OPINION

Flawed above

In any institution like the NHS, where reorganisation is a way of life, there is an inclination for the victims of change to believe that its instigators are sane and logical. The few who doubt the sanity of our leaders, be they politicians, senior managers or God-like clinicians, often tend to believe that the change induced is the product of some evil conspiracy.

It is essential for all nurse managers to doubt at all times the sanity and logic of their colleagues, to discount the belief that their ‘elders and betters’ are capable of conspiracies (usually their behaviour is due to a cock up), and demand always and everywhere both an explanation of change and evidence that the proposal is based on facts rather than rhetoric and ‘religious’ (often ideological) belief.

Whether it is your local trust, the local primary care centre, the purchaser, or even the NHS Management Executive of the Department of Health itself, all decision makers are reluctant to base their policies on evidence. In the NHS, like all other health care systems, certain things seem almost immutable and likely to destroy any reform aimed at increasing efficiency and enhancing equity.

The first characteristic of health care is, as they say in Yorkshire, that nobody knows ‘owt about nowt’.

The accountants have little idea of the cost of most procedures. The NHSME demands that they set prices equal to average costs, but whether your local accountant follows the ME’s silly rules is a dying you should discuss with the finance director after the third bottle of wine.

She or he will confess that you can define costs in many ways and that prices usually reflect ‘what the market will bear’.

The second characteristic of health care is that there is little data about whether treatments kill or cure – no one likes to measure outcomes, or enhancements in the length and quality of life. Florence Nightingale advocated the use of a three point measure of success: dead, relieved or unrelieved.

She went on to argue, like some latter day management consultant: ‘I am fain to sum up with an urgent appeal for adopting this or some uniform system of publishing the statistical records of hospitals.

There is a growing conviction that in all hospitals, even in those which are best conducted, there is a great and unnecessary waste of life. In attempting to arrive at the truth, I have applied everywhere for information, but in scarcely an instance have I been able to obtain hospital records fit for any purpose of comparison.

‘If they could be obtained, they would enable us to decide many other questions besides the ones alluded to. They would show subscribers how their money was being spent, what amount of good was really being done with it, or whether the money was doing mischief rather than good.’

Of course this advocacy was 130 years ago and we can’t expect change to happen overnight. Nor has it done so. Each hospital collects mortality data which is ignored. Why don’t you use it in your job to augment clinical audit?

No hospitals routinely follow up their customers to determine whether they survive treatment, drop dead in the car park or live for many years. No hospitals measure quality of survival after procedures. Can your patient ‘dance the light fantastic’ after you replace her hip, or are they chairbound for the rest of her lives? Why don’t you measure the quality of survival (a nice project for student nurses perhaps)?

As a consequence of our ignorance about costs and outcomes, it is not surprising to find that there are large variations in what clinicians (and nurses) do to patients of similar age and sex, and with the same health problems.

Two and three-fold variations in medical and surgical activity rates across hospitals, districts, regions and countries are commonplace. Five, six and more-fold variations have also been found, and reflect clinical uncertainty about diagnosis and treatment (let alone prognosis).

Occasionally the research community produces some ‘facts’ about the cost effectiveness of competing treatments. There are two problems with this.

First, much clinical and economic research is very poor in design and execution. Doctors, to get promotion, have to do research but all too often the products of their labours...
are not worth reading. Why? Because the clear things are not taught how to do research and, as a result, even after data torture, sloppy peer review, and publication in the worthy British Journal of Ingrowing Toenails, the sum of human knowledge is not increased.

If nurse managers feel such a conclusion to be extreme, they should read Douglas Altman’s article in the British Medical Journal of January 29, 1994. He argues that ‘the temptation to behave dishonestly is surely far greater now, when all too often the main reason for a piece of research seems to be to lengthen the researcher’s curriculum vitae’.

He quotes Bailar who suggested two decades ago that ‘there may lie a greater danger to public welfare from statistical dishonesty than from any other form of dishonesty’.

And when, unusually, the scientific methods used are adequate, the results of research are often ignored or take a decade to affect nursing and medical practice. Why are you so unreceptive to new knowledge?

We know, for instance, that many young women are unnecessarily assaulted by the NHS. United Kingdom diagnostic D&C rates are six times the level in the US, and most of these interventions have no benefit, except in keeping clinicians and nurses from greater mischief elsewhere.

It seems that the insertion of grommets in children with glue ears is a useless procedure in many cases. Doctors and nurses should be indulging in ‘watchful waiting’ (ie glue ears self correct in many cases) rather than unnecessarily assaulting young children.

Any manager or reformer should proceed cautiously in the face of this ignorance about costs and outcomes, which is exacerbated by the large and unexplained variations in clinical practice, and the medical and nursing professions’ reluctance to take any notice of effectiveness research.

They should distil the pearls of elusive knowledge from the horse manure of opinion and rhetoric. They should challenge all advocacy with the demand for evidence.

All nurses should instruct patients, when told by the doctor what treatment they will get, to demand the citing of three clinical studies to substantiate their conclusion. Let’s demand facts, and in their absence assume that the people issuing instructions further up the line are ‘managing on the hoof’ and behaving illogically and with dubious sanity.

After all, if we are honest, we are all guilty of such misdemeanours.

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