



Committing the AMA to quality in Australian health care

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Don Hindle makes some reasonable points in his editorial on what has become a notorious case of breakdown in performance review resulting in unnecessary deaths. The worst aspect of that event was the very long delay between the initial complaint and the commencement of a reasonable process to inquire into the problem. If the Bristol Royal Infirmary had had a satisfactory mechanism to deal with concerns about the performance of individual surgeons, much harm could have been avoided.

I am seeking to make the quality of health care in Australia a major focus of my presidency of the Australian Medical Association. Accountability is at the core of a free profession. I want to focus on the whole health system, not just hospital practice. A key issue is the involvement of the general practitioners in the maintenance and assessment of quality of health care. We lack the resources, the measures, the clinical guidelines, the coding and computer systems but most of all, a government and health community with the will to make something happen. In this respect, I agree with Don Hindle: the problems are wider than medicine – and the weaknesses in medicine itself are more a consequence of government policy and community values than of the nature of the profession itself.

Increasingly, health care services are provided in the community. We cannot ignore hospitals but nor can we ignore the community. Considering the hospital, we need an open medical culture and open quality management systems. Our adversarial legal system makes human error in medicine a matter of great public consequence and embarrassment. This reinforces prevailing attitudes not to admit to mistakes. The medical profession can do much to address this, going right back to the university, but the culture of other parts of our society also needs to change.

We need local mechanisms. Local resolution of quality issues is more effective and less threatening. The Bristol case demonstrates this adequately. The case has achieved international notoriety, although it could apparently have been resolved locally and quickly if there had been sufficient goodwill. National mechanisms and data collections will always be necessary as an appropriate reference, and specialty-wide quality assurance strategies will always be helpful, but the best way is still to think globally but act locally.

We need clear criteria and ground rules at the institution level for quality management. There needs to be a clear mechanism for raising concerns at the local level. There must be ways of doing this confidentially, and of protecting the rights of the complainant and the respondent from frivolous or vexatious actions. The participants must be adequately indemnified.

The objective of the quality management activity at the institution must be the improvement of the quality of health care provided at that institution. It must be rigorous. It must not be punitive. The legal processes in our society and the medical boards are there to deal with punishment. Quality assurance must be separate from this and protected from it. If it becomes identified with punitive outcomes, participation will naturally decline.

The question to consider is not whether Bristol could happen here, but how can we constantly strive to make next year's health care better than last year's. That is what I want the Australian Medical Association to do.

Time for professional and individual accountability

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The incident which is the focus of this article has become a seminal case study for contemporary discussions about benchmarking, peer review, whistle blowing and evidence-based practice. That this incident occurred at all should be concerning for all of us working in health in the late 1990s. However, my own response to the case is not one of great surprise. Years of working in intensive care, and more recently in a clinical professorial position in an Area Health Service, have confirmed the widespread practice of health professionals working in a vacuum, rarely challenged about what are apparently out-of-date practices. Those brave enough to question the 'hierarchy of credibility' are either sidelined or harassed.

My recent experience in the clinical area revealed many practices which are known to be either superseded, inadequate or without clear evidence of making any difference in terms of patient outcomes. My attempts to bring such practices to the attention of the individual professionals themselves and/or the institution confirmed that the health care system seems to trail behind what has become relatively routine outside the system, namely, the increased responsibility individuals have in terms of work performance and personal accountability measured through performance contracts with clearly defined outcomes, quality reviews, self and peer reviews. In health care these are evident at the executive level of management but not always at the level of practitioner, although specific groups are extremely diligent.

Merrilyn Walton (1998) addresses many of the ethical dilemmas underlying practices which are able to continue without up-to-date evidence of their effectiveness (or worse, about their outright harm to individual patients). She places much of the responsibility for this in the lap of the medical profession and research institutions. She highlights the fact that in this country the Australian Medical Association has focused on promoting the profession rather than on the conflicts of interest which are inherent in medicine. This has led to the situation where the medical profession, unlike that in the United Kingdom or even the United States, has avoided regulation of any kind, believing this to be an infringement of individual rights.

While her book focuses mainly on medicine, all groups of health professionals need to examine their practices. In our contemporary world of increasingly informed patients, high levels of technological and pharmacological interventions and complex surgery, there is an even greater imperative for us all to ensure professional accountability and integrity in all aspects of practice.

There are signs of change. There is a national attempt to tackle issues of quality and professional accountability through such vehicles as the National Expert Advisory Group on Safety and Quality in Australian Health Care and the NSW Ministerial Advisory Committee on Clinical Quality. The increasing call for evidence-based practice and benchmarking of specific episodes of care may also go some way to identifying cases such as the one in Bristol through a systems approach. This avoids the difficulties inherent in whistle blowing, not the least of which is the personal and professional harm to the whistle blower. (See Walton's exposition of the McBride case.) But we cannot be complacent or believe that it cannot or is not happening in Australia. We need to be accountable not only as professional groups but as individuals.

Reference

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Complex systems and the nature of professionalism

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Hindle's editorial has merit but perhaps under-analyses the event. He is astute to observe that there are three main issues – culture, systems changes and patient rights – but this may not get to the heart of the matter. A fuller account might look more closely at the characteristics of complex systems and the nature of professionalism. This cannot be accomplished in the space available, and thus I will restrict myself to a brief sketch of some aspects of these two areas.

While the Bristol case is disturbing, it is paradoxically both predictable and instructive. Let me say with some sadness what many of us know in our hearts: Bristol will occur again in some form. Yet this is by no means an argument for inaction. The history of organisational behaviour tells us that no matter how much reform or control is exercised, one cannot prescribe against systems failure. The lessons of Chelmsford in New South Wales (Slattery 1990) and NASA's Challenger disaster (Vaughan 1996) are not that we will succeed in eradicating error but that inevitably, in complex systems, unanticipated crises will emerge sporadically. This is what is meant by the assertion that Bristol is predictable.

But it is also instructive, because it highlights flaws in the structure of the system and professions. What is it in the nature of systems that causes them to fail? From a systems perspective, the health system, like all systems, exhibits certain features. There is some purposive behaviour evident (that is, goal-directedness). There is a series of interlocking parts. The system is open, meaning it interacts with, influences and is influenced by, external events or other systems. Change (which politicians call 'reform') happens more slowly than is prescribed and sometimes only across generations. This is because, *inter alia*, there are counterbalancing forces that tend to act to maintain homeostasis. Precise standardisation is unachievable, and variability will always be exhibited in any system.

Provided my brevity has not done violence to a fuller description, these characteristics expose certain consequences. Any major change, such as in medical culture or, say, in the number of people speaking out, will affect other parts of the system, or other adjacent systems, in hard-to-predict ways. If too many people blew the whistle on others, public confidence in the system would

likely be diminished and this might have an adverse effect on system performance or health outcomes. Too few speaking out, and inappropriate or negligent behaviour might be perpetuated. Somewhere between keeping a lid on everything and everyone whistle blowing simultaneously lies a reasonable balance. The challenge is to get it right. It is also the case that systems that do more volume will tend to be more efficient and effective than lower volume systems in the same way that clinicians and units that do more are likely to have a lower cost per case and better outcomes than their lower volume counterparts (for example, Bates et al. 1996).

We may be able to discern, however dimly, that there are encouraging systems changes under way already. The restructuring of large hospitals into clinical directorates is an attempt to fuse clinical and managerial responsibility in the hands of clinician-managers and improve governance, oversee performance and provide direction to clinical units (Braithwaite 1995). And the move to embrace clinical pathways can be seen as the introduction of mechanisms to make clinical processes more visible. Both of these, when more fully fledged, may act in concert to reduce the probability of future Bristol-like incidents.

It seems evident that patients have been too little involved in clinical decision-making processes in past eras. It is unclear whether this is changing. One worry, however, is whether a better system would result from patients instructing their clinicians in what treatment to provide, having read about it, say, on the world wide web. In any case, there will always be information asymmetry between providers and the majority of patients, given the expertise, training and judgement needed to make clinical decisions. But there seems to be plenty of scope to involve patients in the system.

On the issue of professionals, we know that their work cannot easily be codified and that they deal with high levels of complexity and uncertainty (Southon & Braithwaite 1998). They make decisions requiring the exercise of expertise and skill with imperfect information. It is hard to specify precisely in advance the outcomes of any particular case. Professional groups of all types create pressure on members to adhere to group norms. Professions prefer to be self-regulating, tend to proffer a code of ethics and guard their members' autonomy (Cruess & Cruess 1997). Phrases such as 'club membership' and 'freedom to be the patient's advocate' are frequently mobilised. The imposition of bureaucratic or chimerical modes of controls are likely to be strongly resisted by professionals (Sewell 1998), but the evidence suggests that peer review has not worked (Berger 1998). Even so, putative members such as Bolsin who go out on a limb, even if they are right, are likely to be marginalised.

Comments about the essentials of complex systems and professionalism should not be used as a shield to negate attempts at reform. They do, however, suggest that reform will be difficult. Yet difficult cultural or systems change is possible if sufficient people are committed to a new order, and motivated to act. Feminism's contribution to gender equity this century, while disappointing in terms of progress to some, is a case in point, as is the demise of apartheid in South Africa this decade. But a sustained campaign is needed, with leaders who believe in and are willing to fight for a profound shift in attitudes and behaviour, in which Bolsin has shown the way.

Finally, we have been challenged in medical and even in policy circles to provide evidence for our contentions. Here is some evidence for mine: organisational culture can be modified, but usually slowly (Stinchcombe 1965); systems tend to resist change (McCaffrey, Faerman & Hart 1995); professions tend to close ranks and ostracise internal critics, especially whistle blowers (Goldbeck-Wood 1997; Klein 1998); and clinicians and units which do low volumes of any particular case type have poorer outcomes than those which do high volumes (Phillips & Luft 1997).

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