Our main business is not to see what lies dimly at a distance, but to do what lies clearly at hand.

Sir William Osler.

The importance of culture.

Culture is not the business we do, but the way we do business. Island Health provides medical and other treatment services to the people of Vancouver Island. This discussion paper does not address any questions about whether the services we are providing are appropriate, and have good outcomes or not. Rather, a discussion of culture reflects on our attitudes and morale in the workforce, focussing on the how rather than the what we do.

While these statements oversimplify matters, there is good literature to suggest that a well-informed culture with clear and well accepted goals, delivered in a respectful, fair and transparent manner improves both efficiency and effectiveness in healthcare.[1] The Mayo Clinic [2],[3],[4],[5] [6],[7]the Cleveland Clinic[8], Intermountain Health[9], Virginia-Mason[10] all deliver medical services, just as we do. While they operate in a different financial environment, within that environment they are respected not just for what they do, but the way they do it. They clearly aspire to excellent care for everybody who enters their doors, but they do not stop there: in providing that excellent care – the outcome – they emphasise corporate belief systems: ideas about putting patients first, or safety first, and then diligently using those lenses in how they organise the care delivery model. How they do it is as important to them as what they do. They believe that while a supportive culture is not, by itself, enough to produce good results, optimum results will not occur in the absence of an appropriate and supportive culture.

This is further supported by the single meta-analysis that I could find, by Braithwaite et al, who concluded:

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[1]Caldwell C, Butler G, Poston N. Cost Reduction in Health SystemsL Lessons from an Analysis of $200 Million Saved by Top-Performing Organizations. Front. Health Serv.Managment 27(2) 3-17

[2] Berry LL, Seltman KD. The Enduring Culture of the Mayo Clinic. Mayo Clin Proc 2014:89(2) 144-147

[3] Bohmer RMJ. Fixing Health Care on the Front Lines HBR 2010 63-69

[4] Patient-Centered Leadership. Rediscovering our purpose. The King's Fund: 2013

[5] Reinertsen JL, BisognanoM, Pugh MD. Seven Leadership Leverage Points for Organization-Level Improvement in Health Care. (Second Edition). Institute for Healthcare Improvement. 2008

[6] Swensen SJ, Dilling JA Milliner DS et al: Quality: The Mayo Clinic Approach. Am. J. Medical Quality 2009 24: 428-440

[7] Shanafelt TD, Noseworthy JH. Executive Leadership and Physician Well-being: Nine Organizational Strategies to Promote Engagement and Reduce Burnout. May Clin Proc 2017: 92(1)129-146

[8] Bohmer op. cit.

[9] Clark DD, Savitz LA, Pingree SB: Cost Cutting in Health Systems Without Compromising Quality Care. Front. Health Serv. Management 27(2) 19-30

[10] Kenney C. Transforming Health Care. The Virginia Mason Medical Center Story. Productivity Press 2011

> *"…organizational and workplace cultures were correlated with patient outcomes in over 90% of studies…patient mortality rates were nearly 48% lower in hospitals with better work environments, and surgical mortality rates were >60%higher in hospitals with poor work environments."*[11]

Any organization dedicated to patient care cannot ignore such data.

The challenge of defensiveness.

Because "culture" is the result of the interplay of all of us, any discussion of cultural problems, and what to do about them can provoke defensiveness and denial of responsibility on the part of all participants. This must be overcome. Fixing a problem first requires recognition that there is a problem, followed by identification of the pathogenic processes and a plan for their reversal. So it is with organizations and their culture.

Is there a problem?

The current culture amongst the medical and clinical staff of Island Health has been identified as poor and unsupportive of good care processes. Island Health is not alone: in the same time frame, the CEO of Vancouver Coastal was hosting town hall meetings to address similar issues. This is Interesting but irrelevant: our culture is our creature, and our responsibility.

Although most attention has been focussed on the Vector Report which related to NRGH at a time of crisis, identical concerns are reflected in three others: the Ernst & Young report, the 2017 Staff Engagement and Safety Survey, and in a simpler, more local one at the ground level in MHSU in Victoria. Island-wide all show extreme feelings of disengagement and lack of psychological safety. Where the questions are asked, a significant majority of current staff saying that they would not recommend their workplace to friends and family, Vector going further to say that they would recommend seeking medical care elsewhere.

The question is not whether we are doing good work: the problem is that clinicians do not perceive their workplace as providing the best that it should be and are frustrated.

Pathogenesis: Development and Continuation of culture.

In any culture, functional or dysfunctional, the processes which foster its development may be different from those which then maintain it. Island Health has had almost continuous change in administrative structures or personnel in the last decade. There have been significant senior executive changes every three years, extensive re-organizations of administrative structures, and personnel changes, permanent or temporary, within many positions.

This means that many current incumbents may validly deny responsibility for the current culture. Yet medical and clinical staff and likely patients have suffered harm; some clinicians have been disciplined in

[11] Braithwaite J, Herkes J, Ludlow K et al: Association between organizational and workplace cultures, and patient outcomes: systemic review. BMJ Open 2017;7:e017708: doi:10.1136/bmjopen-2017-017708

a public manner, many others report being threatened. Successful reconciliation processes throughout the world start the healing process with a public acknowledgement of the part that past behaviours played. This public acceptance of accountability, coupled with visible steps to rectify the wrongs allows those who have been victimized by the system to accept the idea by that, to reform the current, dysfunctional, system past hurts must be set aside and all parties must work together.

Ernst and Young identified this administrative problem in their commentary:

> *"medical and organizational governance was in a state of flux",*
>
> *"key Health Authority medical and clinical governance functions, roles and structures were missing, unfilled, or ineffective"* [12]

Some of these traits undoubtedly were known before this. Many of the changes sought to address this – to have greater physician input into the organization and management of programs of care, to make the programs more responsive and appropriate. Island Health markedly increased the budget for this work, again showing good intent. It was the implementation that was chaotic. The change was revolutionary rather than evolutionary, and it seemed like many of the new managers came to their tasks with little to no guidance or on-boarding supports. They had to learn on the job. Although this may not be the responsibility of the current incumbents, for, as Dr. Etherington said to me, he arrived on the job the day after the new structures were put into place, neither was it the responsibility of the medical and clinical staff on the ground. Clinicians deserved better from the organization.

Accountability is different from responsibility. Even accepting as valid the claims of lack of responsibility for the development of this culture of estrangement, it is important for senior management to acknowledge the veracity of the criticisms as a step for the organization to be accountable and to accept responsibility to ensure that similar situations do not happen again.

The Vector Report made headlines. The real tragedy lies not the headlines, but rather that the reason for the headlines – the culture in Nanaimo – had apparently had been either missed or ignored by the senior executive and Board for so long. When the level of distress of the medical staff is such that they feel driven to appeal outside the organization for support, to open themselves up to disciplinary action, and subsequently find their concerns supported by external reviewers, the senior managerial processes cannot evade accountability for failing to notice and respond. Bazerman, the co-director of the Harvard Kennedy School's Center for Public Leadership puts it thus:

> *"It is the responsibility of leaders to notice when things are going seriously wrong in their organizations… Leadership comes with responsibilities. A critical one is noticing the outlying evidence.. it is the job of leaders to identify what information is needed and how to obtain that information, rather than acting on the information that is in the room."* [13]

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[12] Ernst & Young: Ministry of Health. Review of Island Health's iHealth Electronic Health Record System. 2017

[13] Bazerman, Max: The Power of Noticing: What the Best Leaders See. Simon & Schuster, 2015.

Saying this should not be seen as setting up an "us vs. them" dyad. HAMAC and the medical staff leadership also must look to its own role:

> *"Stakeholders reported that HAMAC was not appropriately involved in key clinical decisions at the time and in some cases was not playing a strong enough advisory role".*[14]

Similarly, the Medical Staff Rules charge Department Heads with not just quality improvement but also supporting the medical staff

> *"through specific activities and plans to promote the wellbeing of Members".*[15]

Even before the current medical leader structures, Department Heads, Chiefs of Staff, Chairs of local MACs and senior physicians generally had a responsibility to address it more forthrightly than done. As a result,

> *"..the lack of effectiveness of board, HAMAC and local medical governance processes may have contributed to the MSA becoming the vehicle to fill some of the void".*[16]

These failures did not serve the organization, the clinicians or the patients well.

The development and maintenance of our culture is not the domain of administrators or medical leaders alone. Individual members of the medical and clinical staff influence culture on a day-to-day basis. Intra- and inter-professional collegiality is challenging when faced with the pressures of bed occupancy soaring over 100%. It is reported that, as part of an informal onboarding process, young staff members or nurses, particularly those working as hospitalists or in the ER are either advised or quickly learn which physicians to avoid calling at night. Bullying and bad behaviour can occur at all levels, both intra-and inter-specialty. Culture – the way we do things – allowed Island Health to have a large number of uncompleted charts, and to have to spend significant resources in rectifying the situation. There may be many reasons or excuses offered, as there is for all sorts of behaviour. Usually there is some valid reason to start the stories: if it takes many weeks for dictated records to be typed, why worry about doing it in a timely manner? The new behaviour then becomes "the way we do business" until it is called out. If you let it go, the behaviour you tolerate becomes the new standard. Subsequently, asking the perpetrator to change is resisted and accompanied by outrage and negative stories. Not asking the perpetrator to change promotes disillusionment, cynicism, apathy and learned helplessness in those who are behaving well. Either way, stories will be told.

The plural of anecdote is not data: the plural of anecdote is culture. Culture is not separate from our selves: it is our shared values. We all know and tell anecdotes.

Approaches to rectification.

[14] Ernst & Young: op cit.
[15] Medical Staff Bylaws for the Vancouver Island Health Authority, 2018.
[16] Ernst & Young, op. cit.

Unfortunately, reading the medical literature gives no guidance about how to change organizational cultures. Certainly there are administrative texts which outline processes that can be used in a hierarchical organization. In contrast, healthcare is a "professional bureaucracy", wherein the workers generally have the same level of knowledge and capability of the work done as most of the leaders.[17] [18] [19]

> "*Workers in professional bureaucracies are already 'empowered' (by their professional affiliation) and do not necessarily need to be so by their leaders. Among such skilled and independent workers, a leader's status depends on their perceived competence in the professional domain."* [20]

Our professional organization requires a different approach. We jointly have to rewrite our stories.

What we can get from the literature are descriptions of the behavioural differences (not what is said) between high-performing and low-performing organizations in both the US and the UK. By considering how these behaviours differ from our Island Health processes might allow us to develop our own pathway to change.

1. Recognize and accept the problem.

Noticing – identifying - the problem is the first necessary step. When bad news is first presented, the initial reaction involves denial as a defence mechanism. "It's not so bad". "It's a Nanaimo problem." "It's an iHealth problem". "We're no worse than XXX".

The literature is clear. All these attitudes, but especially the last, are characteristic of low-performing organizations.[21] High performing systems do not compare themselves to others: they constantly strive to be better.

It is essential to be abundantly clear about where we are. The system is now working perfectly to produce the outcomes we now get, so to change the outcome we must change the system. For this to happen, the first requirement is an evaluation that is

> *"brutally realistic and not unduly rosy-eyed about the real work at hand .*[22]

Virginia Mason annually celebrates "Mary McClinton" Day on November 23. This was the day on which, in 2004, Mrs. McClinton died due to a preventable medical error. It promptly disclosed this fact, set aside its dozen or so organizational goals to focus on one only: to ensure the safety of patients through the elimination of avoidable death and injury.

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[17] Mintzberg H. Power in and around organizations. 1983
[18] ' Sullivan H, McKimm J. Medical leadership: an international perspective. Brit. J Hosp. Med. 2011, 72, 638-641
[19] Ham C. Doctors in leadership: learning from international experience. Intl J Clinical Leadership 2008. 16, 11-16
[20] Bohmer R. Op. cit.
[21] Caldwell et al: op. cit.
[22] ibid

"Our board said that if we cannot ensure the safety of our patients we shouldn't be in business."[23]

That was blunt and clear.

2. Recognise the role of leadership.

High-performing organizations have leadership which focuses intently on the primary mission of the organization: to serve patients while constantly increasing safety and quality. One careful (and representative) review, investigating organizations chosen for their performance on a variety of comparators, and focusing on behaviors observed within the organization (rather than what the organizations said) identified five themes: a shared sense of purpose; leadership style; an accountability system for safety, quality and service; focusing on results, and collaboration. [24]

Leaders of the top performers were clear that patient care was the first amongst the missions of patient care, teaching and research in their organizations. They had a strong sense of dissatisfaction with the current state of quality and safety in their institutions, and instead of focusing on comparisons to peer groups, dwelt on gaps between the reality they saw and the ideal state.

In contrast, the lower-functioning sites were typically satisfied with their current state, often pointing to external awards and recognition. They ignored signals they did not wish to see. They regard quality and safety as part of the right thing to do, rather than a requirement for the strategic survival of the institution.

In top-performing organizations, the CEO was passionate about improvements in quality, safety and service and had an authentic, hands-on style. Staff had many personal encounters with the CEO, who also had frequent visits to, or unscheduled "walk-arounds" of the clinical areas. There was a strong alliance between department chairs and the executive leadership, which contrasted with less well performing organizations which had less clarity at the leadership level. Senior executives were rarely seen in patient care areas.

As Kenney states in his book, you cannot produce such change from inside an office.[25] Leadership is necessary – we can't all be thinking about culture all the time. Writing emails, memos or policies, or holding meetings, is neither management nor leadership. While these are sometimes necessary, they do not replace active engagement.

3. Recognise that change cannot come from leadership alone.

While leadership has many responsibilities, culture comes from all of us. Traditionally, physicians have seen themselves as independent professionals. Yet, in the context of Island Health, they become part of

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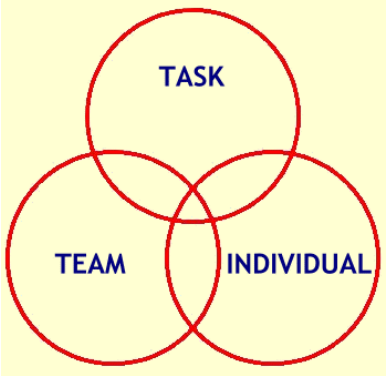
[23] Virginia Mason Institute. Terrible tragedy – and Powerful Legacy – of Preventable Death. https://www.virginiamasoninstitute.org/2014/03/terrible-tragedy-and-powerful-legacy-of-preventable-death/

[24] Keroack MA, Youngberg BJ et al.:

[25] Kenney, Charles. Transforming Health Care: Virginia Mason Medical Centre's Pursuit of the Perfect Patient Experience.

an organized system. Most recognize that, in accepting privileges, they are becoming part of a team. However, just saying that one is part of a team does not make it so.



Adair points out that effective leaders pay attention to three areas of need in successful teams: the task, the team itself and also the ambitions of the individual team members. While at any time the emphasis on each circle may vary, all are interdependent, and so the leader must watch all three.[26] Team functioning merits attention equal to that of goal setting, a comment that is also reflected in the statements from Mayo, Virginia Mason and other high-functioning healthcare organizations who readily admit that they pay great attention to whether the individual will accept their underlying cultural ethos prior to hiring as well as during their frequent evaluations.

Sense can be made of the crisis in Nanaimo if it is considered as the development of an imbalance between these various factors.

This attitudinal change from a separate, totally independently functioning professional to a member of a team of professionals underpins much modern quality improvement. Improving processes and thereby patient care requires that they be done first in a standardized fashion that is agreed to by the group of clinicians, then with the outcomes measured and a clinical discussion then ensuing about changes to be made.[27] Properly done, this change complements the concepts of professional autonomy, the freedom of physicians to exercise professional judgement in the care and treatment of their patients. [28] By this process, physicians can have greater confidence that the treatment offered the patient is well-founded in modern medical science, yet they retain the authority to vary from this when necessary for patient-specific reasons.

This process also allows contrasts to be drawn where the services delivered vary from what evidence suggests should be delivered, thus asking important questions for the organization: is the program delivering what the evidence says we should be delivering? If not, why not? Is it a function of the individual practitioner, or a failing of the way the program is organized? If, for example, the evidence

[26] Adair John: Effective Leadership Masterclass. 1997
[27] James, BC. Implementing Practice guidelines through Clinical Quality Improvement. Frontiers of health services management 10, 3-37
[28] Doctors of BC. Professional Autonomy. Policy statement, 2017 https://www.doctorsofbc.ca/policy-statements/doctors-and-professional-autonomy

identifies better outcomes if fractured hips in patients over the age of 70 are treated within XX hours, but the program treats in XX +36 hours, questions must be asked. This process of asking the question, getting the data and developing a solution will, in itself, improve team functioning and morale.

Change requires thoughtful leadership, but culture change cannot come from leadership alone. Appointing physicians to "leadership" roles, while necessary, cannot be a substitute for broader medical engagement.

> *"Importantly, all organizations emphasized that engagement efforts should be proactive and persistent and should be extended to the entire medical workforce, not just those in designated leadership roles."* [29]

4. Address the need for psychological safety.

This theme is present in all the results reviewed. When people are afraid to speak out, bad things happen. It will be a real challenge for administrative colleagues to address. If your manager has bullied you, or dis-respected your opinion, how can you work with him or her to change the culture? If you fear to go alone into the manager's office, how can you speak openly in meetings?

The consequences of not addressing it directly can be great. Such cultural fear, such silence in the face of administrative drive to impress was, at its extreme, a major contributor to the Mid-Staffordshire crisis in the UK.[30] Indeed, many of the concerns expressed in the Francis Report[31] parallel those of Vector. Many of the recommendations would be applicable here.

This is a must-fix.

5. Address the separate but complimentary roles of clinical and administrative knowledge.

In 2007, Don Berwick wrote:

> *"It is remarkable, and sad, that a large proportion of healthcare professionals today – maybe a majority – would likely describe the environment of their work in terms that bespeak alienation. They might call themselves "battered," "pressured," "hassled," and, deeply, "misunderstood." I do not think they would generally say that about their clinical work; these are not their feelings about their relationships with patients – their experience of trying to help and to heal. These are the feelings about those who set in place the conditions of their work – the rulemakers, the paymasters, and to some extent the institutional executives.*
>
> *It is also remarkable, and sad, that those who shape the environment – the rulemakers, the paymasters, and many executives – feel no less pressured than the clinicians do. I believe that many of them feel hassled by their own sense of ineffectiveness. They have hard jobs, involving the navigation of a no-man's-land of goals while also guarding limited resources and pursuing*

[29] Atkinson A, Spurgeon P, Clark J, Armit K. Engaging Doctors: What can we learn from trusts with high levels of medial engagement? NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges 2011
[30] National Advisory Group on the Safety of Patients in England. A promise to learn – a commitment to act. 2013
[31] Francis R. Reprot of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive Summary. 2013.

the great ambitions of modern medicine. They are the stewards of possibility, and they seem to me perplexed that the clinical forces so often misunderstand them." [32]

Organizations which reduce this clinician/administrator split have done so by focusing on the clinical microsystem, the team that actually delivers care to the patient, and focusing on what makes this system work, how to make it better, and how to reduce any impediments.

To achieve this, and to change from an organization of clinically average performance to one of clinically high-performance, the Institute for Healthcare Improvement lists the first element as a "mind shift":

> *"a mind shift on the part of hospital administrators. It suggests that the question we have been asking – "how can we engage physicians in the **hospital's** quality agenda?" – could also be rephrased as "How can the hospital engage in the **physicians'** quality agenda?" This question forces hospital administrators to recognize that physicians **are** interested in quality – in particular, two attributes of quality: patient outcomes and personal waste, especially wasted time. Interestingly, these two quality concerns of physicians – outcomes in time – are not independent variables. They are strongly linked."*[33] (emphasis in original).

Island Health acted to address this by the reorganization of medical administration. For this, our Board and administration warrant our respect. Such changes, even administrative ones, should be subject to the PDSA cycle, the outcome reviewed and corrective action taken where necessary. No change is promoted with the intention of making matters worse; all are thought likely to improve. It can be very difficult for the change developers to step back and, with humility, recognise that the results were not those hoped for. This requires openness and honesty in a culture of psychological safety and respect for the reasoned contributions of others.

In their evaluation of the Nanaimo crisis, the consultants noted that

> *"medical and organizational governance was in a state of flux"*

> *"key Health Authority medical and clinical governance functions, roles and structures were missing, unfilled, or ineffective"*

resulting in a

> *"broad lack of confidence in the ability of providers, clinicians, administrators, managers, and leadership to deliver an effective solution."*[34]

Clinical managers must bring clinical content knowledge to the organizational table. Non-clinical managers must bring administrative knowledge to the organizational table. The combining of these two streams of knowledge to address the needs of the various clinical microsystems is the raison d'être of the organization. The two are not interchangeable, and muddling the roles creates confusion. Promoting clinicians into administrative roles on the basis of good clinical practice may not be successful. While the

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[32] Berwick, Donald M. in Nelson, EC Batalden PB Godfrey MM: Quality by Design 2007 Jossey-Bass, San Francisco
[33] Reinertsen, JT, Gosfield AG et al. Engaging Physicians in a Shared Quality Agenda. IHI Innovation Series white paper. Cambridge, Mass: Institute for Healthcare Improvements 2007
[34] Ernst & Young. Op. cit.

CEO of Mayo, Virginia Mason, the Ottawa Hospital are all physicians, and promote a culture of focusing on the clinical microsystem, they recognize the need for strong and supportive managerial processes. Similarly, high-performing organizations with administrative CEOs ensure respect and attention to strong clinical direction. Not respecting these two separate themes leads to confusion and poorer outcomes.

Examples of this confusion include comments regarding the role of the medical Department in quality assurance and quality improvement. The Bylaws charge the medical staff organization to be accountable for the quality of medical care provided in our programs and facilities. To do this, physicians are organized into departments, and must participate in departmental functions. The Department, in turn, must report to HAMAC.

It has been said that the only role of the Department is to credential and supervise the individual departmental members. This very restrictive definition of medical care causes confusion at the boundaries of what is a departmental role versus a program role. Departments are the repository of the clinical knowledge of the medical staff, and are required to say to the Board what are the standards of good medical care. Translating those standards into practical operation then becomes the responsibility of the program managers.

To return to my previous example of fractured hips: it is the role of the Department to say who is, or is not, qualified to operate on the fracture. It is the role of the Department to say what standards should be applied to the clinical condition: when should surgical interventions be considered, when not? What are the recommended timelines from admission to surgery? The program then ensures that the patient care processes support and respond to those standards effectively and efficiently.

Without senior, knowledgeable clinical input the program will not deliver the results required; without senior, knowledgeable administrative input the patient will not receive the care necessary. Effectiveness and efficiency are two separate questions. Both overlap, both must be addressed, and both must be reported upon. Confusion over roles, or a failure of one, leads to the medical and clinical governance problems identified by Ernst & Young.

6. Address the need for open sharing of data.

Developing efficiency and effectiveness requires the identification and sharing of information to provide the necessary feedback loops. Data must address both successes and problems.

This requirement for clear and easily understandable results carries challenges. Although the Canadian healthcare system is labelled as publicly administered, the reality is that it is politically administered. The Board is appointed by the Minister. The Board changes with a change of government, receives an annual mandate letter from the Ministry, has to develop a work plan on priorities established by the Ministry, and report back on these. The current Mandate Letter from the Minister to the Board lists 42 priorities for this year! Many are aspirational statements; some are reflective of the recent challenges. It was helpful for physicians to have someone beyond administration to be able to reach out to when problems could not otherwise be sorted out. This is reflected in the Mandate Letter, which instructs strengthening

relationships between health authorities and physicians, improving medical staff engagement, making sure that their views are more effectively represented, etc.

Unfortunately, a political culture seeks "no bad news", at least for the Government in power. This reduces the drive to celebrate the identification and correction of mistakes and errors. This challenge is one of positive and negative cultures.[35] People living in negative cultures fear to make errors, and if one does occur, they do everything to hide it. Such a culture has little chance to learn from errors and to discover new opportunities. On the other end of the spectrum are positive cultures that make errors transparent, encourage good errors and learn from bad errors to create a safer environment.

Gigerenzer offers two examples of opposing error cultures: commercial aviation and medicine. The culture of the former is a positive one, and the reason why flying has become so safe. Pilots learn from one another, discuss errors, and, although safety is already extremely high, efforts are made to further reduce the number of accidents. He believes that nothing like this exists in hospitals. The culture of medical organizations is largely negative, dominated by defensiveness, critical incident reporting is haphazard or rare, and national systems of reporting on learning from serious errors, as happens in aviation, rarely exist. The result is that patient safety in hospitals – unlike passenger safety in planes – is a major problem.

The Board and senior Executive have the challenge of balancing these two approaches: politicians who would rather minimise problems when they are in charge, and clinicians who need the information for improvement.

As clinicians, we may support Virginia Mason's celebration of the death of Mrs. McClinton. It's open acknowledgement served as the springboard to a culture of patient safety. The Mayo Clinic has a similar policy of openness and transparency.

> *"When a serious adverse event occurs in 1 of our 22 hospitals across 5 states, within a period of hours all relevant colleagues know of its occurrence. Transparency serves as the key to engage our top leaders and all members of the staff; it serves as a "wake-up call" when we fail to provide "the best care to every patient every day," accelerating and intensifying our efforts."*[36]

Dilbert offers the opposing approach:

[35] Gigerenzer G. Risk Savvy. How to make Good Decisions. 2014

[36] Swensen et al: Quality: The Mayo Clinic Approach. Am J of Med. Quality 2009 24:428

As Gawande says, we will falter in our endeavours:

> *"No matter what measures are taken, doctors will sometimes falter, and it isn't reasonable to ask that we achieve perfection. What is reasonable is to ask that we never cease to aim for it…. Better is possible. It does not take genius. It takes diligence. It takes moral clarity. It takes ingenuity. And above all, it takes a willingness to try."*[37]

Admitting this, working diligently to rectify it is our organization's task. Doing this in a culture that does not wish to talk about failure is a great challenge.

7. Address the role of HAMAC.

As the senior medical committee, tasked with providing advice directly to the Board, HAMAC should play an important role in the medical governance of the organization.

This is not the first time that it has been challenged. A 2010 review described the then HAMAC as being focused

> *"more on credentials, disciplinary issues and bylaws revisions -- with little on quality".* [38]

Although changes have been made, the external reviewers suggest that it still does not properly fulfil its function. Members must question themselves about this critique, and develop an action plan to rectify it.

Has the reduction in Departmental numbers reduced content expertise at this level?

As the senior medical committee, how much time annually is spent considering matters of quality of care?

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[37] Gawande A: Better: A Surgeon's Notes on Performance. 2010.

[38] Murray AM, Baker GR, Denis JL et al.: Effective Governance for Quality and Patient Safety in Canadian Healthcare Organizations. January 2010 Canadian Health Services Research Foundation.

Is it possible for HAMAC to complete its supervisory and advisory tasks meeting for 1.5 hours every two months?

Are all of the subcommittees necessary and performing well? Some have not formally met for over a year. This suggests that either they are not necessary, or they do not have the appropriate personnel assigned.

Are there medical governance tasks relating to patient quality and safety which are not being addressed through the current HAMAC processes, as suggested in the Vector and Ernst & Young reports?

Final comment.

It would be easy to identify problems with administration, with medical-staff-as-a-group culture and suggest that "they" should do something about it. Unfortunately, culture is all of us, HAMAC included: the stories we tell, the way we behave. If we are to build a culture of responsibility and accountability, of patient safety and high-quality care, then we must all of us look at inward as well as outward.

Improving engagement, culture, performance and patient care will always require change. The necessary changes cannot be made without us, but cannot be made by us alone. Everyone must contribute, or we will all fail at our calling. Such a future is not acceptable.