Quality of care:
clinical governance and pathways

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Australia is fortunate to have medical clinicians with the scientific rigour, ethical drive, and enthusiasm exemplified by Stephen Bolsin. This said, we are not comfortable that these attributes are enough to ensure the cultural resistance to progress is overcome as rapidly as we would want it to be. This commentary will outline the main reasons for our discomfort.

On first reading, Stephen Bolsin's editorial presents an encouraging and optimistic view of the way in which medical clinicians see their future roles and responsibilities regarding maintaining standards in Australian health care (Bolsin 2001). Referring to the Bristol case (Bolsin 1999; Hindle 1998), Bolsin says that past lapses provide "unequivocal guidance to doctors in both clinical and managerial positions". Thus the judgements made and the guidelines proposed in the aftermath of the Bristol scandal (reflected in part in local concerns with quality, risk, safety and benchmarking) require that clinicians respond in "a professional manner", which includes providing "appropriate care for the sick".

But what is appropriate and where do we find the criteria? In answering this question, Bolsin makes reference to the situation in Australia, where criteria have been framed under the banner 'clinical governance'. However, Bolsin says the responsibility for clinical governance rests at Area Board level in NSW. This locus of responsibility appears to be reason to refrain from elaborating any further on those principles or on what they might or should mean for (medical) clinicians. One might be inclined to wonder at this point whether Bolsin's paper suggests that principles formulated by policy makers are necessarily of limited relevance for those at the clinical coalface. We will return to this question in a moment.

In noting that responsibility for clinical governance rests at the Area Board level in New South Wales, he says that "… the accountability of the Board at this level is both to the community and the Government for the services provided by all staff employed by the service (but) the High Court of Australia has placed a *higher standard on medical practitioners*" (Bolsin 2001, my emphasis).

Is Bolsin suggesting that the accountabilities that are embodied in the relationships among Area Boards, communities and the medical fraternity (and which are crystallised into the notion clinical governance) do not rate as highly as do the High Court's pronouncements? For Bolsin, too, it is these elevated legal pronouncements which "require a cultural change in the attitudes of the medical profession". This logic rates Chappel v Hart (1998) higher than accountability to policy makers and the public. More balefully, it sees legal cases as providing better guidance as to why and how to change medical culture than, for example, the application within clinical work settings of principles such as 'responsible autonomy' and cross-disciplinary transparent accountability'.

What happens when our views of the future do not proceed from a workplace focus is well illustrated in Bolsin's treatment of data generation and application. While Bolsin is explicit about the centrality of performance data to ensuring optimal patient outcomes and maximum patient safety, he is silent about how connections between performance data and patient outcomes and safety might be brought off. Performance data collection, Bolsin informs us, "… leads to documented performance measures (and) facilitates adverse outcomes reporting". While that is all very interesting, the question remains: what are the steps that need to be taken (and who decides these steps are to be taken) to get from adverse outcomes to more positive outcomes? Put more directly, what

mechanisms are required to be put in place within clinical settings (additional to data collection and data analysis) to ensure that conclusions drawn from the data gathered are acted on?

Bolsin's silence on these issues together with the weight he gives to recourse to law suggests that in his view the appropriateness of care is something which cannot be determined *proactively* (using available research and data to map out what constitutes good care), but only *retrospectively* (in response to crisis and disaster). All this points to the absence within Bolsin's account of insights on the practical and simultaneous interconnections between clinical work performance, data collection, data analysis, and changes in practice. What is important here is that the more that task performance and data collection about these tasks are separated in time, space and agency, the more game-able, irrelevant, hierarchical and contestable they will be perceived by those who are subject to them.

An overwhelming lesson from Bristol is the limitation of peer review. Equally, while increased managerial supervision, more frequent monitoring and improved information technological support have all been cited or even imposed as solutions, none of these have been able to deliver on their promises. Neither has the dissemination of findings of the Cochrane kind ensured their incorporation into evidence-based clinical practice. Again, clinical practice information means little if such data are not an integral part of both clinical practice and of its review by those immediately involved.

In contrast, clinical data can be construed as resulting from what *clinicians themselves* decide counts as usable information on grounds of how adequately it enables them to represent, review and revise their clinical work. In this scenario, both the act of data collection and the data that is collected are far removed from that which characterises 'at a distance' bureaucratic surveillance, or, for that matter, disinterested science. It is at the interstice of clinician-generated data and practice review on the basis of that data that we see the principles of clinical governance as being realised.

In practical terms, what is called for is clinical *self-governance* (Degeling 2000; Bloor and Maynard 1998). Construed in ways that emphasise the centrality of frontline clinicians as both its authors and focus, clinical governance provides means for realising 'responsible autonomy' and 'transparent accountability'. This realisation, however, requires that it be seen not in legalistic accountability terms (as referenced by Bolsin), but as a *mode of communication* which brings together clinicians who have a stake in and are active participants in particular domains of clinical work; that is, doctors, nurses, and allied health, and so on. Second, this communication mode is enacted on the strength of an ethos of respect: all voices are to be heard, and expertise, specialisation and rank do not translate into privilege. Third, this practice is the locus where these people negotiate i) the broad outlines of clinical practice, ii) the prospective costs of that practice, iii) the evidence for that practice, and iv) the benchmarks governing the outcomes and quality of that practice.

This practice of communicating about and reviewing the clinical work in multi-disciplinary groups has been referred to in the literature as 'pathwaying' (Degeling et al 1998; Degeling. et al 2000; Hindle and Degeling 2000 manuscript). Put quite technically, pathways are "… systematically developed written statements of the agreed sequence of diagnostic and therapeutic processes which, in light of available evidence and stated resource constraints, are essential for achieving nominated outcomes for specified clinical conditions" (Hindle and Degeling manuscript: 3).

Whether or not clinicians are able to pathway their practices successfully along these lines is contingent upon four factors. First, fellow clinicians need to recognise the importance of negotiating and agreeing on the broad outlines of their practices as configurations of multi-disciplinary skills and expertise. Second, clinicians need to have access to information systems which are capable of monitoring variation from the pathway with respect to task composition, sequence, resource usage, quality and outcomes. Third, there need to be structures and practices set in place which enable clinicians to evaluate and benchmark their performance over time and come to an agreement over remedial action. Last but not least, management needs to support and respect clinicians' initiative to pathway their clinical practices.

For all these conditions to be satisfied, it is clear that both clinical and managerial expectations about the nature and role of clinical data need to change. It is interesting in this regard that generic and profession-specific devices such as guidelines and protocols have not been perceived to challenge clinicians' expertise and have found a place in most clinical settings.

Multi-disciplinary pathways, by contrast, are often talked about as inappropriate, too reifying, or too intrusive. More particularly, in the eyes of the medical fraternity, pathways unduly simplify the complexity of medical

work; they are detrimental to the artistry of expert judgement, and they impose limits on professionals' autonomy. The view is that pathways could perhaps be useful in a restricted number of settings, but they are certainly not appropriate across the board (Iedema et al in press).

One wonders though whether the opposition to pathways and the arguments mounted against them derive from clinicians' (and managers') own trial and experience, or whether they arise as matters of principle. The intent of pathwaying certainly appears to go against the beliefs, values and attitudes of most clinicians, in so far as that they challenge the routine and professional sub-cultural nature of clinicians' work (Degeling et al 1998). This is perhaps because practice review, within the purview of the clinical pathway, becomes a multi-disciplinary team matter, rather than remaining a mono-professional privilege built on trust and discretion.

Perhaps resistance arises against practice itself having to be grounded in scientific evidence rather than in personal experience alone. Resistance may also arise as a result of clinicians being asked to give rough prospective estimates about the resources required for doing the clinical work, which requires them to be explicit about the criteria used for privileging some treatments, patients, drugs, or technologies over others. Or it may be that the clinical outcomes and quality of the care are now publicly recorded dimensions of clinical treatment, and no longer the preserve of the private consciences of individual practitioners.

Bolsin is undoubtedly right in saying that performance monitoring is a "potentially sensitive project". In comparison, however, conceiving of clinical work in terms of a multi-disciplinary pathway is a radical paradigm shift. It involves making explicit to other clinicians what used to be private, confidential, intuitive, unspeakable, and taken-as-given. It involves changing people's assumptions about how they communicate, about what, with whom and what for. It means convincing people that while some of the descriptors available to map the clinical work may fall short, it is up to them to find better, more workable ones. It also means that we are not merely talking about "trainees in all specialties in Australia", but about clinicians in general. Nothing short of this meets our criteria for responsible autonomy.

Perhaps in spite of himself, Bolsin writes in a way that is emblematic of how medicine at times positions itself in relation to clinical reform initiatives. By denying itself a role in realising mechanisms conceived to ensure better quality, outcomes, effectiveness and efficiency, medicine sets up precisely those conditions which it predicts will scuttle the plan.

In parallel fashion, Bolsin's argument creates its own conditions for failure: undue sensitivity about the scientific accuracy of performance data and about medicine's reception of such data; silence on the relevance of clinical governance to clinical work, and a privileging of medico-legal crisis as a motive for determining clinical appropriateness. The consequence of such stance will be to the detriment of efforts to centre the organisation of clinical care more directly around the perspectives of those immediately involved in treating patients, and it will leave policy authorities with no other option than to pursue proliferation of abstracted accountability systems. Most seriously, this stance is likely to mean that health care policy in acute care delivery will continue to be driven by the distrust and related crisis of confidence that has pervaded the field (Degeling et al 1998).

By failing to consider the communicative potential of clinical governance, Bolsin in effect is contributing to maintaining the status quo, and with that the conditions which are antithetical to the principles of responsible autonomy and multi-disciplinary-based, transparent accountability. Should Bolsin's view prevail, the substantive contributions we envisage for clinical governance, particularly in clinical quality and effectiveness improvement, are likely to be displaced because activity on clinical governance is restricted to what the 'top' does, and clinicians at best enact it in formalistic, ritualised terms. Without providing structures and processes, such as the multi-disciplinary pathway, endorsed by on-the-ground clinicians, notions like performance, quality, and the like will remain as abstract and meaningless as any new managerialist rally cry.

As this comment has sought to argue, no amount of data collection or medical litigation is going to be able to produce better care. Only explicit strategies that set out how the clinical work is to be talked about, carried out, and reviewed will enable clinicians to both determine and strive for clinical appropriateness and provide means for addressing the autonomy and accountability issues that are raised by tragic systems failures, such as that of Bristol.

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