because it spoke about the clinical gaze. I have written an article on the changing clinical gaze which should now be on quality —previously the clinical gaze was that doctors decided what health was, and what disease was. They decided the "maladies" they created the hospital as a "palace for scientific investigation and the construct for modern disease management". I believe that we have the wrong construct for the modern age. We need to ask, "What do people believe about health, disease, about relationships with doctors, about the doctor's relationship with the patient's belief?"

Culture is about beliefs and attitudes of the doctors, of the patients and that leads to action. What they believe and accept. If a doctor doesn't believe that he or she infects a patient, or doesn't believe the need to wash hands, then improvement is difficult. Doctors should believe that paying attention to detail on the prescription is the most important thing they do because medication harm is the biggest harm. It is about belief.

Another belief system to change is that the view of a doctor is more important than that of the patient. And that differs in every society. Understanding local belief systems is a key in developing safety programmes. All the time I'm learning more and more about the culture and the context where I teach, so even if the content is the same, how I teach is totally different.

Even in different places of the same country?

Yes. So, what they believe up in the North is different from the South. So that's the key factor in improvement, is the understanding the context and belief systems of whom you work with, and to paraphrase [William] Deming, "You first have to know what to do and then do your best." We have got a lot of doctors doing their best, but then they don't know what to do.

I think that the patient safety movement is very transactional even when I talk about transformation. We need to move to the idea that though we manage health and disease, this is not actually our business, rather safety is our business.

If I go to any hospital in the world, and ask the CEO "Do you know who is the sickest patient today in the hospital?" he/she would not know. Management often work in a vacuum. They often have no idea what's going on down below. We have the hospital working totally inefficiently because some parts are busy, some are not busy, and no one knows what is going on. Then, they create all the systems to try to find out but they still don't know how to integrate. What one should have is like in air traffic control; they know every plane that's flying into an airport today at any time. We need retraining of the staff, including the management staff to enable and understanding of quality and safety. That is what it really means "safety is our business". One needs a deep understanding of the theories and practices of patient safety, of process control, of how to improve.

We are now changing the hierarchy concept; the first step is to change culture.

—That's very difficult because of the paradigm given. If you go to a hospital, you can test it as follows. I do not know if this happens here. But if you have male and a female provider and a patient comes in and you say, "Which one is the doctor?" They choose the male. That's how they do it, what you can see is a gender hierarchy. And if you now have a trainee doctor, and a nurse, who do you want the opinion from? Often a patient chooses the doctor, even though if the trainee doctor may know less. That's culture. That's ingrained hierarchy that doctors are men and that doctors know more than nurses.

What do you think about health quality in Latin American region?

Basically, every country in any region needs to have standards of healthcare. So you have universal healthcare and everybody has the right to healthcare in your constitution. What is really needed is that everyone must have the right to equal healthcare. And, the next approach is that you must have equal quality and safe healthcare. If you go to a private clinic or a hospital clinic, your safety and quality should be the same not depending on how much you can pay; that's universal healthcare for me. And to do that we need standards, a way of measuring standards and improving on them. That's where the accreditation bodies come in. They are there to assist hospitals to reach the standards. It is more than a badge of attainment but rather a way to continually improve. Once you receive the accreditation, you must have continual improvement and that includes a cultural change, quality control, quality management, quality improvements, quality strategies that accreditation is only part of that cycle and that one of the things in standard should be: how do you continually improve? And when you reach the standard, how do you exceed the standard? The standards are reaching the minimum not the maximum. So, when people say, "Oh, we reach our standard" they should then ask, "is there anyone else who does it better?" Because that's where you're going to go next —and with have knowledge sharing, they can improve. This is what ISQua is doing with the improvement networks. The basis is Deming's profound knowledge which means one is always searching for the answer to be better.

Could you explain us the relevance of having accrediting organisations, accredited by ISQua in different countries?

—ISQua is an international organisation, acting as an honest broker that can bring people to the same levels of standards. And the approach applies for the accreditation bodies to improve continually. For me, the accreditation process must be easy to do and there is another saying we use for improvement that says, "Make the right thing easy to do and make it easy to do the right thing." So, you must make it easy for them to do the accreditation and make the process easy as well as the accreditation easy at a high standard. We could simplify the rules and make it easy to do without lowering standards.

Do all accrediting organisations comply with the same standards independently of the region?

You can adapt how they apply standards not, what they should do. Standards have to be uniform everywhere, how you apply it and how you do it may be different because of circumstances and context. People need to understand the local context.

Talking about health facilities, accreditation should be mandatory or voluntary?

Accreditation is a voluntary system because organisations want to be accredited. The mandatory part is what the government says you must do —the minimum standards. Accreditation is about exceeding the minimum standards. Every hospital must comply with certain minimum standards. Every hospital should aspire to the highest standards that accreditation provides —that's the difference. So, if accreditation becomes mandatory then it becomes it in the minimum standards. Accreditation is to aspire to be higher than the minimum standards, as safety and quality are the business of healthcare.

How about ambulatory treatments? It's increasing here, it is not usual.

We have concentrated on hospitals but the approach applies across all healthcare settings in including ambulatory and primary care.

Talking about the future, how do you manage the integration of quality and safety in patient care in a university's programs?

Ideally, when you are around a patient, one usually discusses disease rather than safety and quality and asks "what is the diagnosis, what is the treatment" etc. rather than "what are the safety issues involved in this patient? What are the quality issues? Is this patient at risk of anything that we need to worry about? How can we prevent that happening?" The key is that we need to start preparing for safety at the undergraduate level. ISQua is designing a course for undergraduates on quality and patient safety . The subjects must be taught as dedicated subjects and, also be integrated

with applying the theory when they see the patients. At every clinical encounter, we need them to be supervised. A nurse or a doctor in training should be asked about safety and quality as well as about disease and the management. So, it that becomes totally integrated. Currently there are few medical schools in the world that teach quality and safety effectively. Why? Because medical schools are very conservative and hierarchical; they say this is not as important as Cardiology, as Surgery, as Gynaecology, as Obstetrics, etc.

Then also we need concepts on how to continually improve? How do we train people continually? For example, how do we use stimulation? An accreditation question could be: "Do your doctors really care about stimulation?"; or "Do you videotape a surgery and play back what happened in the operation room so that the surgeon can self-learn and see how to continue to improve?" In the aviation industry on that plane there is a black box that it's recording everything that's happening so that if something goes wrong they know; they have the evidence. Why does this not happen in an operating room. It's all part of the cultural shift.

Which are the expectations for the next conference?

When people come to the conference we want them to go home infused and excited to do new things. That's the main thing that I want to do. We are planning Malaysia and then Cape Town. We try to make each conference different and my aim is to spread learning around the world.

In the last conference in London we had some sessions on policy, how to improve safety and person centred care. There was a good mix of topics. We had a focus on

middle and low income countries. We had experts on how to manage quality and safety in periods of crisis, e.g. the periods of crisis for Latin America of Zika, for Africa it is Ebola, for everywhere it is refugees, and war. This was a totally new area for us. We had some many fun sections such as one on the depiction of safety and quality in the cinema, and there were also sections on safety and the patients' sense of care.

Finally, one of my reasons for coming here is to encourage more members from this region. We reduced our fees for members, according to the region they live in as per the World Bank categories. ISQua must go forward as international organisation, and have representation from all the areas of the world.

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