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Editorial: People not paper: challenging document dependence and audit addiction in contemporary health care

Provision of health care remains a highly politicised and intensely regulated area of professional practice and government. Governments worldwide seem incapable of resisting the urge to 'do something about health care' regardless of how capable, qualified and experienced (or otherwise) they may be to do so. Political careers have been made and lost on pledges and assurances about health care, reminding us of the old adage in politics that 'health may not win you an election but it can certainly lose you one.' Promises and 'assurances' about hospital waiting times, access to health care, quality of health care, number of health care providers, types of health care providers, costs associated with health care provision and the nature and duration of health professional education are all political and policy 'grist to the mill.'

However, despite the prolonged and intense interest of government and policy makers, the health sector continues to present with multiple and seemingly intractable challenges and problems. Despite frequent claims of 'inclusiveness' and 'transparency,' many large organisations such as hospitals and health care services are notoriously unwilling to discuss or even acknowledge faults in their systems and even the most well meaning of due processes are relatively easy to corrupt if the intention behind actions is less than honourable. Organisational problems and deficiencies can easily fester and metastasise under cloaks of 'confidentiality,' spurious reliance on 'privacy regulations' and managerial demands that all staff be 'on message' to the extent that any kind of questioning or expressed concern can be perceived as being tantamount to disloyalty (Darbyshire 2008). Such attempts to ignore or silence professional or patient concerns have been regularly highlighted in the numerous inquiries and investigations into health care and health care service provision, and in their often damning reports, see e.g. (Kennedy 2001, Thomas 2007, The Patients Association 2009, Francis 2010).

A plethora of evidence in the form of first person patient and relative reports, investigative reports, media exposes and varying levels of research evidence indicates that all is not well in health sectors across the world. Indeed, rather than being sanctuaries, hospitals are paradoxically dangerous places, and concern is growing that our hospitals may be failing in their core function as places of healing and care for patients and families. The 'hospital scandal' is now almost a staple media item in many countries that would normally wish to pride themselves in the quality of their health systems. From Bristol to Bundaberg, the stories have become almost a predictable refrain with equally familiar findings and recommendations emerging from seemingly endless reports. Ironically, such reports of personal and system failures are emerging at a time in health care when we have never relied so heavily on documentation, written policies, audits and other procedures. And yet, the responses in and to such inquiries are often another call for, inevitably, even greater documentation, recording, monitoring and audit. Truly, 'when the only tool you have is a hammer, everything looks like a nail.'

The 'usual suspects' identified in such inquiries and reports include the following: poor communications, lax or dysfunctional systems, cultures of fear and intimidation, managerial failure to listen and respond to clinicians' concerns, myopic focus on today's 'topical' priority or target, tokenistic concern for patients' and families' experiences and the belief that has become something of an article of faith in every documentation-driven organisational culture; that having a process, policy or document equates with having addressed a problem. As Robert Francis observed in his report into the Mid Staffordshire NHS Trust:

> I was left with the distinct impression that this witness (a Director of Nursing) equated a committee structure and policies with an effective system. (Francis 2010, p. 245)

This may seem obvious, but simply 'having a system,' or a form for this and that, or a committee somewhere with 'quality' in their title, or a policy insisting that 'Staff must…' is inadequate in the absence of a positive and healthy organisational climate, a continuous evaluation of the effectiveness of the system and a willingness to adapt and change course when necessary. Likewise, the answer to a panoply of paperwork that does not work is not to introduce more of the same. The rise and rise of what has been called 'the audit society' (Power 1997) has fostered an over-reliance on documenting as a solution to the many complex challenges facing health care and service provision. While a profusion of policies, audit tools and compliance checklists may provide an illusion of assurance, there is a high price to pay for such 'documentation hysteria' (Furåker 2009, p. 276).

There is limited time in the day, and evidence suggests that the demands of increasing documentation may have acted to reduce the amount of contact

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between patients and nurses (Lundgren & Segesten 2001, Furåker 2009). In a Swedish study, which echoed findings from studies in other countries, Furåker (2009) found that 'nurses generally spend 38% of their working time with patients (nursing) and the remaining time on other activities.' (p. 269). This in itself is an enormous concern, as one common theme that arises from the many reports about health care and specifically nursing care is the need for nurses to 'be with' patients, that is spending time observing, interacting, and carrying out direct care [see e.g.: the Releasing time to Care initiatives in the United Kingdom and New Zealand (http://www.institute.nhs.uk/quality_and_value/productivity_series/productive_ward.html and http://www.scoop.co.nz/stories/GE0811/S00032.htm, accessed 20 May 2010)].

Despite the demands of documentation, the truth is that statistics, spreadsheets and other numerical information generated from audit and quality assessments will provide only an incomplete and partial account of a problem, albeit one with a seductive veneer of certitude and precision. The danger here is that pages of numbers can be mistaken for a clinical or service reality that may not actually exist. Vital parts of the 'big picture' are lost, and some problems and issues are rendered almost completely invisible if the more human and narrative dimensions of health care provision are overlooked, trivialised, rendered invisible or simply lost because they cannot be recorded via a checklist. Furthermore, audit tools can effectively mitigate and obscure human elements, and even the best audit appraisal tool will only work as well as the person using it.

We do *not* suggest, of course, that all documentation and audit is pointless and should be abandoned. There is an absolute imperative in nursing and health care to document accurately and to count and measure that which can be meaningfully counted and measured, so clearly, audit and scrutiny have a valid place in health care. Used well, they can identify problems and issues at an early stage and be a trigger for action and improvement. They are not, however, foolproof and cannot be relied on as the only (or we argue, even the preferred) response to rectifying problems. Documentary audits are vulnerable to inaccuracy and falsification and as with any instrument, audit tools restrict the information that can be captured and provide a series of predetermined options that can render some phenomenon invisible.

A telling case in point is the UK's Francis Report (Francis 2010). The Mid Staffordshire NHS Trust executive had access to regular and copious spreadsheets and audit-based data about patient safety and experience, yet the executive and board expressed shock and surprise, claiming to have no idea of the serious failings in care that were happening until 'real' patient stories were personally presented to them by family members whose relatives had experienced substandard care (p. 183, 314). The report raises a metaphorical eyebrow at the 'astonishing apparent recovery' (p. 367) that (according to 'Dr Foster' data) placed the Trust in the 'top 14 hospitals for safety' (p. 367) at the same time that Francis was conducting his forensically critical inquiry. Yet again, Robert Francis 'cut to the chase', reminding us that 'monitoring and figures may provide some corroboration for standards of care but are no substitute for knowing about the actual quality of care delivered.' (p. 367).

Therefore, we are back to the human element which should, of course, have been our starting point and all points in between. Ultimately, the provision of effective health care is dependent on people and on the positive therapeutic and collegial human relationships that occur between people as patients, as health care providers, as relatives and carers and as colleagues. Any service that loses sight of the centrality of human relationships and experiences and put all their eggs in the one audit and documentation basket is courting disaster.

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