Coming to your TV — the ideal health care professional

> I'm trusting my instincts — sometimes you have to take a chance to save a life.
> *Grey's Anatomy* 26 Sep 2005

Consumer behaviour research confirms the notion of references — "any external influence that provides social cues"[1] (p. 341). These references assist us in forming our attitudes and behaviours and in differentiating what is right from what is wrong. Television acts as a powerful reference, often providing us with idealised images of what life is really like beyond our own narrow existence.

> Among the interns there is always one fool, standing around, trying to show off — and this time that fool is you. Get out.
> *Grey's Anatomy* 12 Dec 2005

Ever since the American soap opera *General Hospital* in the early 80s, health care professionals have been portrayed in a variety of interesting ways on television. In recent months there appears to have been a reawakening of interest in small screen medical dramas and soapies, many created and filmed in the United States. American shows such as *House MD*, *Grey's Anatomy*, *Scrubs*, *ER*, *Strong Medicine* (and Australian versions such as *The Surgeon* and *All Saints*) provide the public with insights (of variable accuracy) into hospital practices. Meanwhile, in the real health system, the US of A has been a leading force in understanding and putting forward solutions to improving quality of care and enhancing patient safety. Recurring themes include the need to develop a non-punitive culture,[2] refocusing the existing "professional prerogatives and separate roles" of health professionals[3] (p. 83) towards a system focus with working styles which support complex team-based care.[4]

> Yes, there is a theoretical capacity for [medical] error — but I cannot make a mistake.
> *House, MD* 2 Nov 2005

Yet the television shows appear to idealise, even romanticise, old-school notions of health care practice. In most shows there is evidence of bullying — bullying of junior staff, of other professionals, and even bullying of patients. There is rarely any disciplinary action for this bullying (or even basic human resource management practices) — is this how the health care system functions?

A surgical consultant to a resident in front of patients and colleagues:

> What incredibly small portion of your brain were you using in there?
> *Grey's Anatomy* 26 Sep 2005

The doctor wearing the "white hat" breaks organisation and system rules to save the patient — usually at the comedic expense of the hapless hospital manager. The manager only cares about the dollars — the noble doctors (in particular) are ethically and morally correct (no matter how many rules they break) because they care about the patient.

> Oh, you people — always with the protocols.
> *House, MD* 2 Nov 2005

The idealised version of hospital life portrayed on television celebrates bad practices within the health care system and some questionable clinical practices as well. For example, when a new medical series *House, MD* debuted in Australia, one of the first things noticed about Dr House (described in the media brief as a maverick anti-social doctor) was that he used his cane in the incorrect hand. Most health professionals would know incorrect use of a cane disrupts basic biomechanics, serves to accentuate a limp and can cause other musculoskeletal problems. Was it his "maverickness" or anti-socialism that caused him to reject basic medical advice?

Despite the years of recommendations for change within the system, most of the television medical shows glorify bullying, endorse finding others to blame and generally destroy the notion

of the need for effective teamwork in providing high quality, safe health care. Is this not a popular confirmation of the entrenched nature of our bad practices and even poorer relations between professions, and between managers and clinicians?

Dr House, after confirming a diagnosis, says to his staff:

> I forget — who said it was nothing?
> *House, MD* 23 Nov 2005

This issue of the Journal explores some of these topics in real life. Glouberman and his colleagues from the Clinamen Collaborative explore some solutions to entrenched health care practices for complex systems. Their message is one of a need for stability (*page 7*). Related workforce papers discuss national case management standards (*page 12*), job sharing in nursing management (*page 17*), the brain drain of doctors from southern Africa (*page 25*), health informatics skills for health professionals (*page 34*), and mentoring in general practice divisions (*page 46*).

Also in this issue, Moorin and colleagues examine private health insurance from a new perspective (*page 73*), Donato and Richardson explore diagnosis-based risk adjustment (*page 83*), Winkler et al discuss the plight of younger people in residential aged care (*page 100*) and Cadilhac and colleagues outline a model to improve access to stroke services (*page 109*). Brown and Bruinsma look at the perspective of women in policy for maternity services in Victoria (*page 56*), and Leggat and colleagues provide a model of priority setting developed in South Australia (*page 65*).

Dr House about a management colleague to his residents:

> Her head is going to explode and I don't want to get it on me.
> *House, MD* 26 Oct 2005

Coming to your desk — but you may need an individual subscription

Speaking of the need to work together across institutionalised barriers, as this issue goes to press, it appears that members of the Australian College of Health Service Executives will no longer receive Australian Health Review as a membership benefit. The College has announced its intention to establish another Australian health management journal for College members.

Discounted individual subscriptions to AHR have been offered to ACHSE members, as well as the option of joining the Australian Healthcare Association. In the interests of the collaboration that is so needed in the health system, we are hopeful that the issues underlying this situation will be resolved and that, come February, the 30th volume of AHR will be in the hands of all our regular subscribers. Regardless, we take the opportunity to record our support for strengthening the relationship between the AHA and the ACHSE, two important peak health bodies in Australia, in these challenging times.

Sandra G Leggat and Judith Dwyer
Editors, Australian Health Review

1 Solomon MR. Consumer behaviour. Englewood Cliffs, NJ: Prentice Hall, 1996.
2 Institute of Medicine. To err is human: building a safer health care system. Washington: National Academy Press, 2000.
3 Institute of Medicine. Crossing the quality chasm. A new health system for the 21st century. Washington: National Academy Press, 2001.
4 Ferlie EB, Shortell SM. Improving the quality of health care in the United Kingdom and the United States: a framework for change. *The Milbank Quarterly* 2001; 79: 281-315. □