Potential for Patients and Community Level Medical Practitioners to Influence High Technology Healthcare: Evidence from Perth, Western Australia

Dr. Terrence David Thomas,

This thesis is presented for the degree of Doctor of Philosophy of Murdoch University, 2007
I declare that this thesis is my own account of my research and contains as its main content work which has not previously been presented for a degree at any other tertiary institution.
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Abstract

Evidence is presented from a Case Study of the Inquiry into King Edward Memorial Hospital, a tertiary level maternity hospital in Perth, Western Australia, that values of medical professionalism can be distorted and contribute to impaired standards of care. Moreover, it is argued that the managerial tools of clinical governance will be insufficient to remedy dysfunctional institutional care.

This thesis proposes that an augmented primary level doctor-patient relationship support a coordinating and advocacy role for general medical practitioners into the care and safety of their patients when those patients are admitted to hospitals under the care of medical specialists. A relationship between patients and primary level doctors willing to undertake such roles would reciprocally support the more personally involved relationship required. This relationship could expand to promote a more appropriate and sustainable use of medical technology.

Research in this thesis explores the adequacy of the primary level doctor-patient relationship in Perth to establish the individual level care of the type necessary to
breakdown the present fragmented nature of healthcare services. Healthcare consumers in focus groups were presented with hypothetical situations designed to illustrate aspects of healthcare by general medical practitioners. There was found minimal support for the concept of continuity of care unless co-payments were discarded and attendance was made convenient and timely.

A number of experienced general practitioners in Perth were also interviewed on their views of the fragmented nature of healthcare, and the degree to which primary level medical care could contribute to its improvement. They all supported the concept that continuity of care was important to primary level healthcare and thought that most of their older patients agreed with this concept. The research found a significant difference in the perceptions of patients and doctors that requires being resolved. Some Perth general practitioners aspire to more demanding professional roles that could include leadership in total patient care. However any hope for an expansive contribution by primary medical care in promoting a patient voice in the use of healthcare technology, including in tertiary level hospitals, is at present unlikely. This thesis makes suggestions into reforms and research that could lead to a redirected healthcare system based around the concept of personalised patient care.
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Acronyms

AIMS Accident and Incident Monitoring System

AMA Australian Medical Association

AMWAC Australian Medical Workforce Advisory Committee

BMA British Medical Association

BMJ British Medical Journal

CAM Complementary and Alternative Medicine

CMAJ Canadian Medical Association Journal

CSA Clinical Staff Association (at KEMH)

GCCCT General Coordinated Care Trials (of chronic disease care in Australia)

GDP Gross Domestic Product

GP General Practitioner

GPFH General Practitioner Fund Holding (in the United Kingdom)

HMO Health Maintenance Organisation

IVF In-Vitro Fertilisation

JAMA Journal of the American Medical Association

KEMH King Edward Memorial Hospital

LOS Length of Stay (In hospital)
M B S Medical Benefit Schedule
M J A Medical Journal of Australia
M O R I Market and Opinion Research International
N H S National Health Service (in the United Kingdom)
O E C D Organisation for Economic Cooperation and Development
P B S Pharmaceutical Benefits Schedule
Q A H C Quality in Australian HealthCare Study
R A N Z C O G Royal Australian and New Zealand College of Obstetricians and Gynaecologists
U K United Kingdom
U S A United States of America
W A Western Australia
This work is dedicated to the memory of Doctor Michael Booth Ph. D., Senior Lecturer in the Institute for Sustainability and Technology Policy at Murdoch University, who encouraged me to think.

Surely there can be no greater accolade for a man, a teacher and a philosopher.

Michael suffered a progressive uncommon lung disease and died on 1st September 2006.
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Preface

A Tertiary Level Medical Professional Reflects on the Quality of Hospital Based Healthcare

This thesis is concerned with healthcare, with the provision of its technological and human components, and with the expectations of the people who need and use its services. Healthcare technology is continuously being introduced into hospitals but is increasingly expensive, uses human, financial and material resources, and impacts on the built and natural environment. Whether or not it can continue to be employed with minimal thought for other areas of human need, or consideration for the resource needs of the future, is a matter of importance to the healthcare professions, to healthcare policy makers and to the public.

My particular concern is with the quality of healthcare, and the degree to which healthcare consumers¹, patients and their families can influence the quality of care provided in even the most technologically driven structure of healthcare, the tertiary level teaching hospital. The proposition is that patients/consumers value a more intrusive primary care general medical practitioner acting both on behalf of patients and the more specialised staff of hospitals in enhancing the governance of hospitals and improving the safety and sustainability of hospital based healthcare. My interest

¹’Consumer’ denotes an economic agent, i.e. a purchaser of personal healthcare; a ‘patient’ is a user, or potential user of health care services. The distinction can be blurred especially if the ‘purchase’ is through a third party, e.g. government or insurance.
and involvement in the investigation need explaining before proceeding to introduce the topic of mistakes made in institutional healthcare.

**Professional Understanding**

‘General medical practitioner’ denotes a qualified medical practitioner having first contact with a sick and/or worried person, and ‘tertiary level hospital’, an institute housing advanced level medical technology, specialists and nursing staff capable of using that technology, and having a teaching function for medical students. It is understood that a general medical practitioner has offices, consulting rooms and is employed by healthcare consumers, who can become patients, from within the general community. A tertiary level hospital is usually a city centre large built structure receiving its patients from a wide geographical area, and, in the Australian healthcare system, by reference from general medical practitioners and from medical specialists. However it will be argued in this thesis that these understandings are just as contested or contestable as are the terms ‘governance’ and ‘sustainability’. We live in times of change and, while some values and principles are immutable, it is necessary to examine afresh those systems of thought and behaviour that may be becoming entrenched to our disadvantage.

Healthcare is that which uses human interaction and technology to investigate ill health, reassure where appropriate, ameliorate the effects of disease, determine a prognosis for a return to health; and occasionally effect a cure (Fett, 2000).
Technology in this sense is more than technical artifacts, i.e. tools, machines and devices. It also includes the necessary support to that equipment from, for example, the built structure of the institution, from specialist technologists, and from the information technology of both administration and healthcare professionals. The nursing staffs of healthcare institutions operate as both their most important human and technological components.

I am a medical practitioner, trained in the United Kingdom and in Australia to have special knowledge and skills to deal with the diseases of the reproductive system in women, and with problems of pregnancy and the delivery of children. I became interested in the specific difficulty of involuntary childlessness (infertility) and eventually into reproductive technology, i.e. in-vitro-fertilisation (IVF). I have spent most of my working life within a tertiary level institution and have been part of advanced healthcare technology.

One of the benefits of my view of healthcare in both the United Kingdom and Australia over forty years is the ability to glean the best features of systems that may have seemed dysfunctional at the time. Those features were undoubtedly part of that time’s particular social and professional milieu and yet have present applicability.

Transferring from the United Kingdom’s centralised public hospital system to Australia’s federal and state mixed public and private system exposed me to the best and worst features of both. The public system in both countries thirty years ago was, as now, supported by state taxation, but was much more than now dependent on junior
staff working long hours, and only poorly supervised and supported by consultant
grade specialists. Specialists in Australia however were not paid, and worked at the
public hospitals in an honorary capacity. Peculiar features of healthcare systems are
part of the political history of nations\(^2\) and Australia is no exception (Gillespie, 1991).

Thirty years ago private patients could, as now, be treated in both private and public
hospitals. The economic survival of medical specialists in Australia then however was
dependent on fees paid by private patients paying health insurance, and referred by
general practitioners. The honorary unremunerated system of care for public uninsured
patients was considered to be part of the beneficence of medical professionalism:
indeed some consultants refused to accept eventually awarded payment for many
years. A major public hospital appointment provided professional prestige. Public
patients cared for by consultants in their ‘charity’ mode however could not expect the
individual attention and care provided to private patients.

The Australian healthcare system, compared with that in the United Kingdom, was,
and still is, a more polarised two-tier structure with both private and public care.
Private insured care is more sensitive to patient/consumer needs, and the ‘consumer’
for specialists is as much the referring general practitioner as the patient. For public
uninsured patients thirty years ago I can recall reluctant treatment of them by some
consultants as almost amounting to abuse. The results of care, i.e. the patients’ return
to health or otherwise, in the private and public arena were comparable. Hospital
doctors, i.e. those training as specialists in public hospitals, after the long years and the

\(^2\) The ability to create a National Health Service on British lines was prevented by the finding that to
register doctors amounted to conscription deemed unlawful by the Australian Constitution
long hours became experienced and capable. The United Kingdom by comparison had very few private patients and hence a much more uniform system of care\(^3\).

General medical practitioners in Australia were also part of the hospital system: they could admit their own patients to be treated by themselves, even to teaching hospitals, and, where appropriate, utilise specialist opinion and care. They have now been largely excluded from tertiary level institutions, both by the insistence of increasing technological proficiency and by the present Health Care Agreements between the Australian States and Federal Governments that preclude uninsured patients admitted to state supported hospitals from care by doctors of their choice, including their own general practitioners. This situation was criticised by a government investigating committee in 1992 as likely to lead to the marginalisation of general practice over the ensuing decade (Commonwealth Department of Health, 1992). That criticism was to do with the effect on the general practitioners: I would argue that it was also deleterious to the hospitals.

Patients are referred to specialists from general practitioners: Australia as in the United Kingdom operates a ‘gatekeeper’ system. The direction of the referral, i.e. to whom, may be at the discretion of the patients being referred. Nevertheless general practitioners had (and still have) the ability and capacity to assess the worth of specialists.

\(^{3}\) Chapter five deals with more recent United Kingdom experience.
My early experience of specialist private practice in Australia is of GPs insisting on helping in surgical procedures to be performed on their patients. They were in fact remunerated for such activity, and they may or may not have been helpful. Some made it clear however that they were tacitly assessing my surgical and management skills, a situation that I, newly fitted out by specialist status, found annoying. Nevertheless their interest was in the care of their patients.

Implicit in the argument in this thesis for a revived role for generally trained community focused medical practitioners is that they would be sufficiently experienced and trained to influence the functional capacity and behaviour of organisations while still remaining responsible to individual patients. It is also implicit that healthcare institutions will be aware of the increased authority of these general practitioners. Hospitals as foreign territory for patients, and their suspicion of the ‘indigenous inhabitants’ point to the need for an intermediary (Hill, 2003). This role is compatible with Australian consumers’ expectations of a general practitioner expressed by focus group research of the Consumers’ Health Forum (Consumers' Health Forum, 1999, Hill, 2003).
An Anecdote

In 1980 I was caring for a woman who had become established in premature labour. This was at the only hospital in Western Australia with a neonatal intensive care unit (NICU) capable of the care of very premature infants, King Edward Memorial Hospital (KEMH). She was delivering an infant after a pregnancy of at the most twenty-five and a half weeks duration.

I discussed with her and her husband the prognosis for the survival of the child. At that time the chances for survival with the best and most aggressive intensive care were less than 50% and there was a chance of prolonged ill health and a poor outcome in terms of disability. Without intensive care the very small infant would inevitably die. The mother requested that no resuscitation be attempted and the infant to be allowed to succumb to its extreme prematurity. I attested to the mother’s wishes and inscribed on the hospital notes that the infant should be allowed to die without resuscitation.

This policy was followed, the extremely small child died, and the mother grieved. A few months later she conceived and approximately one year later delivered a healthy full term infant. I have no doubt however that she remembered, and will continue to remember, the unfortunate premature labour and its unhappy outcome.

I was subject to considerable criticism and the case encouraged intense debate. It was claimed that I should have involved the specialist neonatal paediatricians who would
have been better able to counsel the mother on the most up to date statistics and provide a better idea of the prognosis for the birth of this premature child. They would probably have persuaded the mother to permit the intensive care of the child, care which could and would have been withdrawn if and when the outcome was seen to be poor.

The decision taken by the mother, and her husband, required information on the chances of a satisfactory outcome for the infant. However decisions to employ medical technology taken by patients even in desperate circumstances reflect many components. Many of these are not recognised, not acknowledged, and may be subconscious. Doctors, aware of this situation, may or may not be able to include these factors in discussion. They are much less likely to concede the many factors that similarly influence their own behaviour and decisions. It is even likely that too much introspection could paralyse effective management.

It must be admitted that the focus for my care and advice was the mother. The care of the newborn had not been a great matter for obstetricians until recently. The College of Obstetricians and Gynaecologists, whose membership certified my expertise, concentrated its educational and training activities on a healthy outcome for mothers. In terms of the history of medicine it was only recently that mothers in the developed world could be assured of surviving the risks of pregnancy and delivery, risks that still exist in the more impoverished parts of the present world. Mothers in our society now expect to survive pregnancy and are becoming increasingly insistent on healthy and normal children. The College had been left behind partially by its own success. I was
in a sense a ‘last survivor’ from an era in which obstetricians expected to have complete control of the medical supervision of pregnant women.

Now, twenty years later, the ‘success’ rate for these very premature infants has improved, the technology has advanced and a majority of twenty-five week old premature infants survive and are healthy. There remains a substantial minority who do not fare well, but paediatricians are better able to diagnose impending and inevitable decline and the parents can be appropriately advised to allow the withdrawal of life support. The barrier to survival has been lowered. Pregnancies of twenty four and twenty three weeks now replace the concern expressed twenty years ago for those infants then a week or so more mature.

However there are matters of cost. The cost is enormous. It is not unusual for these premature infants to accumulate $A250,000 for their in-patient hospital expenses. Even when eventually allowed home, they are frail, suffer multiple medical problems, and many have major disabilities. These infants can continue to be a call on healthcare budgets for many years. The sort of intense care needed is only found in Western Australia in a single public hospital, King Edward Memorial Hospital.

The cost is enormous: for the baby, but also mental, physical, social and financial for the parents. There is even a substantial environmental cost from the toxic waste of intensive care units (Simbrunner, 1993). Parents guided by paediatricians are responsible for decisions leading to years of joy - or of grief. The use of technology is not infrequently compelled by the fear of future regret; that if technology is refused or
not employed the consequences will be blame and condemnation, so-called “anticipation decision regret” (Tymstra, 1989).

Much of the cost is borne by public funding, and it may be argued that the money would be better spent elsewhere. Even costs borne by private insurance maintain high premiums for others in the community. A decision to cut off intensive care for very premature infants at a certain level of intra uterine maturity would be cost effective, decrease long term morbidity and disability, and relieve others of difficult decisions. It has been carried out in Holland; and subsequently condemned by the College of Paediatricians in London (Sheldon, 2001). We can ask neonatal paediatricians to take decisions, or issue advice, that note all the outcomes of intensive care; but must they also reflect on the cost of intensive care: or should those decisions be taken by governments, funding organisations, management committees, or ethicists?

If cost and a poor outcome are to be the markers for withdrawal of aggressive healthcare then questions will be raised on the validity of treatment for others on the margins of survival. Those questions would be raised for those with advanced cancer, or those of advanced years, or those without hope of ‘normal’ life. Advanced cancers, however, can be treated, 100 year lifespans may shortly become the expected (Schwartz, 1999), and compensated disability become a measure of a nation’s civil standing (Morello, 2004, Delpy, 1998). Arbitrary restrictions in a democratic society can at best only be guidelines on care, as indeed they are in the Leiden neonatal intensive care unit of Sheldon’s paper noted above. Parents in that Dutch hospital can impose their own conditions for the care of their very premature infants.
The concept of a healthcare system without limits does, however, raise awkward questions. Just how far the medical profession and medical science should be ‘allowed’ to explore the margins of survival? Should there be an insistence that the quality of life be assured before its longevity? How and by whom is the quality of life to be determined? What cost strictures should be placed on marginal health gains, however those gains are to be measured?

The application of scientific advances to healthcare services enables health professionals and healthcare institutions to become more technically adept. However medical technology like all technology is inevitably flawed (Wynne, 1988). It is flawed by technical breakdown and by human error. The cost is borne by those damaged by error, and by the cost of its management. A public understanding and participation in the control of technological error is a crucial part of the sustainability of medical technology.

An example would be the present furore over stem-cell technology, its concentration on the ethics of the use of human embryos, and the fears of effects on the valuation of human life. My concern is with public awareness of potential error and excess in the application of healthcare technology. Occlusive coronary artery disease resulting in cardiac muscle decay can involve open-heart surgery, radiologically guided artery stents, expensive and prolonged medication and, potentially, stem-cell therapy. The numerous technologists involved have to be trained, certified, and re-certified as technology advances, the inevitable errors reviewed and outmoded technology
rejected, and determinations made as to the use of technology for different clinical situations. Much of this will be expensive, highly technical and complicated but must in the end be directed at individual patients with their own foibles and fears. Society through its political representation can insist on controls but this thesis is concerned with the ability of individual patients to influence the application of healthcare technology, and cumulatively to influence the governance of healthcare technological institutions.

These questions are not new but are now part of a wider concern with the impact of human activities included in the term ‘sustainability’. What effect might either the intensive care of very premature infants or an insistence on the prolongation of life of the very old have on the environment, on the social fabric of society, or on its economic well-being? Is any present benefit of healthcare in our society bought at the expense of communities elsewhere, or of generations in the future?

Is there any real prospect that a society inured to consumerism will forgo the search for, and use of, expensive advances in healthcare technology in order to conserve material, human, and financial resources for the use of others less fortunate? Is it not more likely that the cost of expensive healthcare technology will be recouped by vigorous marketing to potential consumers, notwithstanding the needs of those consumers to conserve limited resources?

This thesis will explore some of these issues but from the direction of what contribution a redirected medical profession might make to the debate and its
resolution. Some have argued that the medical profession is ill equipped to make
decisions on the direction of healthcare services (Waltner-Toews, 2000). Doctors
should maintain a devotion to the care of their patients and the defeat of the diseases
afflicting them. In trusting a doctor with our life and wellbeing do we wish him or her
to be distracted by concerns with ‘sustainability’?

What has this to do with the story of my management of the woman in premature
labour? It contains references to professionalism, to a specialisation of medical care, a
progressive focus on skills necessary to cope with advancing knowledge. This thesis
is to claim that this progressive specialisation has come at a cost, that of a loss of a
wider view and the creation of a distance between the object of care and the providers
of care. This is not to suggest that neonatal paediatricians have not developed
considerable expertise in the handling of parents and family while caring for tiny sick
children. However I believe it pertinent that at no time in this scenario did anyone
suggest that the family doctor, the woman’s general practitioner be involved: I did not,
the paediatricians did not and, even more pertinently, neither the patient herself nor
her family did not.

This situation continues. General practitioners, who may be involved in much of a
patient’s healthcare, are excluded from tertiary, and in many circumstances
secondary

A ‘secondary’ level hospital is an institution to which patients are referred for care by specialists and
some general practitioners; it operates at a ‘district level. A tertiary level hospital is allied with a
university medical school, teaches medical students and also receives patients requiring higher levels of
technological equipment and expertise. It is usually a city-centre establishment.

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This thesis will claim that this situation is to the advantage of no-one: not the specialists, the child, the mother, the family, or the wider community, and not to the professional position of the general practitioner. As a private patient, i.e. supported by self-funded insurance, the patient could have requested her GP to attend, and thirty years ago this was common. A public patient in a state-funded hospital at this time cannot request her own GP to visit, in that, under the Health Care Agreements, she has no right to a doctor of her choice. Even a private patient’s general practitioner can only act in a medical capacity if the ‘owners’ of the hospital through the medical director permit him or her to do so.

What might a general practitioner have contributed to a situation requiring specialist expertise? Probably nothing if he or she was not well known to the patient. However if the patient and the GP had an established relationship of trust and care then that relationship could have been used as a bridge between the technology of a large hospital and a vulnerable subject. My patient’s general practitioner could have been a vital ancillary to a hospital-based team and yet an advocate for family and community interests.

I have noted the alienation of the hospital environment and the perceived interests of the “indigenous inhabitants”, i.e. the nurses, doctors and other staff employed by the hospital and unknown to the patient (Hill, 2003). Notwithstanding my position as a specialist ‘chosen’ by the patient and my knowledge of her over months, I would still be considered ‘indigenous’ compared with a general practitioner; and especially one known to the patient over many years. What could he, or she, however have done?
The most up-to-date knowledge and skills were those of the highly specialised neonatal paediatrician; that of a general practitioner however wise and worldly could not have replaced that detailed knowledge. However our possibly hypothetical general practitioner could have known of the patient’s and the patient’s family’s psychological and social resilience, their religious and spiritual resources, their commitments to family, community, and work, and their aspirations.

Our hypothetical, and now future, general practitioner might come to know the hospital and unit staff, how decisions and advice are governed, what trust can be expected, and what values motivate them. While evidence best practice may be dictated by current statistical analysis, decisions are influenced by multiple factors, not all of which are admitted or acknowledged. The ‘lifeworld’ of a patient noted in many sociological analyses of doctors and patients (Barry et al., 2001, Scrambler, 2001) is matched by the ‘lifeworld’ of a technological institution. It is the claim of this study that the highly trained and motivated general practitioners of the future will be more involved in the latter.

While I, as an obstetrician, accepted the responsibility of clinical decisions reflecting the patient’s wishes I would have been the one person least affected by what those decisions would be. Neonatal paediatricians are committed to long term follow-up of their newborn patients and the hypothetical general practitioner has concerns for the future mother and her child, if child there is to be. The paediatricians and general
practitioners have mutual concerns that would have been better served by meetings at the bedside. The prospective parents complete the team - not the obstetrician.

This thesis argues that decisions hesitantly taken by patients will combine specialist expertise with interpretations of changing individual and institutional nuances by generalist doctors trusted to act as their agents. It will be claimed that such symbiosis will better sustain medical technology and contribute to the sustainability of medicine.

**Quality in healthcare: the Douglas Inquiry**

This thesis is in many ways an outcome of my interest in quality management, i.e. the collated review of healthcare outcomes and processes to determine compliance with best practice. I became interested in this area because of awareness that mistakes were made in care, that they were not infrequently recurrent, and were associated with a professional reluctance to expose their incidence. The objective assessment of that practice deemed ‘best’ remains debatably, and ‘practice’ can be both the processes of care and clinical outcomes. Within my medical specialty the management of pregnancy and childbirth has for many years been special amongst the medical disciplines in reviewing the outcomes of care at institutional and national level (United Kingdom Department of Health, 1995, National Health and Medical Research Council, 1998). The results of these triennial reviews were used to improve care and to influence government into the provision of facilities for childbirth. Initially this was related to concerns about maternal mortality. In underdeveloped and developing
nations this is still a problem but in developed nations like the United Kingdom and Australia investigation progressed to also deal with infants stillborn or dying shortly after birth (Health Department of Western Australia, 1992).

It is only comparatively recently in Australia or the United Kingdom that surgical disciplines have managed to obtain the agreement of their members to review the outcomes of treatment (Aitken et al., 1997). The difference is in the assumption of prior health on the part of the majority of pregnant women whereas surgery covers a spectrum of previous and present pathology and assumes prior ill health on the part of most patients.

My colleagues and I began to gather statistical evidence of healthcare outcomes, if only to reassure ourselves that we were caring for our patients as well as could be. It became necessary to ensure that we were measuring comparable cases. Technology data analysis became important and we grappled with the need to comprehend computers and the introduction of information technology. I was appointed as a part-time quality assurance officer at King Edward Memorial Hospital (KEMH) in Perth from 1993 to 1995.

These years were those when healthcare services were to be exposed to competition as an economic policy (Klein, 1990). Quality management was directed to the same ends. Politics and economics are persistent themes and will recur in chapters four, five and six of this thesis. In chapter four the question of the economic viability of healthcare services will be discussed within the concept of ‘sustainability’. In chapter
five I used focus groups to investigate patients’ preferences for types of general medical practice but had not anticipated how important economic factors were to these preferences. In chapter six economic incentives are used as a means of influencing healthcare expenditure, and the behaviour of doctors, by the provision of funding by government to general practitioners to purchase medications, surgical interventions, investigations, and even consultant advice for their patients.

An example of the relationship between quality management and economics is in the determination of hospital lengths of stay (LOS). We were able to show that at KEMH the length of stay in hospital was more related to whether or not the patient resided in Perth or in rural areas than the degree of ill health or the patient’s response to treatment. This was of interest to hospital management, not only because of reassurance on hospital standards but because of weightings to be applied to invoices for hospital services in a proposed open market for those services. The discussion in chapter four includes the linkage between hospital costs, healthcare financial sustainability, and general industrial sustainability.

Diseases, disabilities, and their treatment were given implicit financial values both locally and internationally (Murray and Lopez, 1996, Johannesson et al., 1996, Lopez, 2003). It became insufficient to express healthcare by the simple expedient of a person’s or an aggregated population’s length of life but to determine the years of expected healthy life lost both to death and to disability. It is worth noting that Gavin Mooney, a health economist, could still express dismay in trying to determine the
economic ‘good’ of healthcare (Mooney, 2000). His difficulty was in dealing with a libertarian economic system opposed to a determination of community values.

My efforts to impress my clinical colleagues at the hospital to engage with quality management processes were singularly unsuccessful. The medical profession had, and possibly still has, a self-serving assumption of inherent excellence that has only lately been challenged, and this challenge happened at KEMH with bludgeon-like precision. I had retired from public practice at the hospital in late 1999, two months before the announcement of an inquiry into both obstetric and gynaecological practice at the hospital over the previous nine years. This was to become a ministerial inquiry chaired by a Queen’s Counsel and former judge Mr. Neil Douglas.

The West Australian State Minister of Health had been persuaded to this action following reports from interstate independent professional experts. They had been asked to review apparently poor results of stillborn infants, infant abnormality rates and early infant death rates. Furthermore there were patients of the hospital with poor outcomes threatening legal action in greater numbers than in comparable institutions. The hospital’s chief executive and his administrative/legal advisor also claimed to have been informed by some clinical staff members of anxiety concerning some clinical practices. While there was doubt about the validity of comparative data (Evans, 2002)), the independent panel did note defective professional and administrative practices in those cases they had been asked to review.
The KEMH Inquiry, with which I was involved, formed the basis for a changed view of dysfunctional medical professionalism and medical professional structure as contributing to impaired healthcare. While I had long supported professional and institutional governance structures I now fear that, with an increasingly fragmented healthcare system, they will be inadequate for the management of error and excess in institutional healthcare. I now believe that hospitals with their healthcare professional staff, perceived and managed as complex adaptive systems, would in many ways benefit from the intrusion of a rejuvenated and redirected community level doctor-patient relationship. It remains to determine if such a relationship can occur.
Chapter One

A Response to Shortcomings in High Technology Healthcare: Hypothesis and Research Questions

Research Methodology

It will be claimed that within high technology health care there is a possible professional dislocation from individual and community values. This will be illustrated in chapter two by a detailed analysis of the Inquiry into King Edward Memorial Hospital in Perth, Western Australia (Western Australian Government (KEMH) Inquiry (2001)). Other scandals in institutional healthcare from Australia and the United Kingdom, with which Australia shares a professional background, will show similar shortcomings.

Chapter three in which the recommendations from the Inquiry are discussed will detail present efforts to deal with error in health care and argue that these efforts may be insufficient. In particular the concept of complex adaptive systems from medical, social, and business literature is explored as an alternative to reliance on top-down clinical governance.

The argument is taken further in chapter four by a literature search on the place for a more emphatic doctor-patient relationship into the sustainability of healthcare services. The economic sustainability of healthcare services is seen as part of overall economic, social and environmental sustainability. The meanings and purposes of healthcare and its sustainability are determined as the cumulative individual needs and
demands of patients aided and arbitrated by a trusted healthcare professional. However before this ideal can be realised changes in the way doctors and patients regard their relationship will be necessary.

The initial question raised by this thesis is:

**Can the consumer of healthcare, the patient, influence the medical profession, its organisation and its values, to ensure that patient concerns on the quality of healthcare are respected within healthcare institutions?**

The hypothesis to be explored is that:

**Patient/Consumers of healthcare can contribute to their own healthcare, the governance of healthcare institutions, and the sustainability of healthcare services, by utilising trusted primary care medical practitioners as mediators, as, when, and if necessary, to negotiate high technology healthcare.**

There are no reasons why present Australian primary care medical practitioners cannot intrude into high technology hospitals in support of their patients, and by so doing contribute to firmer doctor-patient relationships. Only minor administrative or legislative processes would be required. The problems with implementation are much more with the attitudes and behaviours of both patients and their doctors.
It was decided to use the qualitative technique of focus groups discussions to investigate patient/consumer attitudes. It is likely that no single method of research can be relied upon to reveal what those attitudes are and how complicated and constrained by other factors they might be (Ryan et al., 2001). However, during group discussions, participants can reflect on the opinion of others, and valuable insights and opinions can be revealed to participants and to investigators that would not be apparent to individuals (Wensing and Elwyn, 2003).

It is of importance in appreciating the methodology employed to understand that I had made prior assumptions that healthcare consumers would uphold the concept of general practitioners willing to act on their behalf in hospitals. Such backing was to be an initial step that I could use to engineer support from healthcare professionals. I am confident that, without any intention to mislead, I could have devised a survey instrument with questions framed to elicit a positive response. However ambiguity in assessing patient preferences for primary level care was considered significant in a wide ranging and critical review of survey instruments (Cheraghi-Sohi et al., 2006). Surveys are constrained by the phrasing and formulation of questions asked and have been criticised by the peak consumer group in Australia (Consumers Health Forum, 1997) as well as professionals seeking consumer opinions (Wensing and Elwyn, 2003).

It would have been possible to ask a representative sample of the population if they believe in the value of a long-term relationship with a general practitioner. The answer might well have been in the affirmative but would have had to be qualified by
what a relationship entails, what values are sought, and what limits are expected from both parties. The doctor-patient relationship has been argued to define the nature of medical philosophy (Frank, 2002, Pellegrino and Thomasma, 1981). It is complex, unequal, and changing. For example, a long-term relationship might expect 24-hour doctor availability, and to cover a wide spectrum of conditions. The relationship may be one of trust; or be reduced to that of a conduit with patient mediated access to specialist services (Morris, 2000).

Qualitative research is more open and less limited by presumed and, in my case wrong, understandings. Had I used a survey instrument I would not have anticipated the main findings from the focus group research of healthcare consumers, findings that caused a different direction to further research, and ultimately different conclusions.

It was decided to use the qualitative technique of forum group discussion (Flick, 1998 chapter 10, Wensing and Elwyn, 2003, Ulin et al., 2005) to permit an open review of complex and diverse opinion. A representative population is invited to participate in round table discussions guided by a moderator to ensure a continuing focus on matters previously determined. The participants are informed on the nature of the matters to be discussed and the discussions can be either structured around previously circulated questions or the discussion allowed more latitude. This latitude is dependent on the skills of a facilitator and does introduce a further variable. The researcher records the conversation and the subsequent transcriptions are analysed for responses, themes and, also of importance, those matters not explored. The number of participants is limited to ensure all take part, preferably less than ten and more than three in each group.
The advantage of round table discussion is that with the capacity for participants to consider the opinions of others there is a more realistic reflection of social communication than in a structured interview or detailed survey (Draper, 1997).

A special feature of the method used for this study was to circulate hypothetical situations to participants prior to the meetings. This is a novel technique although Ulin, Robinson and Tolley (1005) do describe the use of stories to initiate focus group discussion. I considered that the presently evolving general practice clinics might reflect present market reality i.e. a wish for ready access to general practitioners with adjacent diagnostic and treatment facilities. However further evolution of this model may diminish long term doctor-patient relationships. The hypothetical situations were designed to indicate those clinical situations in which a long-term doctor-patient relationship might or might not be valued. They were intended to enable the moderator and/or participants to select those they wished to use but there was insistence in all the groups that all hypothetical situations were addressed. These ‘stories’ are included in the main body of the text to enable group responses to be more easily understood.

It is also hoped that discussion within groups will raise questions as well as resolve them and further research guided by the results of discussion. This has been recognised as a distinct advantage of this methodology (Wiles, 1996, Phillittere et al., 2003). The main disadvantage of focus group research, as admitted by Bruce Berg
(Berg, 1995), is the necessity of organising meeting times that may not be convenient to otherwise willing participants.

Narrative extracts from the group discussions can be used to illustrate and make points of argument (Wiles, 1996) and, despite the inevitable discretionary nature of qualitative research, much valuable material can guide research and generate further theory and concepts (Grbich, 1999 p.29).

No direct research on the effects of an intrusive general medical practice into healthcare institutions is presently possible but general practitioners have been empowered to affect institutional healthcare in other situations like those of the holding of funds to purchase healthcare on behalf of patients. These attempts are explored in chapter six both by a literature review of fund holding in general and by conversations with professionals known by me to have been involved in general practice fund holding in the United Kingdom. Fund holding is an economic tool that in the context of the National Health Service in the early nineteen nineties was intended to generate a pseudo market of hospital services competing for patients. This competition was aimed at earlier access for patients and to reduce waiting lists. My interest was into whether or not this competition extended to the quality of service provided.

The other party to the relationship aimed at improving hospital services in Perth was the patients’ general medical practitioners. I needed to know how they would perceive
a more intrusive role acting on behalf of their patients based on long term relationships and, hence, continuity of care.

Focus groups have been used to elicit the opinions of Australian general practitioners on the topic of continuity of care (Sturmberg, 2000). Nevertheless it was felt that the topic of general practitioners and an intrusive access to hospitals might be too divisive and politically sensitive to permit focus group research. Structured survey material, i.e. answers to a questionnaire, was considered less likely to reveal the varied constraints of general medical practice than that of discussions around a topic. Hence, to determine the attitudes and restraints of general practitioners and general medical practice, it was felt better to rely on confidential semi-structured interviews. Narrative extracts are extensively used from these interviews to illustrate many of the points raised. These results are presented in chapter seven.

Prospective participants were informed of the nature of the interviews before any decision to take part and this circulated information is contained in an Appendix. Similarly the questions at interview hopefully encouraging discussion are contained within the Appendix.

The research nature of the meetings was noted and taped recordings made for subsequent analysis. These recordings would be kept secure and any reports would not include identifying information. The participants were promised and provided with summaries of the proceedings and asked to provide any additional material they might think worthy of inclusion. No payment or re-imbursement was offered to
participants. Consent was obtained and the proceedings conducted under the auspices of the Human Ethics Committee of Murdoch University.

The research from the focus groups and from the semi-structured interviews was returned to the participants to, in some way, contribute to respondent validity. Hence the results presented are those checked by the participants. It is accepted that this can be criticised as being too consensus seeking and insufficiently disinterested (Murphy and Dingwall, 2001). No checking criteria were employed accepting the argument of Murphy and Dingwall (2001) that such checking can distract from the research data:

“We argue that the evaluation of qualitative research is always a matter of informed judgement and that it is impossible to side-step this by means of checking criteria, which may all too easily, come to be treated as an end in itself rather than enhancing the validity of the study”

(Murphy and Dingwall, 2001 p. 166)

This research from multiple sources and with multiple conflicting results was subject to resolution and summation in chapter eight. The expectation of fresh concepts emerging from this qualitative research has been accomplished to support the hypothesis.
Chapter Two

Error in High Technology Health Care

The Profession of Medicine

Case-Study of King Edward Memorial Hospital

Impaired Care in Other Health Care Institutions

2.1 Introduction: A Professional Background

This introduction encompasses a résumé of the incidence of mistakes in healthcare involving hospital admissions. It will note the background to the medical profession, the doctor-patient relationship and the growth of medical specialisation, and finally the reasons behind the surprisingly delayed revelations of impaired healthcare. I use ‘surprisingly’ because there was no evidence of any recent decline in healthcare standards and it is probable that there have always been mistakes made in the care of patients.

The revealed documentation of substandard health care relates to King Edward Memorial Hospital in Perth, Western Australia. Short reviews of possibly similar substandard health care from the Bristol Royal Infirmary, the Alder Hay Hospital and Northwick Park Hospital in the United Kingdom, Cambeltown and Camden Hospitals in New South Wales, and the Bundaberg Base Hospital in Queensland are presented later to discuss if professional poor quality care is becoming exposed. The question to be asked in this chapter is whether or not part of that substandard care resides in an unsatisfactorily adapted medical professionalism; ‘unsatisfactorily adapted’ in
maintaining an illusion that advancing knowledge and technological skills precludes a need for attention to the safety of patients/consumers of healthcare. Reducing the rate of error might therefore demand change in a present culture of high technology medicine involving greater awareness of the individual needs of patients.

A detailed analysis of the Report of the Inquiry into King Edward Memorial Hospital, published in 2001, (Western Australian Government (KEMH) Inquiry, 2001), and in which the author was involved, forms the main background to the hypothesis of this thesis. This is that healthcare standards and healthcare sustainability will depend on the influence of patients assisted by their community level general medical practitioner; and not only on self-generated reassurance from professional or institutional governance measures.

Healthcare must be considered impaired if approximately 1 in 6 of patients admitted to both public and private hospitals suffer harm from mistakes in care (Wilson et al., 1995). The Quality in Australian Health Care (QAHC) study was made on 14,000 patients admitted in 1992 to selected hospitals in New South Wales and South Australia.

Extrapolating the results to Australia as a whole could mean that, associated with mistakes or ‘adverse events’, 25,000 to 30,000 people would have suffered permanent disability, and 10,000 to 16,000 would have died.

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5 ‘associated with’ not ‘caused by’ as many patients were very ill at the time
The cost in extended hospital care needed to manage the harm caused has been variously calculated but likely to have been in excess of $A650 million. It must be borne in mind that those extrapolations are for one year without evidence that they cannot be repeated each year.

This incidence of ‘adverse events’ is certainly not confined to Australia (Vincent et al., 2001, Brennan et al., 1991, Michel et al., 2004). Effort has gone into attempts to reduce this serious rate of error (Australian Council for Safety and Quality in Health Care, 2003), and Bruce Barraclough, the Council Chairman, still anticipates that much will improve (Barraclough, 2005). However in 2005, ten years after the original report, the lead author, Ross Wilson, with the editor of the Australian Medical Journal, Martin Van Der Weyden, considered the level of error to be so entrenched that, if the study were to be repeated, the results would be the same (Wilson and Van Der Weyden, 2005).

That which constitutes an ‘adverse event’, the term encompassing error or mistakes in care, can be difficult to define and hence the methodology of these studies has been criticised (McNeil and Leeder, 1995); however, even with that caveat, the rates of error are disturbing.

Care in hospitals is also more than a technological resolution of disease or injury but encompasses humane considerations of compassion and sensitivity. The Health Consumers’ Council of Western Australia, responding by multiple public meetings to
the Preliminary Report of the Health Reform Committee (Reid, 2004), concluded a lack of compassion as the most significant defect in health care:

*Health professionals and the health system as a whole should be more compassionate*  
*p. ii*

*Community members consistently emphasised the need for compassion and expressed serious concern that health professionals today were typically not compassionate*  
*p. 33.*

(Health Consumers' Council, 2004)

Consideration of healthcare quality as being more than the eradication of error is widespread. Steven Woolf writing after the publication of the report on error rates in the United States (Kohn et al., 2000), which caused consternation by affirming the death of 44,000 to 98,000 Americans due to medical error, insisted that policy changes must encompass both defective care and compassion (Woolf, 2004).

Joel Hill, writing in the prestigious British medical journal, the Lancet, noted the environment of hospitals as alien, and that poor doctor-patient relationships were inherent (Hill, 2003). Eliot Freidson, who has written on the sociological characteristics of medical professionals for thirty years, notes that ‘depersonalisation’ of hospital patients is expected (Freidson, 1970a p. 170).

Doctors, as healers, are as old as is humankind. There have always been those members of the tribe with a reputation, deserved or otherwise, who, managing the present, aspired to affect a likely grim future. A medical profession in the European tradition claims its origin from the ancient Greek oath of Hippocrates when healers professed to certain codes of behaviour in their dealings with sick and injured clients.
A correct doctor-patient relationship, that has been held as significant to medical professionalism from the very earliest of times, remains valid, though for various reasons and at different times has needed to be re-affirmed (Hurwitz and Richardson, 1977, Medical Professionalism Project, 2002). The doctor-patient relationship is argued to contribute a transcendental quality to medical professionalism beyond that of a scientific discipline (Pellegrino and Thomasma, 1981). However other views are of medical professionalism, and its values, as much more socially constructed and sensitive to changes in society (Wildes, 2001). This contradiction in a philosophical sensitivity to change is the background to much that is debated in this thesis.

The history of modern medicine, especially that of Victorian England, is of disparate professions or crafts coming together to create a generalist doctor, the general practitioner (Peterson, 1978). However physicians and surgeons, both before and after the United Kingdom 1858 Medical Act that recognised general medical practice, developed subspecialties and respective institutions in large population centres. This development concentrated marketable expertise into specific areas of disease and disability, e.g. eye clinics, dermatology hospitals, maternity units. In late Victorian England it was knowledge and science that followed specialisation, and not the converse (Peterson, 1978): it was to be almost a hundred years later that advanced technology, or applied science, could start to be associated with specialisation.

The recognition of medicine by Act of Parliament in the United Kingdom and later in the colonies and dependencies of the Crown (1894 in Western Australia) reserved title and public appointment to those able to demonstrate medical skills and training. The
specialties later sought similar identification, ostensibly to protect a purchasing public, but also to conserve market share. My own specialty of obstetrics and gynaecology was created to keep those special diseases of women, i.e. gynaecology, from becoming a surgical discipline within the College of Surgeons (Muscucci, 1990, Peel, 1986). From the mid twentieth century the rapid expansion of science and technology has led to such a degree of sub-specialisation within the long established disciplines of internal medicine, surgery and obstetrics/gynaecology that general physicians, general surgeons and general obstetrician/gynaecologists risk becoming disparaged and outdated.

The majority of high technology medicine takes place in high technology hospitals and these institutions become fragmented into separate units of sub-specialisation. The hold on general medical knowledge is through more general specialist areas that always persist, and through junior hospital medical staff in training for specialist recognition. Knowledge, research and repetitive exposure to similar clinical encounters maintain specialist practice. However there is no evidence that mistakes in care are related to absent or forgotten general medical skills. The analysis of substandard care, to be discussed, reveals more that the attainment of advanced medical knowledge and skills within hospitals is associated with an assumption that high quality care is an inevitable accompaniment of that knowledge and that skill. In short, an inherent professional self regard is shown unsupported by healthcare outcomes.
The studies of rates of error in hospital care were undertaken not because of concern with falling healthcare outcomes but for financial reasons. In Australia the QAHC study stemmed from the Professional Indemnity Review of the financial impact of rising professional insurance premiums (Tito, 1995). Similarly, the more recent pursuit of quality assurance in health care, which has a much longer history in the United States, is largely a matter of concern with ever rising health care costs (Berwick et al., 1991). However in the last decade of the twentieth century there occurred exposures of sub-standard medical care in the United Kingdom and Australia, which, although having economic components, were more to do with betrayals of public trust. Each had its own separate distortions of medical professionalism that warrant investigation. One of these was the Inquiry into King Edward Memorial Hospital (Western Australian Government (KEMH) Inquiry, 2001). There are features of that inquiry, with which the author is familiar, that enable it to be used to determine aspects of medical professionalism and specialisation that might contribute to less than satisfactory care within health care institutions.

The review to follow in this chapter is a selective analysis of a Western Australian Government report that is extensive, and details issues related to hospital organisation and not with medical professionalism (Western Australian Government (KEMH) Inquiry, 2001). However the report refers repeatedly to a need for cultural change that can be argued as dealing with entrenched unreflective medical professionalism. In appealing for change (in hospital or professional culture) there is little or no suggestion from the 237 recommendations of the Inquiry as to how this might be accomplished.
The Report is to a state government and the recommendations are for types of regulatory activity within hospitals⁶ that can have only indirect effect on philosophical or sociological attitudes.

If this analysis is to be selective in terms of those items considered to reflect professional beliefs and attitudes then it is necessary to be clear as to what is meant by ‘medical professionalism’. The discussion of medical professionalism will be followed by a case study of the Report of the Inquiry and then by literature based examples of substandard care in healthcare institutions elsewhere. The search is for evidence that some values of the medical profession are not those appropriate for present and future healthcare.

⁶ In Australia public hospitals supported by both state and federal taxation are under the jurisdiction of separate state governments.
2.2 Medical Professionalism

A profession in the way that it is usually applied to an occupational professional elite is a group of individuals marked out by the certified possession of special knowledge and skills (Freidson, 1970b). The group ‘professes’ to knowledge, and to ethical standards in the use of that knowledge, with the assurance that standards will be policed by the profession, and that those members infringing ethical behaviour will be cast out. A profession granted such autonomy is resistant to interference in its conduct of affairs by those ‘outside’ the profession. The possession of knowledge, skills and autonomy provides considerable social and political power.

Professional and, by association, professionalism have unfortunately become perverted terms. The Macquarie Australian dictionary now has nine separate definitions of ‘professional’ of which only the third (‘engaged in one of the learned professions’) applies to medicine (Macquarie Dictionary 1982 p.1376). It might be accepted that the term also applies to ‘one who makes a business of an occupation in which amateurs engage for amusement or recreation’ but to describe the Bali bomber terrorists as ‘professional’ because they were able to demonstrate training, expertise and effectiveness, shows a need for a fresh concept (Elegant, 2003). Indeed for much of history medical ‘professionals’ were, in contrast to terrorists, poorly trained, inexpert and ineffective, and held themselves as professionals only by virtue of behaviour. It is then appropriate to abandon attempts to discuss professionalism as applied to the medical profession and discuss medical professionalism as an exclusive term.
The core beliefs espoused by medical professionalism are:

**To do no harm**: or in Hippocratic terms to *abstain from whatever is deleterious and mischievous*\(^7\)

**To do good**: or *follow a regimen of benefit to my patients*

However Hippocrates was concerned with other precepts more to do with professional protectionism:

*to reckon him*\(^8\) *who taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction. I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others* (my emphasis).

*(Classics, 1910)*

Hippocrates was aware of the potential for exploitation within a dependent relationship and abjured mischief and corruption, and specifically the seduction of males, females, freedmen (employed ex-slaves) and slaves. He condemned the disclosure of confidential information.

Hippocrates also condemned as unethical those doctors invading the crafts of those who would ‘*cut for stone*’, i.e. surgery (for bladder stones); and lauded a life of purity and holiness. Surgery is now very much part of the profession: and very few doctors

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\(^7\) and specifically not to procure an abortion

\(^8\) The translation from the archaic is not gender neutral. Women now participate equally in the medical profession.
would consider themselves as ‘holy’. Much has changed and will continue to change. Euthanasia and abortion challenge the doing of ‘no harm’; and ‘good’ is complicated if monetary reward is expected. The ‘duty’ to do ‘good’, from the power to do so, is claimed as not reciprocated by a patient’s ‘right’ to expect goodness (Harre, 1995).

Eliot Freidson, affirming the importance of knowledge, autonomy and consequent professional power, also considered that, sociologically, professionalism must also include the protection of professional prestige and earning power; and to involve those elements of professional self-delusion that characterise any professional work as non-routine, and to require great skill (Freidson, 1970b). Freidson was writing at the end of the era of the most rapid advance in medicine, at a time when autonomy, i.e. the control of medical standards by the profession without scrutiny by government or society, was accepted as just rewards for a vision of the end of human suffering. Contagious disease could be considered as largely overcome and other diseases awaited their own pharmacological solution.

It was not to be: humanity unfortunately remains bedeviled by chronic diseases that elude explanation and rational treatment (Le Fanu, 2000). James Le Fanu, a medical writer, claimed that many of the advances of medicine were fortuitous and not based on any understanding of the underlying causes of disease. As healthcare services became ever more expensive, and a consuming public better informed and more sceptical, medical professionalism necessarily acquired other attributes. Proven competence became insufficient without recognition of the limitations of competence: and competence became outdated with rapidly advancing knowledge and technical
skills that required reassessment and recertification. Moreover the processes of care and competence were required to be accountable to a consuming public. Paul Hodgkin in a British Medical Journal editorial writes of this scepticism as ‘Credicide’ the death of belief (Hodgkin, 1996).

Medical and scientific advances introduced ethical conflicts into medical professionalism and the employment of the ‘professional ethicist’. Ezekiel Emmanuel argues that it is not the ‘advances’ per se that require philosophical resolution but the abrogation by medical specialism of its ethical ends by a concentration on technical skills (Emanuel, 1991) p. 31). Moreover Paul Komesaroff considers that these ‘big picture’ ethical conflicts are irrelevant for most of medicine and that ‘micro-ethics’, dealing with day-to-day doctor-patient contact, highlights the more significant conflicting value systems of doctors and patients (Komesaroff, 1995). He notes the need for doctor versatility in negotiating the differing meanings given to words by a consuming public and refers in philosophical ways to what he notions the ‘language games’ of Wittgenstein (Wittgenstein, 1974). The Australian surgeon Miles Little takes this point further in promoting the education of medical students into the different values and meanings of patients in understanding, for example, evidence and probability (Little, 1995).

The Inquiry into King Edward Memorial Hospital can be argued as exposing outdated medical professionalism and possible distortions of traditional core values (Western Australian Government (KEMH) Inquiry, 2001). It challenged the different meanings of ‘responsibility’, ‘supervision’, ‘accountability’ and ‘adverse events’.
I have been at pains to note that the inadequate standards of care revealed by the Inquiry cannot be assumed to apply only to one tertiary level obstetrics and gynaecology hospital in a unique environment like Western Australia, and those deficient healthcare standards may be more widespread. More examples of defective practice in healthcare institutions will be presented later to illustrate other aspects of a dysfunctional medical professionalism. Unless there is scrutiny of a possibly more widespread and philosophical basis for errors and defects in healthcare efforts to encourage change will be concentrated on practice in individual institutions. Use will then be made of institutionally directed and possibly coercive management initiatives. Examples of such coercive practices are discussed later; the Healthcare Commission used in the investigation of maternal deaths at Northwick Park in the United Kingdom (Healthcare Commission, 2006), and government efforts to determine guilty parties in Campbelltown and Camden Hospitals in New South Wales (New South Wales Minister of Health, 2003).
2.3 Report of the Inquiry into King Edward Memorial Hospital

(Western Australian Government (KEMH) Inquiry, 2001)\(^9\)

2.3.1 Introduction

The Report of the Inquiry into King Edward Memorial Hospital is contained in five volumes (Western Australian Government (KEMH) Inquiry, 2001). There are 1874 pages of transcribed evidence, and preceding these details in Volume 1 is an executive summary and a list of 237 recommendations. The final volume, Volume 5, includes over 500 pages of overall outcome data and charts comparing KEMH with other similar hospitals in Australia. However comparisons were admitted to be difficult because of case-mix variation, and conclusions as a result possibly invalid.

In the references below ‘Vol’ refers to one of the five volumes, the next number refers to the chapters numbered sequentially throughout the Report from 1 to 14, then to the sections of that chapter, and finally to sub-sections of those sections. Hence Vol 4.11.3.32 refers to chapter 11 contained in the 4\(^{th}\) volume and to section 3, sub-section 32 of that chapter. Volume 1 contains both an Executive Summary and also a list of 237 Recommendations that are numbered according to the chapter they represent and to the section within that chapter. Hence Recommendation R.9 3 refers to a recommendation stemming from chapter 9 section 3. The ‘Summary’ and ‘Recommendations’ in Volume 1 have page numbers in Roman numerals.

\(^9\) This section of this chapter draws selectively from the report made up as an electronic access pdf file, as a hard copy and as a CD disc.
King Edward Memorial Hospital (KEMH) is a hospital devoted to medical and surgical problems peculiar to the reproductive systems of women, and to the care of pregnant women and the newborn. It is sited in a suburb of Perth, the only metropolitan area of Western Australia. The hospital is special in being the only hospital for high-risk obstetrics in Western Australia, accepting all complicated cases from the huge area of that state. The map below shows the geographical area of Western Australia containing approximately 2 million of the 21 million population of Australia. The population of Perth is 1.17 million (2001), the fourth largest of Australia’s cities (Search, 2001).

Figure 2.1  Perth  Western Australia on the Map of Australia
King Edward Memorial Hospital (KEMH) was founded as a maternity hospital in 1916 at a time when public hospitals housed the poor, and at a time when puerperal fever, involving infection of the genital tract after the delivery of children, made these women a risk for other patients. In effect it was an isolation hospital. This concept of isolated maternity hospitals is a long outmoded historical anachronism; and it means that women admitted to KEMH do not have access to the multidisciplinary skills and technology of large general hospitals.

Although King Edward Memorial Hospital, as a teaching hospital, does admit ‘normal’ midwifery, it deals with a preponderance of complicated obstetrics from patients initially referred to it, and those that have been recognised as complicated when seen in secondary level hospitals. This feature makes it difficult to compare its treatment outcomes in terms of complication rates with any similar institutions. Section 7 of the Report deals repeatedly with difficulties in any form of comparative data analysis both as regards the special nature of the hospital and of the demographic characteristics of the state. The Inquiry employed a ‘Consortium’ of experts to review data from KEMH and other Australian specialist hospitals with results contained in Vol 5 Annexure 14. The conclusions on both obstetrical and gynaecological information contained reservations in forming an opinion on the standards of care at KEMH (p. A 153 and p. A 155).

The background to the inquiry was concern in 1998 by the Chief Executive, his assistant legal officer, and by other staff, that the quality of care at KEMH was not as good as it should be. The Chief Executive was, however, neither medically nor
scientifically qualified. He reported his concerns to his superiors and eventually to the Western Australian Department of Health and its Chief Medical Officer. Other independent advice was sought with the decision to ask for assistance in evaluation from outside Western Australia.

Dr. Andrew Child of New South Wales and Ms. Pauline Glover, a senior midwifery nursing professional from South Australia, produced the ‘Child-Glover’ report following two weeks of review at KEMH in year 2000. This report was such as to persuade the Government of Western Australia to commission an in-depth inquiry into all aspects of care at KEMH from 1990 to 2000. This was to be chaired by a former judge Mr. Neil Douglas; it was to take more than eighteen months to complete, and it was to cost A$7 million.

2.3.2 Methodology of the Inquiry

In order to determine standards of care a selected sample of case files were examined. The selection was of those from high-risk cases, those with a possibility of medico-legal risk, and those from patients who, because they considered they had been harmed, responded to newspaper advertisements. Eventually 605 files were examined in detail. If some 52,619 cases were dealt with at KEMH over the eleven years from 1990 to 2000 (Vol 4 7.2.11 p. 647) then this sample represents 1.2% of the total. The methodology was directed not to finding out how KEMH managed overall, as a statistical exercise, but to learn from its poor outcomes, its accidents. It might suggest
however that any hospital examined for its bad outcomes over a long period might show similar defective care. Consequently any ‘lessons’ from the Inquiry may well have broad application, and this was supported by McLean and Walsh reviewing the Report on behalf of the Council for Safety and Quality in Healthcare (McLean and Walsh, 2002, McLean and Walsh, 2003).

An approved methodology for the determination of adverse effects has been attempted (Michel et al., 2004) but is yet to be agreed upon. That study from the Aquitaine in France noted different methods of assessing adverse events. It suggested from its own work and from that of others that retrospective studies would be appropriate for estimating the rate of adverse events, but that a prospective method is preferable for cause evaluation and for measuring risk reduction programmes. The KEMH Inquiry is a retrospective study and, in insisting on a change in its terms of reference, it was recognised that it could not determine the ‘incidence’ of adverse events, and its aim changed to determining their ‘occurrence’ (Vol 1 Sections 1.2.2 to 1.2.4).

The Inquiry into King Edward Memorial Hospital, with its legal counsels, interviewed 70 former patients, and 106 current and former members of KEMH staff including the author. These later interviews were conducted in a quasi-legal situation with questions arising out of an accumulated evidence base. The responses were transcribed and sorted into sections of similar information in an inevitably arbitrary fashion.
The terms of reference of the Inquiry addressed four main areas (Section 1.1.2):

1. To investigate what obstetric and gynaecology services have been provided, and how they have been provided, at KEMH over the period 1990 to 2000
2. To assess whether these services, or aspects of these services, are “acceptable”, “appropriate” and “adequate”
3. As part of that assessment, to identify any deficiencies - including the nature, extent and causes of those deficiencies - in the provision of those services and
4. To recommend changes to address those deficiencies.

The Inquiry achieved these ends and the Report was highly critical of the care provided at the hospital and, as noted, made recommendations many of which have already been implemented at the time of this study. However after reading the Report I wished to know why the hospital’s standards of medical care were occasionally so defective. It is a defining characteristic of the medical method that treatment of a disease cannot be undertaken without a proper attempt at a full diagnosis. I was concerned that the full diagnosis of the problems at KEMH had not been obtained. I wished to know if and what aspects of a misdirected medical professionalism were revealed by the KEMH Inquiry. If so, and if problems of the type revealed by the Inquiry are more widespread, then some type of professional change will be necessary.

I took the natural pride of a senior professional in belonging to an elite and learned group. Moreover in the early 1990s I had acted to promote quality improvement and,
although aware of how little regard there was for the processes of quality management, I was nevertheless perplexed by the revelations of inadequate professional standards. The KEMH had a reputation for medical excellence based on teaching and research similar to many tertiary level hospitals. If teaching and research excellence were inadequate to protect the patients of the hospital then my insistence on quality assurance measures was more valid than I had expected. I was, however, far from confident that these measures by themselves would be sufficient. The initial focus of my interest in the Report of the Inquiry was to determine if there were more ingrained problems with medicine and its values systems. Why were my colleagues so opposed to quality assurance? Why did the Report refer to a defective culture at the hospital? If ingrained cultural matters are involved just what were those matters and were they special to KEMH? As a senior clinician I had been asked to review defective care in other hospitals and knew that defective care occurred elsewhere.

I knew of the Quality in Australian Health Care study with its record of harm done to patients in hospitals (Wilson et al., 1995). I was aware of the considerable government and professional activity that had followed the revelations of that study (Task Force on Quality in Australian Health Care, 1996) (Australian Senate, 2000) (Australian Council for Safety and Quality in Health Care, 2003). I had, however, an active clinician’s innate suspicion of political and bureaucratic activity.
2.3.3 The Methodology of the Case Study of the Inquiry

In covering a possibly defective medical professionalism my interest was in covering those areas noted above as being values and characteristics of medical professionalism:

a) Autonomy, and the reactions of medical professionals to the Inquiry, i.e. an insistence that only medical professionals are equipped to judge medical matters

b) The claim to ‘Do No Harm’ and measures taken by medical professionals to limit harm and to

c) Assure high standards of competence, i.e. quality assurance, (the doing of ‘good’) and measures taken by medical professionals to

d) Control the use of new technology.

What efforts were taken by medical professionals to

e) Ensure care and compassion, and

What efforts were taken to encourage a

f) Learning environment for medical professionals.

The pages of the report were colour coded to enable collation and analysis. The selections of appropriate passages are subject to judgment, and are, consequently, arbitrary. They are however very informative as to what role medical professionals play in the maintenance of the standards of healthcare.
In dealing with autonomy, was there an insistence that only medical professionals can scrutinise medical matters? Confronting the avoidance of harm and the ‘doing of good’, how were standards of care professionally assured? The introduction of new technology is a challenge for any undertaking, and how medical professionals deal with that challenge might reveal much behind its philosophical underpinnings. The human dimension of care, so important to the Health Consumers’ Council noted in the introduction, is reviewed to determine if there are any medical professional behavioural characteristics diminishing human sensitivity. Finally examined is an aspect of medical professional behavior roundly criticised by the Inquiry i.e. that of how professional structures dealt with mistakes in care.

2.3.4 Professional Reaction

Medical professionals from KEMH complained of the poor effect of the Inquiry’s ‘peering in from outside’ (Vol 1.Exec summary p.xviii), and that the initial scrutiny from the Child-Glover Report was ‘amateurish’ and ‘erroneous’ (Vol 1.Exec summary p.xxi). The Executive Summary lists four separate letters to newspapers from the Australian Medical Association (West Australia Branch): that the KEMH Inquiry was ‘a farce’, a waste of money, and outdated (Vol 1.p. xix).

Later, in dealing with mechanisms for the management of mistakes, or adverse events, the Inquiry noted that an order was made that these events be reported to the Chief Executive and his legal adviser. This was opposed by the Chairman of the Clinical
Association and by the then President of the Western Australian Branch of the Australian Medical Association (AMA). The President, in a communication titled “Doctor Alert” sent to AMA members, noted that if the Chief Executive was not medically qualified, any such report should be to a Medical Director (Vol 4.11.3.77 and 11.3.79). The opposition was framed in legal and industrial terms, but the objection to non-medically qualified personnel had much to do with professional autonomy. Indeed the Chairman of the Medical Board in Western Australia in a letter to the Chief Executive of KEMH on 13th Sept 2000 noted the clinical responsibilities of Directors of Medical Services, and of medical practitioners serving on Medical Advisory Boards (Vol 1.3.3.79 p.144). By that time KEMH had not had a Medical Director for two years.

It must be concluded that the claim for professional autonomy was a strong component of the professional reaction to the Inquiry. This will be further discussed.

2.3.5 The Supervision of Professional Standards

One of the most significant findings of the report in regards to poor results was that in many of the most high-risk cases, those involving conditions of most risk to the mother and/or child, junior hospital staff did not obtain the advice and supervision of more experienced staff. It was concluded that consultant specialist staff expected these inexperienced doctors
‘to know when they needed supervision, rather than on senior doctors to determine when junior doctors were sufficiently competent to provide care’

(Vol 1.Exec Summary p xiv).

These doctors were, in the main, in training for specialty recognition, and an ability to manage problems was expected. However in those obstetric cases defined as ‘high risk’ one in three had decisions taken at the most crucial stage by the most junior medical staff (Vol 2.6.3.6 p.586). The report notes this issue as ‘a fundamental cultural, management and accountability problem’ (Vol 1. p. xiii).

Modern medicine as a behavioural philosophy can be viewed as a quasi-military service. People die after a ‘battle with cancer’ and the medical profession takes part in the ‘conquest of disease’, with doctors as warriors; and those in training to be assessed like junior officers for their ‘moral fibre’. To call for help might indict one as ‘lacking’10. It is suggested that a request for help could signify incompetence and affect subsequent professional advance (Vol 1.Exec summary p xvi), but I believe the reluctance to request help to be more than a fear of revealed incompetence. Later in the report there is a suggestion from a senior midwife that junior doctors might need some type of support and counseling to cope with adverse events (Vol 4.11.3.31). The request for counseling would not have come from senior medical professionals at KEMH. This was corroborated in a note from a senior medical consultant as to ‘how good nurses are at this (support) and how bad we (doctors) are’ (Vol 4.11.3.32).

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10 ‘to be ‘lacking in moral fibre’ was a serious indictment of soldiers dating from the First World War inferring cowardice
2.3.6 Clinical Responsibility

The report notes the long history of difficulty with the assignment of clinical responsibility for public patients attending the hospital, i.e. which specialist was responsibility for the care of any one patient at any one time. The analysis of this problem is extensive (Vol 3 9.3.1 to 9.3.225)

To some extent this was also a leftover from the history of public hospitals and specialists in Australia. Public hospitals in each Australian state were originally created to care for the indigent sick (Hillman, 1999). They were charitable institutions. Qualified specialists were appointed as ‘consultants’ to hospitals, i.e. they were to be available for ‘consultation’ in public hospitals at listed times, as Hillman claims “for several hours each week” (Hillman, 1999 p. 325). They were to provide advice, as and when necessary, and to be responsible for that advice, but were not expected to be responsible for overall clinical care. These specialists were unpaid, providing their ‘consultation’ as an honorary commitment to their teaching hospital, their alma mater. A teaching hospital appointment provided professional esteem and was professionally valued, “the clinician’s conscience and sense of righteousness were satisfied” (Hillman, 1999 p. 325). Public charity based hospitals like KEMH were traditionally dependent for day-to-day clinical management on poorly paid academic and semi-administrative staff; and on doctors in training; but not on occasional visits from benevolent consultant specialists.
This historical attitude to public hospital service pervaded the problem of clinical responsibility. At a signal meeting of the Clinical Staff Association of KEMH (the representative body for medical staff), there was a statement that public patients, ostensibly receiving ‘free’ treatment, could not expect the same care as private patients (Vol 3.9.3.100). Indeed I can remember the comments as expressing fears that if public patients were equally treated then there would be no incentive for the public to take out insurance for private care.

The consultant specialists most affected by and most resistant to change in matters of clinical responsibility, were those providing occasional supervision, the visiting consultants. These doctors while wishing to retain ‘influence’ (Vol 3.9.2.12) were not committed to KEMH in a way that was becoming required (Vol 3.9.2.296): they did not attend hospital educational and management meetings, did not participate in research, were determined to ‘work-to-rule’ in clinic/session attendance, and left public patients to attend to their private patients. It was evident that the hospital would have been much easier to manage if specialists could have been employed to work full time at KEMH. However with pay and conditions as they were, and with restrictions on hospital budgets, this was not possible.

These factors, though involved, do not get to the heart of the matter of a distorted professionalism. This is more revealed by the continued failure to embrace clinical responsibility. The Inquiry made much of the obduracy of the Clinical Staff Association (CSA) in coming to terms with change, and I have noted the historical background to clinical responsibility and to ‘consultation’. The then Medical Director
in 1998 emphasised in a letter to the CSA that the patient, and the other members of the health care team, needed to be aware of the relevant caregiver (Vol 3.9.3.6). Later he insisted that there were imperatives for clinical accountability (Vol 3.9.3.92):

   a) The patients need to know of their responsible specialist
   b) Other health care team members need to know of the responsible specialist
   c) Referring GPs need to know of the responsible specialist
   d) Hospital administration managing governance issues need to know who the responsible specialist is.

In response, the Chairman of the CSA, following the meeting with his colleagues, refuted all but the last ‘imperative’, that related to administration and quality audit (Vol 3.9.3.100). He later regretted his statement (Vol 3.9.3.127), but mainly with regard to the expectations of private and public patients. He considered that GPs already knew of the consultants in charge, which was patently untrue; indeed the whole point of the Inquiry’s criticism is that no one knew who was really ‘in charge’. Incidentally this is one of the few occasions when GPs were mentioned in the report.

The Chairman of the CSA approached other similar hospitals in Australia to determine if similar difficulties were present (Vol 3.9.5.129). One hospital had sought legal advice on responsibility issues, and another, with responsibilities allocated in a comparable fashion to KEMH, had comparable difficulties with daytime cover.
2.3.7 Technology and Credentialling

Other historical trends that impacted on KEMH in those years were changes in technology and in the nature of specialisation. Marked improvement in lighting and optical resolution became available for endoscopic and laparoscopic surgery and enabled an increase in ‘minimal access’ surgery. However skills and training were necessary for the employment of this new technology, and these needed to be assured. The monocular view of endoscopes and the loss of tactile receptivity inherent with the use of this technology exaggerated a learning curve of complications over time. That is to say those surgeons and the operating theatre teams ‘learn’ from the complications suffered by their patients in the early days of any new technology. King Edward Memorial Hospital was similar to all hospitals in this regard. Patients and hospitals were exposed to clinical and legal risk, but professional standards were matters for the professional Colleges\textsuperscript{11}.

King Edward Memorial Hospital had to impose proper scrutiny of technological skills. The Royal Australian College of Obstetricians and Gynaecologists was able to insist on standards of training and provide training programs, but risk and scrutiny were matters for hospitals, and this was a novel exercise. This credentialling of often established specialists at KEMH took from 1991, when it was first mooted, to 1999 to become established, a very desultory and poorly supported progress (Vol 3; 9.4.1. to 9.4.249).

\textsuperscript{11} The Learned Specialist Colleges, following examination and supervised experience, granted specialist recognition. These Colleges accept responsibility for setting specialist standards.
The following is an extract from the Report.

9.4.236 A number of Committees at KEMH considered the issue of credentialling. The Medical Advisory Committee highlighted the need for credentialling at its meeting in November 1995. The minutes recorded that –

“Concern was expressed regarding the lack of a credentialling process for doctors for various surgical procedures. It was felt that there should be a process for credentialling new and developing procedures”.

9.4.237 Despite numerous discussions about, and acknowledgments of the need for, a formalised credentialling process, the process prior to that time, at best could be described as “ad hoc”. Indeed the Child & Glover report in April 2000 noted there was “no evidence of a formal credentialling process”.

It was not until mid-2000 that KEMH adopted a formal credentialling policy.

Technological change also influenced the traditional conjunction of obstetrics, the care of mothers and newborn, with gynaecology and progressive subspecialisation. Gynaecological oncologists, treating cancer, and urogynaecologists, managing bladder problems in women, wished to supervise their own patients, and not to take part in obstetrics, in which they were becoming inexperienced. General gynaecology was becoming affected by an overall positive trend of reduction at KEMH in numbers of women requiring hysterectomy, the removal of their uterus. Hence the hospital needed consultants willing to cover obstetrics, an often out-of-hours activity, but did
not need their part in general gynaecology (Vol 3.9.2.25 and Vol 3.9.2.293). This was not an attractive option for many specialists.

Moreover some highly trained specialist obstetricians, now to be termed feto-maternal medical specialists were no longer exposed to gynaecology i.e. it was no longer part of their normal clinical work. They did not wish to cover gynaecology cases that might require technological skills with which they were unfamiliar, e.g. laparoscopy, on evenings and weekends. This in effect meant the hospital had to arrange cover for two specialties, obstetrics and gynaecology that had in the recent past been one. Costs and cover were affected by this occurring progressive specialisation (Vol 3.9.1-3.9.733). However, in contrast to the need to certify new technological skills, progressive professional specialisation cannot be an indictment of professional values but of a failure by government to anticipate the increased funding required.

2.3.8 Caring

I referred in the introduction to this case study that in health care there must be a dimension of hospital care involving psychosocial concern, i.e. that care involves compassion, and sensitivity to emotional and social issues. The Inquiry explored this matter noting four main themes arising from secondary analysis of patient complaints and staff comments to the Inquiry (Vol 2.5.16.2). The four themes were:
a) failure to provide explanation of poor outcomes
b) failure to include women and their partners in decision making
c) lack of sensitivity, respect/dignity and support
d) failure to listen and respond to subjective symptoms.

In any large organisation dealing with the public there will always be a level of discontent. Health care providers are not inhumane insensitive people, but are human enough to be tired, stressed and over-worked. I can remember a short discussion in 1999 with the then State Minister of Health, when visiting Princess Margaret Hospital, a tertiary level childrens’ hospital in Perth with which KEMH became joined for administrative purposes. We agreed that the first casualty of over-stretched human resources within hospitals, as in many institutions, was kindness: both between clinicians and patients; but also between clinicians themselves. With urgent demands on limited time clinicians will prioritise clinical activity before the psychosocial, and will sometimes deal with patients and their colleagues in ways that they will subsequently regret. The Report lists individual patients’ complaints under the headings above and, from the point of view of the medical profession, they are all regrettable.

The question to be phrased is, however, whether or not insensitivity to the human needs of patients is professionally as well as personally mediated. Is there any evidence that a professional culture diminished this aspect of care at KEMH more than that that accounted for by an excess workload? I believe that the notes on psychosocial issues in Vol. 2 reveal such a situation (5.16.1 to 5.19.14.). There is
listed a series of complaints by patients ranging from poor sensitivity to outright rudeness. What stands out is the inability of patients to access explanation or redress. The problem lies in the hierarchical relationships from nurses/midwives to junior medical officers, serving perhaps six monthly appointments, then to registrars of different seniority undertaking specialist training, and then to consultant specialists. The Report eventually notes the need for midwives concerned that a patient is being mismanaged to directly access responsible consultants (Vol 2 5.19.14). In other words, the patient needed a trusted advocate to deal with perceived impaired care, and medical professional structures did not provide such advocacy.

2.3.9 The Management of ‘Adverse Incidents’

The Report is critical of the hospital’s management of error. The QAHC study, already noted (Wilson et al., 1995) led to an insistence that all hospitals monitor the occurrence of adverse events. They were to put into place procedures to deal with patients harmed (and those ‘almost’ harmed) by errors in care. The hospitals were to use these events to create processes to reduce both the rates of error and the damage and impairment that resulted. Harm caused by adverse events is not only physical but also generates a sense of grievance and disillusionment.

The details of cases at KEMH that suffered harm remain confidential\(^\text{12}\) but are listed by number (Vol 4.11.1.96). They include technical failure, inadequate action from

\(^{12}\) Confidential details were not finally released until December 2006
available information, failure to request additional information and advice, and lack of care and attention.

The Report noted the reluctance of doctors to report incidents involving adverse events (Vol 4.11.2.h) and that any reporting was largely by nurses and midwives (Vol 4.11.2.248). One senior doctor stated to the Inquiry that

“it wasn’t part of the culture to bare your soul and confess all because doctors don’t do that sort of thing. I suppose more recently that it is more a fear of, “if I’ve made a mistake or an error of judgement I might get sued to hell and back”. It’s true here too I think that when people make mistakes they feel bad about it.” Vol 4.11.2.277

The Report mentions the preference by doctors to use informal non-structured mechanisms for the discussion of mistakes; and only to involve medical professionals. It noted the Perinatal Mortality Meetings which were at different times encouraged to be special to medical staff; and to be conducted to determine fault (Vol 4.11.4.6 to 11.4.50).

The report noted one senior midwife’s comment on the Meetings:

“… [didn’t] know exactly what the latest update is, but we used to go and the doctors felt quite threatened that we were making suggestions, so there was a time when we were not encouraged to go”. Vol 4 11.4.24

A senior medical consultant admitted:

“a sense of senior staff blaming junior staff” and explained that –

“It always seems that the consultant-in-charge somehow sort of manages to separate themselves from the case”. Vol 4 11.4.47
‘Blame’ was not a theoretical concept. One registrar interviewed by the Inquiry noted:

“I have seen my colleagues walk out of a Perinatal Mortality meeting in tears. With me, as a resident, I stopped going to the meeting for a while after that”.

Vol 4. 11.4.40

These meetings were informal in that no records were kept; the ‘discussions’ remained an in-house activity. Very few policy initiatives stemmed from error revealed at these meetings. One former clinician and senior administrative medical officer, both in the hospital and in the West Australian Department of Health, and a previous surveyor from the Australian Council on Healthcare Standards responded to questions on whether or not policy activity stemmed from these meetings

“No, and, I mean, that certainly was a deficiency in the process and I think is still a deficiency in a lot of hospitals around this country.”

Vol 4 11 4 59

The degree to which those taking part in these meetings felt that the meetings were purposeful was also critised by the Inquiry.

Many clinicians, especially midwives and nurses, were critical of the feedback they received. This applied to feedback following the review, by the Perinatal Mortality meetings, of cases in which they had been involved. More generally, it applied to feedback given to clinicians in respect of any incident in which they had been involved and particularly an incident that they had reported.

Vol 4.11 4 61

This reluctance to engage in a formal reporting mechanism covered most of the decade, changing only with the adoption of the Australian Incident Monitoring System
AIMS) in 2001. This involves the use of computer software designed to correlate clinical incidents and adverse events.

This analysis has already noted the eventual conflict between hospital administration and organised medicine as represented by the AMA in regards to a reporting mechanism for adverse events to non-medical administrative staff (Vol 4.11.3.77). This was to lead to the hospital’s Chief Executive to approach the Metropolitan Health Services Board and, eventually, to the Inquiry itself (Vol 4.11.2.202).

It is now appropriate to summarise the points made in respect to professional dysfunction and the Inquiry. Again this is made under headings of those characteristics that delineate medical professionalism, i.e. autonomy, certified competence, a special doctor-patient relationship, and professional prestige (Freidson, 1970b, Pellegrino, 2001).

2.3.10 Summary of Professionalism and the Inquiry into King Edward Memorial Hospital

The inquiry noted a culture within KEMH that, it would seem, inhibited efforts to identify poor practice, permitted poor practice to continue, and thwarted efforts to remedy poor practice:

“a problem arises not only because of procedural deficiencies but also because of underlying cultural or organisational factors” (Vol 1.p. xx)
What aspects of medical professionalism might be considered part of such dysfunctional behaviour? A most significant professional characteristic to be examined is autonomy, i.e. the wish for the profession to be responsible for its own affairs without non-professional scrutiny. This might be acceptable were the profession able to ensure professional competence. Further, to what extent was the profession able to sustain a doctor-patient relationship largely dependent on trust? Had trust been lost? Lastly, had professional prestige and value been diminished?

**a) Autonomy**

Medical staff at KEMH expressed considerable irritation at the concept of an ‘outside’ review. They were supported by the organised medical profession in the shape of the Western Australian Branch of the Australian Medical Association. The insistence on autonomy for the profession in Western Australia was as outmoded as the existence of a separate maternity hospital. An autonomous profession might have had relevance when the role of government was limited to giving recognition and title but governments are now largely responsible for the disbursement of public moneys to support both healthcare technology and also professional remuneration. Government is also expected by a democratically empowered population to be responsible for standards of operation of its public facilities. Hence the operation of a public hospital is subject to public scrutiny, including from outside the medical profession.
The imposition of quality improvement programs on medical professionals at KEMH was however resented as an intrusion on professionalism. The appointment of non-clinical administrators was most resented:

“If you ask a clinician about quality, he will say ‘course I do quality, I do quality all the time, I don’t need you to come in here and tell me what we need to do for quality, I don’t need you to tell me we need systems in place, and we need this...I do it all the time, I’m a clinician for God’s sake”

Quality Manager, Director of Continuous Improvement

(Vol 5.14.4.99 p.1864)

Eliot Freidson anticipated the need for external control of medical practice standards in 1970, even at a time when, with the suppression of contagious disease, the reputation of medicine was at its zenith:

"Only the requirement of a formal, periodic, outside professional review can provide the counterlever to the tendency for the development of self-sustaining, parochial standards in practice settings".

(Freidson, 1970b p.224)

‘Parochial standards’ would be an apposite phrase for King Edward Memorial Hospital. Twenty years after Freidson, Don Berwick (Berwick et al., 1991) saw the demand (for public accountability) as more economically framed. However it took studies such as the QAHC study in Australia and, earlier, that in Boston, Massachusetts (Brennan et al., 1991) to concentrate external agencies onto medical error.
However accountability through the imposition of practice standards, performance indicators, audit, and the clash of wills demonstrated by the resistance of KEMH and the AMA, is related to the issue of who is to set these standards. In the next chapter the imposition of clinical governance by outside agencies like government and corporate bodies will be argued as risking exposure to values and motivations other than that of clinical excellence, for example those of fiscal and medico-legal restraint. This thesis is to suggest that to be effective clinical governance may need a more immediate accountability to healthcare consumers.

b) Competence

An expectation of certified training and competence is an initial prerequisite for any professional encounter. As revealed by the Report a patient attending or admitted to KEMH between 1990 and 2001 could not expect such assurance. The competence of junior hospital doctors was in keeping with their inexperience, but they lacked the support to request help from those more able. The hospital and its specialist medical professional staff did not ensure that junior doctors only operated within the limits of their competence.

The Executive Summary of the Report notes a clinician as stating:

“Low morale at the hospital stems from years of lack of supervision/teaching. Junior staff feel unsupported and over criticised (sic) – Residents have been left to their own devices and there is simply little or no supervision for junior registrars.”

p xiii
The Report itself commented that:

“For many years, there has been a culture at KEMH, ingrained in day-to-day practices, of junior medical staff providing care in complex cases without supervision.”

p. xiv

Also on the same page that:

“The Hospitals handling of the supervision of junior medical staff is also indicative of underlying and systemic management and accountability problems at KEMH.”

p. xiv

The Summary goes on to make the point that although increasing staff numbers might be necessary this would be insufficient without addressing ingrained cultural problems. However from the perspective of a search for examples of distorted professional values it is relevant to ask what aspect of medical professional culture could be involved in permitting incompetence. Is it possible that senior medical specialists at KEMH could avoid the direct supervision of junior staff because the lack of supervision would remain undiscovered? The profession could rely on its autonomy while educational programs for its newer members continued. Those programs could be rigorous but conducted behind professionally closed doors. Moreover, with junior staff unprotected from blame by senior specialists, autonomy also extended to the closure of meetings to fairness and probity.

This distortion of professionalism to include bullying is disturbingly common, as revealed by surveys in the United Kingdom (Quine, 2002) and the United States (Daugherty et al., 1998). The denigration of junior hospital doctors at KEMH meetings had minimal educational benefit.
The professional demands for special technological skills and knowledge changed during the 1990s but, from the review of credentialling by the Inquiry’s Report noted above, no system of ensuring compliance with safe levels of skill and knowledge was created at KEMH until the end of the decade. This was a similar situation to that of junior staff. Public patients, and public facilities, were considered most useful for initial experience, and with professional autonomy there was little risk of critical exposure.

The other consequence from technological development was progressive sub-specialisation and the need to recognise such sub-specialists. I have noted the recognition of gynaecological oncologists, urogynaecologists and feto-maternal specialists. General obstetrician-gynaecologists are, like general paediatricians, specialists but with, in many respects, primary care type practices. They see patients by referral in the Australian healthcare system but often for routine and recurrent review. The referring general practitioner does not evaluate the presenting problem; the patient is referred on without primary scrutiny; at the patient’s request. Gynaecologists can therefore build up long term relationships with their female patients very similar to that of general medical practice. However within KEMH these general gynaecologists over the period of study by the Inquiry were becoming less relevant as the specialty sub-divided into various sub-specialty areas. Inevitably in many circumstances tertiary level specialists, now become ‘sub-specialists’ can only have short-term relationships with patients.
The Report’s findings from a retrospective case-file search were of substandard care in enough cases to conclude that there was a culture of impaired professional and hospital standards. There was however minimal evidence that these results were special to KEMH; and they might well apply to other hospitals and to other professional groups. For example a comparison between KEMH and other tertiary maternity hospitals (Vol 5 Annexure 14 of the Report) noted an excess of still born infants at KEMH that might have been because many patients found to have an intra-uterine death elsewhere in Western Australia would be directed to KEMH for the eventual delivery. Also the definition of a ‘birth’ was different for different states. In Western Australia a birth included all those known to have exceeded 20 weeks of gestation but in other states there were definitions that included birth weights and different weeks of gestation (Evans, 2002). At these very early weeks of birth babies are more likely to be still born. There were also higher rates of assisted vaginal deliveries (forceps and vacuum extraction), but also increased use of epidural anaesthesia that might explain the difference.

A review by McLean and Walsh for the Council for Safety and Quality in Health Care noted that the peculiarities of KEMH and the demographics of Western Australia made comparisons with other hospitals difficult (McLean and Walsh, 2003). They emphasised the findings and recommendations of the Report of the Inquiry as of more universal application.
c) Doctor-Patient Relationship

The relationship between a trusting patient, trustworthy doctor and caring institution is at the heart of medical professionalism. It is the characteristic of medical professionalism that, according to Pellegrino and Thomasma (Pellegrino and Thomasma, 1981) marks it out as different from an applied science.

In a public hospital staffed by specialists it is difficult to make possible the individual human trusting relationship that depends on reciprocal knowing of one person by another. It is even more difficult with acute, frightening, painful, and sometimes unhappy situations. There is minimal time to develop trust between doctors and patients. The continuity of care discussed by the Inquiry (Vol 3.9.1.3) is more to do with accountability than that of patient trust. Patients need, i) to trust doctors to care for them, ii) to trust doctors not to exploit their vulnerability and, iii) to trust doctors to be sensitive to their unvoiced fears and misgivings. The only area where this sort of relationship was developed was the Midwife Birth Centre.

The Inquiry noted the need to identify clinical responsibility to “communicate with, and involvement of, the patient in respect of the patient’s treatment and care” (Vol 3.9.3.5 p. 887). As outlined in chapter four of this thesis health care consumers’ forums considered that they would be unlikely to meet the consultant responsible for their care in a public hospital. They assumed that hospital doctors appointed to their care would be competent. However at KEMH, as noted above, 1 in 3 doctors were of resident status and very inexperienced at times of most need for expertise.
Furthermore, as also revealed in chapter four, quite experienced health care consumers have no idea of the grading systems applied to hospital doctors, i.e. residents, registrars and (previously) senior registrars, and would not appreciate those that were experienced as opposed to those that were not.

The Inquiry exposed that for some patients of KEMH there was both a lack of competent care and also an inability to express a caring relationship. It was claimed that this was related to inadequate specialist numbers and inadequate finances to acquire specialists (Vol 3.9.2.302 p. 763). The links between inadequate resources and a trusting relationship have also been noted elsewhere (Illingworth, 2002, Jones, 2002).

The professionalism of doctors at KEMH was affected by the economic, political and social situations of the times. The Inquiry revealed that management and administrations at all levels were undergoing change. The Annual Reports of the Health Department of Western Australia constantly refer to ‘reform and ‘change’ (Vol 1.3.2.71 p. 124). The Report notes that change was to do with management structures rather than clinical care but management change can potentially compromise medical professionalism as illustrated by the change to clinicians becoming involved in management, the process termed ‘devolved management’.

At KEMH the administrative policy of ‘devolved management’ was also part of the political landscape. This process was intended to enable clinicians to take administrative control of their departments away from professional administrators.
The then Chief Executive Officer noted the objective of devolved management to “facilitate integrated quality patient care in a competitive environment” (Vol 1.3.2.31 p. 117).

These changes were directed towards cost containment in some shape. Clinicians were to be faced with the reality of limited financial and human resources. This required medical professionalism to relate individual patient care to the equitable allocation of resources. They were meant to ensure a clinical component to the competitive environment noted above.

A further element of the changed social landscape was, and is, the public regard for medicine and Eliot Freidson claims this to have decreased in response to general egalitarianism, education levels and threats from other professions (Freidson, 1986). If social prestige has been stated as one of the reasons visiting consultants continued to work at KEMH, then why should they figure so highly in the difficulties in organising clinical responsibility? A statement by the then medical director on ‘clinical responsibility’:

“It had been well debated. The issue still very much related to the way in which the services were structured and the visiting medical staff who were on-call for a service and their lack of presence in the hospital and therefore their lack of willingness to accept responsibility”.

(Vol 3. 9 3 131)
d) Professional Prestige and Value

In assessing the Report of the KEMH Inquiry one is puzzled by the incongruent history of visiting consultants; honored to serve public patients at the hospital for no financial return in the 1960s becoming doctors unwilling to undertake supervisory activities for poor remuneration in the 1990s. Can beneficence have altered in a few decades? Has the profession become a reflection of a society that can only value work in monetary terms? The answer supported by an editorial team from the Australian Medical Journal (Chew et al., 2003) is probably – ‘yes’. This may also reflect how doctors view themselves following turbulent times in the development of the medical profession; no longer aspiring to heroic status, but now to be viewed as professionals worthy of hire (Glannon and Ross, 2002, McKay, 2002).

However medical professionalism from the days of Hippocrates has within it an element concerned with the protection of the profession. Freidson (1970) linked professional prestige with earning power but he also noted a professional ‘etiquette’ “Furthermore, professional etiquette itself discourages observation and criticising one's colleagues' work” (Freidson, 1970b p.223). A clinician would never know when he, or she, in his, or her, turn might need the protection of professional solidarity, i.e. to avoid the disclosure of error.

In summary the Inquiry into KEMH has disclosed a dysfunctional professionalism unable to assure competent care and unwilling for this to be exposed. A professional doctor-patient relationship was shown almost non-existent and, while there were
changes in the political, economic and social environment, medical professionalism had remained unwilling to adapt to demands for public accountability.

The Inquiry into KEMH was not the only exposure of inadequate and impaired healthcare in the last decade. If a defective medical professionalism is apparent then these other examples should be examined from the same perspective. It is possible that the same or different relations are involved.

These disclosures of sub-standard care to be discussed occurred in Australia and the United Kingdom, which share a common healthcare professional background. They will be examined to assess differences or similarities to the KEMH Inquiry. They also point to different measures taken to respond to revelations of sub-standard care. It is this response which forms the hypothesis of this thesis and is the substance of the next chapter.
2.4 Other ‘Scandals’ of Hospital Care

The following short accounts of poor institutional healthcare are used to illustrate aspects of impaired medical professionalism with their own lessons for future change. The scandal at the Bristol Royal Infirmary shows that the medical profession can support accountability but take little notice of the results, and the Alder Hey childrens’ hospital’s use of post-mortem organ parts points to an inhumane professional insensitivity. The maternal deaths inquiry from Northwick Park Hospital in the United Kingdom is more recent with conclusions and recommendations surprisingly similar to those of the KEMH Inquiry. The Cambelltown and Camden Hospitals investigations in New South Wales were special in the insistence by responsible government to determine personal fault, and the Bundaberg Base Hospital’s Dr. Patel exposure extended to more direct political matters concerning the Queensland Government Department of Health than was apparent at KEMH.

2.4.1 Bristol

The conduct of cardiothoracic surgery on children at Bristol Royal Infirmary between 1991 and 1995 has passed into folklore. The government produced report considered that, of the 71 children operated upon, 30 to 35 would not have died if they had been operated upon elsewhere (Bristol Inquiry, 2001). The scandal was not only that the standards of care were poor but that they were known to be poor and nothing was done about it. Hence amongst those eventually deregistered by the British Medical Council
was the medical administrator, who had no contact with the children but who was considered to have ignored the known inferior results (Dyer, 1999).

The knowledge of this event may well have encouraged the Chief Executive of KEMH to report his disquiet to his immediate superiors in Western Australia. The difference was that at KEMH there was found to be no definite evidence of overall poor results in comparison to other institutions. Nevertheless substandard care at KEMH was tolerated almost as a learning opportunity. The Bristol failure however struck at the very heart of British medical professionalism in a way that did not happen in Western Australia. It is interesting to consider why this was the case.

It appears to me that the reason for this is related to the vehicle of exposure. In Britain the Bristol failure was revealed as a media exposé; the medical establishment displayed as fraudulent, and as needing the people’s voice to amend core corruption. George Taylor writing about lessons from the Bristol case insisted that the Department of Health knew of Bristol’s poor results, the Royal College of Surgeons knew and the Regional Advisory Group knew; and all did nothing (Taylor, 2003).

In Western Australia it was a government asking for explanation of possibly poor standards. However although politicians and government bureaucracy may be pursuing legitimate activity they may be suspected by a sceptical public of tainted motives (Brenton, 2005, Toynbee, 2005). Scott Brenton concluded that Australians supported democratic ideals but were critical of how democracy works in practice. Polly Toynbee (2005) in a Guardian newspaper web site voiced public opinion in the
United Kingdom as becoming increasingly sceptical of government ethics:
"Politicians never were much trusted, but things have got worse: the number saying they trust government has halved since 1986." (Toynbee, 2005)

2.4.2 Alder Hey; the ‘dark side of the force’

A large children’s teaching hospital in the outer suburbs of the city of Liverpool in the United Kingdom, linked to the Medical School of the University, appointed a new head of child pathology in 1988. It subsequently transpired that he instituted a policy in the Liverpool area of widespread collection of internal organs from children dying and having post-mortem examinations. He did so without the knowledge or permission of the parents. The organs were to be used for some future research but were kept in temporary storage in his private consulting rooms, and with only perfunctory records.

Again the revelation was an almost accidental media occurrence stemming from chance remarks at the Bristol Inquiry noted above. There was minimal and clumsy cooperation from hospital authorities, who indeed may have known little of what had occurred (The Secretary of State for Health, 2001). The further point was that, although the recently appointed head of paediatric pathology at Alder Hey had greatly increased the incidence of wholesale organ retention, similar activity was long established and widespread (Innes, 2003).
The inclusion of the Alder Hey scandal into a discussion of professional standards is to point to a possibly dark aspect of medical professionalism. This is the interest by medical professionals into the disease process rather than into the human situation of those suffering the effects of the disease. It is to some extent the clinical ‘gaze’ that Foucault found so disturbing (Foucault, 1973).

The charitable hospitals of the middle ages were refuges for the sick but, post-enlightenment, could be used for the ‘rational’ observation of the diseased. Initially Sir Thomas Sydenham and, much later, Sir William Osler (Osler, 1932) were to emphasise the learning of medicine by observation at the bedside. The bedside for students was to be found in the teaching hospitals. Sydenham’s quotes have become legendary:

“I know an old woman in Covent Garden who understands botany (the source of materia medica) better than I, and as for anatomy, my butcher can dissect a joint full as well; no young man, you must go to the bedside, it is there alone you can learn disease.”

(Bender, 1966 p.122)

Sydenham still devoted himself to the humane side of medicine, for his emphasis was not to discard this part of medicine but to jettison a reliance on books of long held beliefs that had no foundation in facts. “Read what you like; reading books will never make a doctor”

(Bender, 1966 p.122)

William Osler began the process of attaching training positions for doctors to hospitalised patients from the time of his appointment to John Hopkins University
Medical School in 1889, i.e. that doctors would acquire experience by ‘practice’ on patients rather than simple observation. However this ‘use’ of ‘teaching material’, largely from the indigent poor, risks dehumanising medicine and, with increased knowledge of human physiology and pathology, the ‘modernising’ of medicine in which doctors saw patients as their constituent parts and processes. Emotional and social involvement was to be avoided as threatening to distract from a proper analysis of the signs and symptoms of disease that enabled diagnosis. Michael O’Rourke remarks on that particular virtue of Osler’s: “the art of equanimity, of detachment from personal feelings and distractions that could interfere with an issue at hand” (O’Rourke, 1999 p.577)

Pathologists were the last link in what came to be called ‘the complete case’ in which the signs, symptoms, investigations and treatments, were followed by the post-mortem diagnosis; to see if clinicians had ‘got it right’.

2.4.3 Campbelltown and Camden

Campbelltown and Camden Hospitals, regional non-teaching hospitals in outer suburban Sydney, were exposed to investigation similar to that at KEMH. In this case four nurses had complained of poor medical care leading to an initial investigation by the supervising area health care authority (Health Care Complaints Commission, 2003).
The Report of that investigation noted very similar problems to those at KEMH: ineffectual reporting mechanisms, inadequate supervision, and a culture of not supporting open disclosure of error. Again analysis was selective; of 71 cases over five years. The problem with selectivity is not that investigation is invalidated but that, without evidence to the contrary from comparative data, the same investigation might well reveal similar problems in all hospitals.

However special to this situation was that government did not accept the report. The Minister of Health in New South Wales considered that there was insufficient exploration of accountability, no determination of who was at fault. The Commissioner (of Health Care Complaints) was dismissed and further inquiry instituted.

It is worth emphasising that again the insistence on accountability, ostensibly to government, is not directed to patients and the community. In this respect Martin Van Der Weyden suggested that Area Health Boards should have local politicians as members to encourage this aspect of responsibility (Van Der Weyden 2004).

2.4.4 Bundaberg

The exposure of poor surgery carried out by a recently appointed overseas-trained surgeon, Dr. Patel, to the Bundaberg Base Hospital in Queensland has had more varied ramifications than many of the other health care scandals of recent years (Queensland Public Hospitals Commission of Inquiry, 2005, Brooks, 2005). The official inquiry
into Queensland Health in 2005 linked him to 13 deaths and to serious complications suffered by at least 31 other patients. In this case the contributing circumstances were the need to appoint an overseas-trained doctor, the inadequate review of his previous surgical and medical history, the time it took to note his poor performance, and again the tardiness in doing anything about it (Van Der Weyden, 2005).

This report pointed to more than the problem of one inadequate and immoral doctor, but also to matters of local and federal medical and financial politics, and to hospital governance issues (Morton, 2005, Evans and Cameron, 2005). The report noted a ‘culture of concealment’ which again points to a lack of accountability, in this case extending beyond medical professionalism. The reason for its inclusion in this debate on medical professionalism is related to the comments of Peter Brooks who claims that continuing scandals might require examination of the whole health care structure (Brooks, 2005). He argues that intermittent examples of poor healthcare are evidence of fundamental problems in healthcare delivery. He was in the process of planning the Health Workforce Innovation Conference reported in early 2006 (Brooks and Ellis, 2006). That Conference was to introduce to Australia concepts of non-medical health care professionals such as nurse practitioners and physician assistants to assume some of the roles at present reserved for medical graduates.

In this thesis I am attempting to argue similarly for a need to view impaired healthcare as more than a local issue of poorly performing individuals and institutions.
2.4.5 Northwick Park Hospital, West London

Sir Ian Kennedy, who chaired the Bristol Inquiry (Bristol Inquiry, 2001), was appointed to chair the Healthcare Commission set up following the Health and Social Care (Community Health and Standards) Act 2003 (Healthcare Commission, 2005). The Commission is an independent body acting as a National Health Service watchdog of healthcare quality in England and Wales. In August 2006 it published its report into ten deaths among women giving birth at Northwick Park Hospital in West London from 2002 to 2005. This incidence of maternal deaths was ten times the national average.

The Commission criticised care in nine of the ten cases. Common factors included in the report are noted below and those highlighted in bold type are most germane to the Inquiry into KEMH:

*insufficient input from a consultant or a senior midwife (in five cases), with difficult decisions often left to junior staff*

*failure in a number of cases to recognise and respond quickly where a woman’s condition changed unexpectedly*

*inadequate resources to deal with high-risk cases: too few consultant obstetricians and midwives,*

*not enough dedicated theatre staff; a reliance on agency and locum staff without adequate managerial or professional support; and a lack of a dedicated high dependency unit*
a working culture that led to poor working practices and resulted in poor quality of care

failure to learn lessons on the unit - the Trust\textsuperscript{13} took action following the deaths but the working environment was such that mistakes were repeated

failure by the Trust’s board to appreciate the seriousness of the situation – the board was aware of the high number of deaths, and should have acted sooner to rectify problems.

(Healthcare Commission, 2006)

Sir Ian Kennedy also noted other Trust bodies with what he termed weak managerial or clinical leadership which can leave problems unidentified or unresolved. A Healthcare Commission of this type with a remit to explore other hospitals does have the power to indicate if problems are more widespread than the hospital under investigation. This is a point that I have repeatedly made in regard to the KEMH Inquiry.

Kennedy further noted in respect to general problems (Healthcare Commission, 2006):

\textit{weak risk management with poor incident reporting and complaints handling}

\textit{poor working relationships and working in multi-disciplinary teams}

\textit{inadequate training and supervision of clinical staff}

\textit{poor environment with services isolated geographically or clinically}

\textit{shortages of staff coupled with poor management of temporary employees.}

I have chosen to highlight those comments that are germane to the Report of the Inquiry into KEMH noted above. Of particular interest is the creation of a special

\textsuperscript{13} The ‘Trust’ is the management body with overall responsibility for the Hospital.
inspectorate in the United Kingdom with a roving commission to improve governance as and when required.
2.5 Summary and Conclusions

Hospital based health care services have been shown to be defective. Error is an inescapable part of any human activity or technology and there is no reason why health care should be different. The consequences of defective health care technology, that inevitably involves medical professionalism, are that patients become damaged, disabled or die; and financial and human resources needed for health care are directed to the repair and reparation of the harm done. The users of health care services become suspicious of health care institutions and of the health care professionals that service them.

It has been suggested (Kohn et al., 2000) that medicine should take a lead from the aviation industry with doctors, like pilots, subject to periodic review, and incidents of error exposed to rigorous analysis as to cause. The ‘To Err is Human’ publication from the United States National Institute of Health notes deaths due to medical error as the eighth leading cause of death in the United States and equivalent to that of motor vehicle accidents (Institute of Medicine, 2000).

The Committee of the Institute made comment on the problem of multiple healthcare providers, none of whom are fully informed, and, in emphasising the magnitude of the incidence of error, noted that it would be “irresponsible to expect anything less than a 50% reduction over 5 years” (Kohn et al., 2000 p.4)
This chapter has explored the proposition that patients/consumers of hospital services have grounds for suspicion that medical professionalism may be overly concerned with the welfare of the profession, and proportionately less with the welfare of patients/consumers. An analysis of the Report of the Inquiry into King Edward Memorial Hospital showed reluctance by the profession to support any processes of quality review from single events to the inquiry itself. Patients attending the hospital could not be assured of the best care because no assessments were made to support such assurance.

The Inquiry concluded that a culture of training future specialists by reviewing the mistakes they made, rather than by supervision to ensure that no mistakes were made was entrenched. It was also difficult to ensure accountability by responsible clinicians because the assignment of responsibility was resisted. Inadequate supervision of inexperienced trainees was a matter of inadequate financial resources for the employment of full time supervising specialists, but it was also historically and professionally based on a two tiered health system in which public and private patients were viewed differently.

To some extent the findings of the review of KEMH were replicated elsewhere especially in regard to Northwick Park in West London in 2006. The investigation into Bristol Royal Infirmary, with which it has been compared, was different in that evidently poor outcomes were ignored. The inhumanity displayed by the child pathology department at Alder Hey was a throw back to a dark past in medical professionalism, but there are some hints of a preoccupation with medical science as
an intellectual challenge in the educational activities at KEMH. That medical science as an intellectual challenge is a motivation for many healthcare professionals is commendable, but must be leavened by awareness that research or an interest in research does not assure adherence to standards of excellence. Moreover an exact diagnosis of the disease process cannot include the social and spiritual component that makes a human being what she or he is.

Walker Percy (1916-1990) was a pathologist with a quite different concept of medical science. He used novels to illustrate a malaise in modern medicine in its progressive reliance on imaging and molecular biology to describe the misery of disease and its effects (Percy, 1980). In the ‘Second Coming’ the psychiatric distress of the main protagonist is reduced to a specific and treatable biochemical disorder. However Percy insists that the patient as person, and the role of language, always compromise the cause-effect relationship of diagnosis leading to treatment and cure; inevitable complexities, and meanings that challenge professional concepts, are returned to in the next chapter.

The Campbelltown and Camden Hospitals in NSW were subject to similar inquiry to that of KEMH with very similar results, but with a greater determination to find individual fault. Such faultfinding was not omitted at KEMH. The then director of obstetric services was subject to both civil and professional legal action, but this was on individual cases of negligence, not on supervisory neglect.
Given that occasional medical professional behaviour has been shown to be at odds with good practice what action should be taken to remedy deficiencies? Should professionalism be reviewed to determine the need for change to reflect changes in society and the development of technology (Muller et al., 1998)? Should the medical profession and health care institutions reflect newer concepts of organisations as complex adaptive systems (Plsek and Greenhalgh, 2001) with outcomes not linearly related to any single input?

In chapter three I explore the Recommendations of the Inquiry into KEMH as a vehicle for discussion on the contribution of the doctor-patient relationship to quality issues and to healthcare sustainability. Managerialism and accountability are discussed as only partial, and possibly unsuitable, mechanisms in dealing with the complexity of healthcare institutions and medical professionalism. It will be of interest to determine the success of an ultimate supervisory body like the United Kingdom Healthcare Commission over a longer time frame.

The costs of healthcare are ever increasing, and the apparent need is for more healthcare professionals, and for more healthcare institutions. What part might a reconceived medical professionalism play in ensuring cost efficiency, and cost effectiveness? In the early 1990s the focus was on cost containment strategies (Klein, 1990), but an evolution is occurring to ensure quality care as an economic issue (McGlynn, 2004). The determination of what constitutes quality in healthcare is however not straightforward (Thomas, 2001, Greenhalgh and Eversley, 1999) and at an individual level should be largely made by and for the individual.
Chapter Three

Present Responses to Errors in Health Care Services:
Clinical Governance: The Concept of Community Level Involvement in High Technology Health Care

3.1 Introduction

‘Rebuilding Trust in Healthcare’ is the title of a booklet written as a response to scandals in United Kingdom healthcare services, including those of Bristol and Alder Hey noted in the previous chapter (Harrison et al., 2003). The inference is that trust in healthcare services has been lost. The headlines from Australian newspapers (Box 2.1) below are taken from an address at a Western Australian government seminar the aim of which was to promote Clinical Governance, the process to remedy error in healthcare institutions.

Box 3.1 Headlines from Australian Newspapers

Plague of errors kills 4500 a year

More deaths blamed on medical error

Negligence cases go unreported

Three doctors’ careers hinge on findings

(Fong, 2005)
Problems with healthcare services and with doctors are freely reported, and are of serious concern to the profession, but it is difficult to establish evidence of any serious loss of trust by patients with the medical profession. A Market and Opinion Research International (MORI) poll in 2002 indicated a trust in doctors at a 91% level: but it must be admitted that this was as regards to truth telling rather than a confidence in competence (MORI, 2002). Indeed trust is multidimensional and can include trust to be competent, but if this competence is combined with an inability to communicate, or to demonstrate care in its wider sense, trust could be eroded. The following is from the on-line Summary Statement of the 1998 Conference of the Breast Cancer Network.

"Consequently it is of concern that many patients, in the state and territory forums expressed dissatisfaction with the way doctors interacted with them. Some women remain deeply distressed long after the events in question."

(Breast Cancer Network Australia, 2004)

Baroness Onora O’Neil giving the Reith lectures on radio in the United Kingdom noted similar news media reports of diminished trust but doubted the validity of the surveys giving rise to them (O’Neil, 2002). She considered that in answer to direct questions people might express lack of trust, but in action continue to demonstrate faith in professionals and institutions by their use of their services, i.e. there was little evidence of the use of ‘exit’ as demonstrating distrust. It is possible that general suspicion of professionals and institutions is increased and, hence, a sensible insistence on information is part of current public life. O’Neil then discussed the use of, and trust in, the increasing dissemination of information and advice. However some commentators see the increasing use of complimentary and alternative medicine (CAM) as just such an ‘exit’ strategy demonstrating dissatisfaction with a current
medical model (Coulter and Willis, 2004). Moreover people with a medical problem may well be wary of the medical profession but have little choice but to seek help from doctors when unwell.

The last chapter detailed and discussed poor quality healthcare in Australia and elsewhere. The Quality in Australian Health Care Study (QAHC) demonstrated mistakes in Australian hospitals associated\textsuperscript{14} with death, disability and financial cost (Wilson et al., 1995). Subsequent analysis showed human error as significant but suggested that, as a certain degree of error is considered inevitable, organisational factors will be required to reduce the incidence of error and to prevent or ameliorate the consequences (Wilson et al., 1999). The Report of the Inquiry into King Edward Memorial Hospital in Western Australia claimed a professional and/or institutional culture involved in providing sub-standard care (Western Australian Government, 2001). That, and similar inquiries into episodes of faulty healthcare in other hospitals in Australia and the United Kingdom, have led to a questioning of the values of medical professionals. Media exposure and professional reflection have led to fears of a loss of trust that is necessary to both the proper care of the sick and to the continuing existence of the profession in its present form (Harrison et al., 2003, Komesaroff, 1995, Brooks, 2005).

In terms of this thesis it is held that professional change can occur with a breakdown of the hierarchical division between primary and secondary/tertiary level care at the insistence of patient consumers of healthcare. Those professional values directed

\textsuperscript{14} ‘Associated with’ not ‘caused by’ as many incidents involved already very ill patients.
towards the sustenance of the profession, and exposed by the analysis of the Inquiry into KEMH and the other revelations of substandard care in the last chapter, would be redirected towards a proper respect for individual patient care.

Although the Harvard study was the first to suggest error as endemic in hospitals (Brennan et al., 1991), the loss of trust in medicine in the United States has been associated more with the influence of business and economics; indeed that the ethic of service has been suborned to money and profit. Hence McKinlay and Marceau (McKinlay and Marceau, 2002), likened the decline of the American and other medical professions to the decline in mediaeval monasticism, and noted major reasons for the deterioration but did not include public exposure of incompetence. In a volume of the Journal of Medicine and Philosophy dedicated to clinical ethics two contributors, Chalmers Clark and Patricia Illingworth, discussing trust in medicine, had no doubt that trust had declined and that Managed Care Organisations were to blame (Clark, 2002, Illingworth, 2002).

In the United Kingdom, on the other hand, the Bristol debacle led the editor of the British Medical Journal to quote W.B.Yeats from his Easter 1916 “All changed, changed utterly” in describing the assault on the reputation of British medicine (Smith, 1998). The difference may not be only geographical or political, but professional and sociological. The devastation felt by Smith is the shame of public exposure, and is felt by the profession itself. Only the perspective of time will judge if the evocation to a
“A terrible beauty is born”, as in Yeats’ Easter rebellion in Dublin, will be realized. McKinlay and Marceau, on the other hand, are describing broad sweeps of economic, political and sociological change over the latter decades of the twentieth century.

Much of McKinlay and Marceau’s paper is, at present, relevant to American medicine, and to the peculiar features of American political life, e.g. health maintenance organisations (HMOs), and the advent of the conservative ‘New Right’ federal administration. However there is much to learn about what might transpire in other healthcare systems. They noted eight social forces conjoined to affect decline in medical professionalism, one being globalisation that, in itself, may well propagate the others.

McKinlay and Marceau also agreed with Anthony Giddens:

“It is wrong to think of globalisation as just concerning the big system, like the world financial order. Globalisation isn’t only about what is ‘out there’, remote and far away from the individual. It is an ‘in here’ phenomenon too, influencing intimate and personal aspects of our lives”

(Giddens, 1990 p.30)

The social factors indicted by McKinley and Marceau as weakening medical professionalism were 1) loss of state support for doctoring, 2) the corporatizing of doctoring, 3) competition from other health care workers, 4) the epidemiological transition, i.e. infectious disease to degenerative disorders, and a consequent changing perception of the human body by the public, 5) changes in the doctor-patient relationship with a decrease in patient trust, 6) an over supply of doctors, 7) the fragmentation of the doctor’s union, i.e. American Medical Association and 8)
globalization. Some of these factors considered more generally applicable than peculiar to the United States, will be referred to later.

John McKinlay, a long time medical academic, now a principal with the New England Research Institute, acted with his co-worker Lisa Marceau as a social commentator without suggesting any remedies for the decline in medical professionalism, or even suggesting that a remedy was necessary. In conclusion they criticised ‘intermediate’ solutions, e.g. emphasis on a new professional ethic, interventions to increase patients’ trust, unionisation of discontented doctors, and a patients’ bill of rights. These they condemned as ‘naïve’ in face of ‘global macroeconomic forces’ (McKinlay and Marceau, 2002 p.409)

If a distorted application of economic rationalism influenced cost constraints and limitations of human resources at KEMH, then features of globalisation reached Perth in Western Australia; and the resultant revelations of professional dysfunction would be consistent with McKinlay and Marceaus’ and Gidden’s theses. However the Report of the Inquiry contained recommendations to deal with dysfunctional professionalism. They are contained within the concept of ‘clinical governance’, a term apposite to that of ‘corporate governance’ used to promote the proper behaviour of business identities in pursuing financial profit. It remains to be determined if clinical governance is a ‘naïve’ concept in dealing with impaired institutional healthcare.
In this chapter I examine the propensity for imposed clinical governance to influence institutional healthcare without change at the doctor-patient level. Change in this most sensitive of relationships might depend on continuity of care and trust, and can, and does, occur at hospital specialist level. However with the doctor-patient contact in acute care hospitals, of necessity, more incidentally related, such a change is more difficult. It will be suggested that continuity of care and trust may be easier with the participation of primary level clinicians acting on behalf of their patients.

There is general agreement that the present divide between primary, community, first contact healthcare and that at secondary/tertiary hospital level healthcare requires to be bridged to encourage better care:

“Poor coordination and communication across the primary care/acute care interface contributes to avoidable admissions, adverse events and poor health outcomes”

(Reid, 2004 p.21)

The agent for such change might be determination by informed and convinced patients/consumers of healthcare. However for primary care clinicians to access high technology healthcare institutions will require a profound professional transformation.

It is further argued in the next chapter that a change of this nature may impact on the utilisation of healthcare resources, and on a reorientation of healthcare towards outcomes dictated by healthcare consumers. These patients/consumers, guided by healthcare professionals dedicated to an ongoing continuity of care, will bind increasingly expensive medical technology to an insistence on suitability, relevance and sustainability.
However before proceeding with this argument the case study of the Inquiry into King Edward Memorial Hospital must be analysed, including specifically its recommendations directed to improved clinical governance and to change in institutional and professional culture.

3.2 Recommendations from the Inquiry into King Edward Memorial Hospital

There were 237 recommendations from the Inquiry into KEMH. The majority related to administrative changes meant to impact on clinical care. The implementation of these recommendations has required many more full time consultant medical staff and the recommendations also detail how these should be deployed. Moreover, to be consistent, the need to provide on-site and continuous consultant level cover for high-risk areas of medical need must apply to similar situations in other acute care hospitals, e.g. intensive care units, emergency care wards, acute mental health units. This will have considerable, and ongoing, budgetary implications.

There are however recommendations that bear on medical professionalism. Independent clinical judgement is to be subject to birth plans (R 27 p. xxxi), and guidelines (R 10.3 p. xiii). There is to be stringent review and follow-up of adverse incidents for which an obligatory policy of reporting will be pursued (R 11.2 p. xiv).

Quality improvement will be managed by a Clinical Governance Committee, overseeing the incident review activity noted above, and responsible for assigning

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15 Ten or more full time specialists now replace one full time and many sessional specialists.
quality improvement activities and regular clinical audit (R 14.4 p. lix). This Committee is to report to the hospital governing body, and its results contained in yearly reports to the Director General of the Health Department of Western Australia.

Individual birth plans are to be discussed with patients; and policies and guidelines formulated with a consumer contribution (R 10.3.9 p. xliii). The incident management program is to be open with patients (R 11.3.3 p. xivi), i.e. to admit error and the consequences of error to those harmed; and to apologise. There are recommendations on the involvement of patients in decision making; and on the development of communication skills by KEMH staff to make this involvement valid.

Hence healthcare providers are to be responsible and accountable to both government and patients; at first sight an admirable objective. Recommendation 40 (R 40 p. xxxii) of the Inquiry Report is for KEMH to conduct regular workshops for medical, midwifery, nursing and allied health staff on how to respond sensitively to patient needs, how to involve women in decision making; and how to respond to women who have had poor outcomes.

Patients, and patients’ families, attending KEMH in the future should be reassured that they will be treated with supervised and proven competence; and by staff sensitive to their needs. Will they, however, put their trust in the clinical staff at KEMH; or are they to trust the regulatory mechanisms that are to be put into place; and the policing of those regulations by some authority? This would then be similar to the sort of trust we place in pilots on boarding an aircraft. This thesis will seek to explore the
inadequacy of a regulatory authority for the complex nature of clinical care and propose that a method more sensitive to the needs of individual patients be devised.

Has the Report of the Inquiry revealed and accepted a loss of the trust that should be part of a doctor-patient relationship and replaced by a quasi-legal consumerist contract? If professional standards are shown to be defective, is there any alternative to imposed clinical governance? This thesis seeks to explore the option of a patient mediated professional intervention not to replace clinical governance but to augment it with a more immediate alternative.

The recommendations from the Inquiry into KEMH involve regulation of a hospital environment that may well impact on professional behaviour. These recommendations are to a State government; i.e. the Western Australian Government. Six years previously the Federal Minister of Health in Australia, alarmed by the results and implications of the QAHC study, set up a Taskforce on Quality in Australian Healthcare. The Report into KEMH quotes the Taskforce report.

“Mechanisms should exist that allow action to be taken to ensure that incompetent or negligent practice is not allowed to continue if it comes to light during peer review. A balance must be found between the inhibitions that such mechanisms may engender and the participation and openness required if peer review is to be effective. While peer review processes should remain the province of peers, submissions to the Taskforce and its public consultations clearly showed that the public requires assurance that incompetent or negligent professional practice will be dealt with regardless of how it might first come to light”

(Task Force on Quality in Australian Health Care, 1996 p.25)
The Australian Council for Safety and Quality in Health Care was created following the Taskforce, and is yet to make a difference to the quality of care in hospitals. Hence professional dysfunction, that may be part of wider social, economic and political factors, is to be dealt with by public exposure of those responsible; and/or organisational changes, adjustment, and/or re-engineering; and/or the imposition of governance and regulation.

These latter points are emphasised in an article for Australian Health Review (McLean and Walsh, 2003) and in the comments made in the article by interested parties following it. One of these was a clinician Mark Siddons who noted that a similar inquiry at any hospital would yield similar results and that not much had changed following the QAHC study seven years before. Another comment was that of the non-clinician, health economist and proponent of case-mix funding of hospital activity Don Hindle. He stated that in the ten countries in which he had worked in the previous three years problems with clinical work were similar. He claimed that problems were not those of poor resources or lack of staff, but were cultural, and resulted in part from poor communication between professions and patients.

In the midst of reciprocal suspicion by society and the medical profession efforts have been made by the profession(s) to come to terms with change. Many of these are those labeled ‘naïve’ by McKinlay and Marceau (2002). That most supported and advocated by professional leaders is the Medical Professionalism Project (Medical Professionalism Project, 2002). Attempts to deal with suspicions of professionally
tolerated incompetence, certainly in terms of the maintenance of up-to-date technical and communicative skills are in the efforts by professional bodies to implement ‘Continuing Professional Development’. One described is that of my own professional college, the (Royal Australian and New Zealand College of Obstetricians and Gynaecologists). These mechanisms will be described and criticised as being minimally sensitive to the demands of society; they perpetuate professional detachment.

3.3 Medical Professionalism Charter

In 1999 American and Canadian physicians combined with colleagues in Europe to launch a renewed sense of purpose for medical professionals. They determined to issue a ‘Charter’ incorporating the basic tenets of medical professionalism that they considered applicable to the coming century (Medical Professionalism Project, 2002). The preamble noted that the need for an affirmation of fundamental principles was “an explosion of technology, changing market forces, problems in health care delivery, bioterrorism, and globalisation” (p. 263). There is no explanation of how or why these factors have impacted on medical professionalism, and, of relevance to this thesis, there is no reference to revelations of impaired medical performance. However there was repeated emphasis in the principles and responsibilities to a need to ensure a trusting relationship between doctors, patients and society.

The loss of trust in this document, as in the paper from McKinlay and Marceau (2002), has more to do with commercial factors residing in the United States. The primacy of
patients’ welfare is to be opposed to “market forces, societal pressures, and administrative exigencies”; principles of social justice refer to discrimination on “race, gender, socioeconomic status”, (Medical Professionalism Project, 2002 p.264). There is to be acknowledgement of medical errors, including the reporting and analysis of such errors, and a dedication to continuous improvement in the quality of health care. However there was to be an insistence on “cost-effective management of limited clinical resources” and on the “avoidance of superfluous tests and procedures” (p.265). The maintenance of trust was directed to avoiding conflicts of interest in the association of medicine with for-profit industries, including medical equipment and pharmaceutical companies.

The loss of trust in the American doctor-patient relationship is argued to be related to the American health system of Health Maintenance Organisations (HMO) and their directives, or incentives, to doctors employed by HMOs to limit care on financial grounds. The ‘Charter’ is to re-assert medical professionalism, much as was argued by Chalmers Clark from more philosophical grounds (Clark, 2002). Another commentator who claims the relevance of HMOs to a decline in trust was Patricia Illingworth (Illingworth, 2002, Clark, 2002) However her approach was to discuss trust in the doctor-patient relationship from the point of the sustenance of social capital. She saw the problem as encompassing a whole of community issue.

“In this essay I have argued that (1) trust is a scarce and valuable medical resource and (2) viewing this resource as social capital highlights our moral duty to preserve the kind of doctor-patient relationship that will cultivate it.”

(Illingworth, 2002 p.43)
The ‘Charter’ appeared in the prestigious medical journals ‘The Lancet’ and the ‘Annals of Internal Medicine’, and then later in the Medical Journal of Australia (MJA). In his introduction to the Charter in the MJA the editor, Martin Van Der Weyden, quoted the editor of the Annals (Sox, 2002): “the challenge will be to live by the precepts and to resist efforts to impose corporate mentality on a profession of service to others.”, but Van Der Weyden chose to replace ‘corporate’ by ‘government’ (Medical Professionalism Project, 2002 p.263). This is meaningful in the Australian context and in the theme of this thesis. Government has a more significant role in healthcare in Australia, but ‘governing’ also infers controls and imposed restraint.

In a letter to the MJA a gastroenterologist, Kerry Breen, noted the absence of a consumer or community input into a ‘Charter’ that was purported to represent a contract between the profession and society (Breen, 2003). I would argue that the MJA editor’s resistance to ‘government’ mentality, (and, I would hold, imposed ‘governance’) is to persuade the profession to the necessity for self-change, and not that engineered by contract. This thesis maintains that ‘self-change’ can only succeed with the cooperation of health care consumers and society. Self-change is the matter for the following section but the profession still sees itself as the arbiter of what that change should be.
3.4 Continuing Professional Development

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) was the first learned specialist college in Australia to insist on continuing education as a condition of continuing Fellowship. It rejected the concept that once specialist status had been achieved this was to be sufficient for a working life. All Australian specialist colleges have now followed suit and the RANZCOG has now published a working document on continuing professional development for all colleges financed by the Commonwealth Department of Health and Aged Care.

The Colleges have in effect insisted that continuing educational activity address any defect in medical professionalism and medical practice. These activities are numerous and varied, accepting that no one method has been shown to change professional behaviour:

“Defined as interventions to change the behavior of physicians, the effects of those strategies were inconsistent across practitioners, settings and behaviors. As a result, in the midst of contemporary discussions about quality improvement and the effects of continuing education, there is no singularly effective method for improving physician performance. Physicians must accept responsibility for their own continuous learning: setting goals and selecting educational activities to achieve those goals.”

(Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2006 p. 56)
However although consumer organisations were invited to submit responses to the working group none are noted, and no consumer representative appears with the Group Membership (p. 99) of professional organisations overseeing the project.

3.5 Audit

Clinical governance is that managerial system which seeks to regulate, control and enhance clinical activity. The most used definition of clinical governance is from the United Kingdom (Scally and Donaldson, 1998):

“Clinical governance is a system through which NHS organisations are accountable for improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.”

(Scally and Donaldson, 1998 p. 10)

It has been adapted by the Department of Health in New South Wales for its ‘Framework’ and ‘Clinician’s Toolkit’ (New South Wales Department of Health, 2001). However the ‘environment’ is created by mandated controls including clinical audit, credentialling, clinical indicators, and other measures of effectiveness (Australian Council for Safety and Quality in Health Care, 2003).

Clinical audit is also included as essential to ‘Good Medical Practice’, the booklet handed out to all doctors in the United Kingdom by the General Medical Council:

“6 You must work with colleagues to monitor and improve the quality of health care. In particular, you should take part in regular and systematic clinical audit”.

(General Medical Council, 1998 p. 3)
Clinical audit, however, must be examined to determine why a process, which appears so worthy and conceptually valid, has been so delayed and ineffectual (Power, 1997).

The term ‘audit’ derives from the assessment of financial accounts. The Macquarie dictionary includes audit as a ‘calling to account’. It is seen as a scrutiny, and as an administrative activity. However clinical audit, as a scrutiny of clinical processes and outcomes, is largely conducted by and for medical practitioners. Indeed, to be effective, it is claimed that clinical audit must be carried out under agreed strict rules of confidentiality (Baker et al., 1999 p. 2). However the intention of audit is to improve clinical performance and outcomes. It is the improvement that should be publicised even if the process of audit is confined.

The problem with much of audit activity is the lack of proven benefit. The booklet “Implementing Change with Clinical Audit”, edited by Baker et al (1999), is predicated on the difficulty of ensuring proven improvement. In essence, an audit of a clinical program can only be completed by a repeated analysis after activities have been carried out to improve any defects revealed by the original investigation. Table 2.1 below is taken from that publication’s introduction summarising the apparent effectiveness (or ineffectiveness) of different programs, mainly from the United States, to promote change in health professional behaviour or practice.
### Table 3.1

**Different strategies for implementing change, and their effectiveness**

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Target</th>
<th>Topic</th>
<th>Evidence of Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feedback</td>
<td>Individuals, groups, organisations</td>
<td>Diverse</td>
<td>Variable; often less when used alone</td>
</tr>
<tr>
<td>Reminders</td>
<td>Individuals</td>
<td>Circumscribed topics</td>
<td>Relatively ineffective</td>
</tr>
<tr>
<td>Opinion leaders</td>
<td>Groups</td>
<td>Treatment decisions</td>
<td>Variable</td>
</tr>
<tr>
<td>Facilitation</td>
<td>Groups</td>
<td>Involving multidisciplinary cooperation</td>
<td>Little evidence available</td>
</tr>
</tbody>
</table>
| Patient mediated        | Individuals                          | Circumscribed topics              | **Relatively effective**
| interventions           |                                      |                                   | *(My emphasis)*                              |
| Conferences             | Groups                               | Diverse                          | Little or no effect                           |
| Educational material    | Individuals                          | Diverse                          | Used alone; little or no effect               |
| Small group education   | Groups                               | Diverse                          | Variable effectiveness                       |
| Educational outreach    | Individuals                          | Circumscribed topics              | Relatively ineffective                       |
| Total quality           | Organisation                         | Diverse                          | Little information available                  |
| management              |                                      |                                   | Relatively ineffective                       |
| Reorganisation of       | Organisation                         | Diverse                          |                                               |
| services                |                                      |                                   |                                               |
| Advertising             | Individuals, groups, Unknown         | Unknown                          | Unknown                                       |

*(Baker et al., 1999 p. 16)*

In terms of this thesis, i.e. that patient participation is a part of medical professional change; it is interesting that patient mediated interventions are considered the only ‘relatively effective’ strategy. These interventions are those in which a patient carries reminders of healthcare procedures to be performed which he or she then shows to a doctor, i.e. as an aide memoir. It is also interesting that Baker or his numerous co-authors do not take this point from the introduction any further.
Audit, both carried out before and after change, must be valid and reliable; and the time between investigations not so long as to risk confounding by other changes. The booklet then seeks to address problems by suggesting methods to improve the processes of audit and to deal with the group and individual psychological barriers to change.

Audit can be effective; including reducing the rate of adverse events in an Australian hospital (Wolff et al., 2001). However the audit cycle described by Wolff, Burke et al (2001) was of a country hospital staffed by general practitioners. It is surprising how few other audits are published. Abi Berger, science editor of the British Medical Journal, despaired of clinical audit as being unproductive (Berger, 1998). Subsequent letters to the journal generally agreed without any constructive suggestions. John Holden reviewing 30 years of audit in general practice concluded that there was little evidence of its capacity to change behaviour (Holden, 1999). However he suggested that effort be devoted to improvement, as in Baker, Hearnshaw et al. (1999), rather than that effort be abandoned.

A rather different approach is to condemn the audit cycle as ambiguous if not basically flawed. Michael Power in an epistemological review of auditing and the ‘rationality of governance’, considered much of the pursuit of audit as essentially government or management public relations, “as if it implemented the programmes which demand it”(Power, 1997 p. 12). He perceived audit as derived from advanced economic systems, and as “ritualised practices of verification whose technical efficiency is less
significant than their role in the production of organisational legitimacy” (p.14). As such, audit and the various components of top-down clinical governance are seen as part of a now-to-be-questioned dominant paradigm of organisational management.

Onora O’Neil (2002) in her Reith lectures similarly questions the zeal of ‘accountability and ‘transparency’. She fears that the imposition of total control, of rigid standards and targets will act as perverse incentives. She expresses suspicion of governance much as Michael Power by concluding:

“If we want a culture of public service, professionals and public servants must in the end be free to serve the public rather than their paymasters.”

(O'Neil, 2002) Lecture 3 Called to Account.

This implementation of governance by controls, targets and measurement is part of a still dominant paradigm of management. The enclosure (Box 2.2) below is from the same presentation promoting Clinical Governance that included the newspaper headlines at the beginning of this chapter.

**Box 3.2**

**Health Services: Goals and Expectations**

- Build culture of safety & quality improvement through:
  - Clinical governance practices;
  - Performance measurement and evaluations;
  - Management and staff accountability for poor performance, adverse outcomes, and their remedies
- Increase participation in internal/external quality improvement & performance measurement activities for individuals and organisations
- Establish reporting mechanisms and evaluation processes

(Fong, 2005)
Hospitals and health services, just as much as industries seeking market share, are engaged in challenges to management theory.

**3.6 Managerialism**

Management (managers or management groups) enables workers in an industry to produce goods or services; and ensures that work is performed satisfactorily. My simple definition has been refined in many ways to suit the needs of different environments.

> “a set of activities, including planning and decision making, organizing, leading, and controlling, directed at an organisation’s human, financial, physical, and information resources, with the aim of achieving organisational goals in an efficient and effective manner.”

(Griffin, 1990 p. 6)

However management theory developing from the 1960s embraces concepts of flexibility and adaption to counter-act conservative maintenance mechanisms (Hodgetts, 1982). Flexibility and adaption are necessary to cope with both technological innovation and to avoid organisational decay. Organisations have moved from mechanistic hierarchical structures to the more free-form organisations that “discourage petty controls” (Hodgetts, 1982 p. 149).

The traditional organisation is assumed stable, contented and at equilibrium. However, with the exploration of non-equilibrium states occurring in the natural world and responsible for common events in physical, chemical and biological situations, it is now questioned if stable equilibrium states are optimal, and even normal, in human
organisations (Stacey, 1996). The future may lay with human organisations seen as complex adaptive systems accepting greater uncertainty as a price of innovative progress.

Moreover the determination of progress in the ‘quality’ of healthcare is difficult. Is it to be determined by the subjective analysis of involved patients/consumers of healthcare? Is it to be determined by the objective analysis of evidence-based-medicine? Is it to involve a cost-benefit economic component? Is it to involve the determination of possibly fallacious outcome data (Lilford et al., 2004), or is it to be almost beyond understanding? Archie Cochrane, the founding father of the evidence-based system of rigorous analysis that now bares his name, found a transcendental quality to care in his arm round the shoulder of a earlier screaming, now quiet, dying Russian ex-prisoner of war, for whom he could do nothing; and to whom he could not even speak (Cochrane, 1972 p. 94)

However, in as far as healthcare involves the use of increasingly expensive healthcare technology (Fett, 2000), some measure of its effectiveness is essential. This expense extends from the manufacturing demands of surgical and imaging equipment, to pharmaceuticals based on new microbiological knowledge. It includes the remuneration of clinical and technical staff, and the demands of increasingly complicated clinical problems. These increasing costs have led to an insistence on evaluation of healthcare processes. Hospitals are only rarely financed by the direct marketing of their product, healthcare, to health care consumers. In most circumstances healthcare finance is from third parties, i.e. insurance and government.
Some problems of healthcare economics are addressed in the next chapter, but at this stage the discussion of organisational management and medical professionalism is with ensuring value in terms of the healthcare provided. This chapter focuses on the realisation that an ethical obligation to best practice by medical professionals at KEMH and other healthcare institutions is confused by obligations to a distorted medical professionalism.

Healthcare outcomes are not clear-cut. This lack of clarity is not that of priorities in areas of healthcare expenditure but the basic dispute between population health and the management of individual healthcare needs. Medical professionalism always states a priority for the individual patient, leaving population health to secondary and special interests. This belief extends from the ‘Charter’ noted above to Boards responsible for the implementation of Medical Acts (New South Wales Medical Board, 2003, General Medical Council, 1998). However there are claims that the emphasis on individuals and individual diseases, and even on errors made in care, masks specialist medical practitioners acting for sectional interests.

"Individual diseases, not global health outcomes, are what motivates policy and medical leaders. The dramatic changes that a global approach demands would be resisted by power centers that face financial, political, and administrative consequences."

(Woolf, 2004 p. 36)

Specialist medical practitioners, ostensibly acting for individual patient care, have been criticised by a general practice directed by policy edict towards population health
Fugelli and Heath were commenting on a publication of the Royal College of General Practitioners. They affirm that, with the movement of general practice towards primary care and population health, a number of ‘incompatibilities’ have become apparent as in a move to teamwork and delegation that they claimed ‘erodes personal doctoring’ and continuity of care. The paper concluded that tighter contractual and bureaucratic control undermines the response to the needs of individual patients. That primary healthcare teamwork may not be sufficiently patient orientated is also claimed by Greenhalgh and Eversley (Greenhalgh and Eversley, 1999), and will be discussed later in the final chapter to this thesis.

Control focused managerialism was also condemned by Alan Cribb, writing for the business journal HEC Forum, as contributing to ‘technical professionalism’ which he quoted from Ann Yeatman as a shift to narrow utilitarian frames of reference by health care professionalism (Cribb, 2001). This was very similar to views expressed by William May in Joan Callahan’s edited book on professional ethics (May, 1988 p. 62). May feared a minimalist and defensive approach taken to healthcare by a medical professionalism constrained by contract.

A recent sociological perspective on managerialism in hospitals is that of Justin Waring (Waring, 2007). He carried out an ethnographic study over two years of the implementation of quality and safety management programs at an English hospital and found that medical staff resisted imposition of these programs and preferred in most cases to carry out their own programs involving traditional professional structures.
The reports of medical resistance to ‘outside’ managerialism were very similar to those expressed at KEMH.

There is then a body of literature condemning the imposition of authority and controls in the management of hospitals and hospital staff. Alternative structures must be explored.

3.7 Complex Adaptive Systems

The traditional management of organisations has been predicated on the achievement of targets in many units of production adding up to overall excellence. However in the complex adaptive system of the business world described by Stacey (Stacey, 1996) the many units contribute to a whole that is by mutual and reciprocal interaction greater than the sum of the individual parts. Even within supposedly concrete disease states, with established causes and remedies, the evidence-based management of each individual factor does not necessarily achieve optimal resolution. For example chronic disease states in Aboriginal children in remote desert communities in Australia have been substantially reduced by the construction of public chlorinated swimming pools (Lehmann et al., 2003) rather than a narrow focus on each disease and its treatment. The use of hormone replacement therapy has become so complex and scientifically uncertain that resort has been made to computer assisted individual negotiation rather than to risk professional advise (Mort, 1996). Tim Wilson and Tim Holt discussing complexity in clinical care use the supposedly clear relationship
between blood sugar levels and insulin to demonstrate how such ‘clarity’ is clouded by complexity (Wilson and Holt, 2001).

If hospitals as organisations are complex adaptive systems then determinist linear models of clinical governance may be inappropriate except as limiting structures. Uri Merry made this point in his conclusion to a discussion on the concept of ‘new science’, and in dealing with ‘uncertainty’:

"The regularity and order within it are maintained not so much by outside penalties, structure and constrictions but mainly by inner-conviction in the values and vision of the system." (Merry, 1995 p. 196)

‘Bottom-up’ processes of emergent behavior may be more productive of beneficial change and innovation as claimed by Stacey (Stacey, 1996 p. 75). A steadily increasing literature questions the present linear, or machine, model of hospital administration; and the imposition of clinical governance (Lindberg et al., 1998, Anderson and McDaniel, 2000, Plsek and Greenhalgh, 2001, Plsek and Wilson, 2001). Stacey’s concepts of organisational behaviour will be important in advocating a place for patients/consumers of healthcare beyond the tokenism condemned by some (Sleath and Rucker, 2001). The paper by Sleath and Rucker (2001) deals with policy matters, and recommends teaching programs for consumer representatives to policy boards; i.e. the ‘top’ people would have ‘educated’ representatives from the ‘bottom’. Policy and management would remain a ‘top-down’ process. A valid ‘bottom-up’ process would be that of patients empowered to represent their own needs. How this agency would impact on a complex adaptive system is, by the nature of these systems, unknowable.
Moreover each patient is different, and, if the empowerment is by healthcare professionals dedicated to continuity of care, the relationship and its effect will be variable. I anticipate that, at this stage, medically qualified general practitioners would be the healthcare professional most suited to this role.

There are features of a doctor-patient relationship that are, moreover, not constant, that are capable of adaptation to a changing world. The paternal relationship noted by Talcott Parsons (Parsons, 1964) and Joseph Jacobs (Jacobs, 1988), and variously dismissed by other social commentators (Frank, 2002), would be welcomed by some patients and resented by others. Similarly, involvement in decision making is not universally cherished or given a high priority (Joffe et al., 2003). Hence any influence on a hospital’s governance by patients and their general practitioners would be variable, unpredictable but, in reflecting the community, valued by organisations maturing as complex adaptive systems.

The necessity of a rich learning environment expected of these systems is not inconsistent with the definition of clinical governance noted above, i.e. an environment of excellence. However any rigidity in controls and targets may be unrewarding. Research on likely outcomes from such a changing non-static organisation is likely to be ethnographic or narrative, rather than that grounded on statistically based surveys or randomised controlled trials that demand controls and stability to establish validity. It is also worth pointing out that participation in hospital governance by patients/consumers of healthcare services must be reciprocated by patients willing to learn from the hospital and from its technology.
The participation of patients in the clinical governance of hospitals anticipates trust in both their primary and secondary/tertiary level healthcare professionals. The loss of an unthinking portion of trust, of faith in a not human medical hero, may be part of a natural progression of an increasingly informed public; a stage of maturation from blinded faith to self-reliance. It is to be welcomed. The trust to be earned is not that in governance structures but in face-to-face human contact. It is human contact that contributes to the type of social capital promoted by Robert Putnam (Putnam, 2000).

The claim of this thesis is that patients, and their family or friends, rightfully and sensibly aware of occasionally impaired practice within healthcare institutions, need a vehicle for reassurance that individual healthcare is as good as it should be. They need this at all stages of their care, and at both outpatient and inpatient sites. The agreed ‘birth plans’, and the participation of healthcare consumer representatives in the formulation of ‘guidelines’ as in the recommendations of the Inquiry into KEMH noted above, will not help mothers concerned that something is awry, and yet intimidated by the ‘alien environment’. They, or their families, would benefit from a knowledgeable intermediary to contact responsible clinicians to be reassured that all is well; or that help is on its way. This ‘champion’, seen as a friend to both patient and hospital, is at this stage the patient’s family general practitioner, or possibly a known agent of that practitioner. In terms of the Putnam concept of trust and social capital I am advocating the ‘thick’ trust of a relationship at community level (Putnam, 2002 p. 10) while accepting that at best only a ‘thin’ trust is appropriate to an institution.
The use of this ‘outside’ vehicle (noting the comments of critical medical practitioners to the KEMH Inquiry in the previous chapter) will impinge on professional behaviour and hospital governance in a more immediate fashion than retrospective audit. It will possibly reduce the incidence and consequences of error; decrease animosity and resort to litigation; and de-alienate the hospital environment. It is an admirable idea but, unfortunately, one fraught with problems.

3.8 Difficulties with an Intrusive General Practice

For patients and health care consumers to trust their general practitioner to serve their interests in high technology health care institutions, they would need confidence that any process would be worthwhile. They would need to know that their general practitioner has sufficient professional substance to be heeded; and that their GP is confident in that substance. On their part they would need to have belief in a mutually trusting knowing relationship with their GP: that their GP is aware of, and sympathetic to, their personal and social peculiarities.

For general practitioners to accept a mediating role between healthcare consumers and high technology healthcare all of the above features are relevant. They need to have confidence in the status of general practice medical knowledge; and that this knowledge is respected by both patients and their specialist medical colleagues. They need to have invested effort in establishing a knowing and trustworthy relationship
with their patients and that this relationship is valued. Of significance to general practitioners is that the community recognises the value of a general practice contribution to high technology care by remuneration attached to their mediating role on the rare occasions when it is required. General practitioner mediators, in addition, would need reassurance that their patients would not abuse the situation by trivial or gratuitous demands. The potential for patient abuse is discussed later.

The attitude of patients to change in general practice is contained in chapter four, and of general practitioners in chapter six. At this stage it would be reasonable to conclude that neither one nor the other would anticipate anything other than minimal benefit from an intrusive role for general practitioners within hospitals. An attitude from patients is summarised by the comment of one participant in the focus groups noted in chapter five:

"I don’t want a cosy relationship with my doctor”. “What I’m looking for is a prescription or who’ll send me off to a specialist, and that’s all I want”. “I don’t want a cosy country doctor relationship”.

This diminished role for general practitioners was anticipated by the Report on the Future of General Practice more than fifteen years ago in 1992:

"supports view of GPs as subordinate to specialists, as managing only simple problems, or as doctors who failed to become specialists".

(National Health Strategy (Australia), 1992 p. 38)
or the National Centre for Epidemiology and Public Health comment from 1991 contained in the same report

"concern that exclusion from hospitals, wary of competing practices and isolation from government health authorities..... may lead to marginalisation of GPs over the next decade." p.36

In 2005 the Productivity Commission, noting the need for more health care staff, anticipates a future of non-medical primary health care professionals (Australian Government Productivity Commission, 2005a). Julian Tudor Hart, a long time iconoclastic general practitioner from Wales in anticipating a ‘New Kind of Doctor’ in 1988, and again quoted in the Australian Government Report above, noted:

"general practitioners dominate primary care by right of inherited tradition, because they are there. This situation won't last; if doctors are to retain a leading role in the future they'll have to earn it, and if some other kind of health worker can do it better in terms of measured health outcome, good luck to them."

(Tudor Hart, National Health Strategy (Australia), 1992)

The demise of general medical practice has been anticipated for many years and yet the demand is for more training posts to fill present needs (Australian Government Productivity Commission, 2005a). The role of general practice, its aims and directions, however remain elusive (Van Der Weyden, 2003, Del Mar et al., 2003). Van Der Weyden (2003) claimed both poor professional satisfaction and reduced vocational attractiveness while Del Mar et al (2003) noted the lack of intellectual
involvement; and both saw the solution as involvement in research. Marinker and Tudor Hart in the United Kingdom and Max Kamien in Western Australia hope for the evolution of a different type of front-line doctor (Marinker, 1995, Tudor Hart, 1988, Kamien, 2002). The evidence would suggest that present general medical practice and general medical practitioners lack the status and confidence to support an intrusive role in high technology hospitals.

Moreover involvement of general practitioners with personal knowledge of patients under their care would require either increased numbers of general practitioners, or practices with other staff capable of providing that type of care. The necessary change might be of the type anticipated by Peter Brooks (2005) and the Productivity Commission (Australian Government Productivity Commission, 2005a) and would be of an increased acceptance of nursing and allied health professionals to fill many roles in healthcare now filled by medical doctors. It might also require a re-emphasis of general practitioners towards individual patient care while general medical practice with the help of non-medical healthcare professionals retains the importance of community based preventive healthcare (Russell, 2005).

However a basis in remuneration, and a simple first step towards hospital involvement, already exists in present Health Insurance Commission Medical Benefit Schedule (MBS) payments (Health Insurance Commission, 2007). Item 728 provides for payment to general practitioners for involvement in patients’ hospital discharge planning, and Item 724 is directed to involvement in post discharge care. A MBS payment for a patient requested visit to a public hospital in-patient by a
practitioner could form the basis for the implementation of change based on the concepts outlined in this thesis and is anticipated by the AMA Position Paper on General Practice and Public Hospital Integration (Australian Medical Association, 2006). The general practitioner might not be permitted to change or initiate treatment, but would be able to discuss clinical management with hospital doctors; and at specialist level.

I emphasise that in this situation, i.e. as a receipt of patient concern, the employment of general practitioners, or of their practice staff, could only be at the request of patients, or, in some circumstances, authorised family members. It is expected that this provision would be rarely used but its availability would be reassuring and empowering. How extensive this role of patient and hospital advocacy can become will be a matter of mutual and informal development between the patient, general practice, specialist practice, hospital management, and government policy over many years. It is expected that its evolution will be part of a redefinition of medical practice and medical professionalism and involve changing patterns of medical and non-medical professional education. General medical practitioners will not intrude into high technology medicine; they will be an important part of its provision.
3.9 Summary and Conclusions

People in developed industrial nations are living longer and healthier lives but healthcare services are expensive. The previous chapter showed that healthcare services are occasionally imperfect and faulty, and that a distorted medical professional culture can be involved. In this chapter I explored the suggested remedies for errors in hospitals that may be endemic. The case study of the Report into King Edward Memorial Hospital was further used to reveal a demand for the imposition of governance structures aimed to reduce error and its consequences.

I have argued that clinical governance with managerial audits, constraints, and targets, will be only partially successful in coercing clinical professionals. They have their own professional values based on professional autonomy and, in responding to change in society and occupation, plead for a reassurance of traditional values. Nevertheless these traditional values might also fail to cope with a rapidity of change within technological, professional, managerial and policy systems that are outdated; and based on machine age reductionism. It is argued that medical care, hospitals and healthcare services may be inherently complex and uncertain; and that imposed hierarchical restraint could be less successful than the acceptance of non-linear adaptive interactive and mutual learning structures.

A vital part of clinical governance based on hospitals as complex adaptive systems is the voice of the patient. To enable participation by patients it is suggested that intercession should be by an agency external to both the clinical and administrative
structures of the hospital; and that the patient’s general practitioner could fill this role.

It is anticipated that considerable professional and functional inertia would make implementation difficult. However change is part of present reality. In later chapters I explore patient/consumer attitudes to a proposal that would require a commitment to continuity of care by general practitioners that currently may be becoming rapidly outmoded; so rapidly that the older general practitioners later interviewed are unaware of its occurrence. In the next chapter I speculate on the potential for a patient-general practitioner collusion to influence healthcare costs and the sustainability of healthcare services in dealing with healthcare technology. It is implicit in much of this thesis that while the organisation of general medical practice should still be directed to primary and preventive healthcare, general medical practitioners themselves will remain focused onto individual patient care.
Chapter Four

Hospitals, the Sustainability of Healthcare, and the Social Capital of a Doctor-Patient Relationship

4.1 Introduction

In the last chapter I claimed that the quality of health care in hospitals would be improved if patients and/or their families were able to enlist the support of committed general medical practitioners at times of unexpected concern. Such a service may be rarely required and, in the main, act to reassure, but the availability of an intercessional agent representing individual patients and hospital clinicians to each other might benefit both patient care and hospital management. It would enable a patient voice to be heard at a basic level. Moreover this would be during the process of care; and not after the event as in the case of either the ubiquitous satisfaction survey or the governance assured clinical audit.

Present mechanisms to ensure the quality and safety of health care were illustrated by recommendations from the Report of the Inquiry into King Edward Memorial Hospital (Western Australian Government, 2001). Those recommendations were intended to provide assurance and guidance for clinical activity. They were contained within a managerial concept involving clinical governance imposed by government and/or hospital management. I have argued that this will be unsuccessful without professional change sensitive to the needs of patients and made known at a doctor-patient level.
I have further noted that those hospitals, and their specialist medical staff, might resist imposed governance. They are more likely to accept the interactivity and interdependent learning of a management style acknowledging complexity; even though the uncertainty of outcome will jar with science based predictability (Plsek and Greenhalgh, 2001). As part of such a system a patient voice guided by primary level medical practitioners could act as a strange attractor: a small disturbance but with potentially large effects (Wilson and Holt, 2001, Committee on Quality of Health Care in America, 2001). As such it could not only affect the rate and consequences of clinical error but influence management towards innovation within that ‘framework of excellence’ defining clinical governance (Scally and Donaldson, 1998).

Both error and the notion of clinical excellence are matters very much affecting the medical profession. The profession, aware of public uncertainty concerning its long professed dedication to patient care (Neuwirth, 2002), has sought to reaffirm professional values. One such example discussed in chapter three is the ‘Charter’ widely supported by professional leaders (Medical Professionalism Project, 2002). These expressions of values while attempting to reflect core beliefs and principles may however represent a response to changing social and economic circumstances peculiar to different nations and national healthcare systems. The needs of patients must also influence professionalism and, again, those needs may well represent the special historical background of each nation and its health system. This sensitivity of ethical behaviour is compatible with philosophical concepts of sustainability that oppose the fixed nature of human values (Graves, 2001, Varey, 2006).
The proposition from this chapter is that demonstrated willingness by general medical practitioners to act for their patients within healthcare institutions will influence more than the healthcare of individuals, but also the nature and strength of a doctor-patient relationship important to the social capital of community. The increased status of primary level general medical practice has the potential to redirect healthcare resources and enhance the sustainability of healthcare services (Dixon et al., 1998). I will argue that healthcare services, threatened by ever rising costs and the inability of society to meet the fiscal demands of healthcare, will affect and be affected by the overall sustainability of human activity. Within the hospital community, and especially the tertiary level teaching hospitals, the greater prominence and status of general medical practice will affect the education of medical students and promote the sustainability both of high technology healthcare institutions and also of community level healthcare now and into the future.

In this chapter I review concepts of sustainability and social capital, and effects on medical professionalism and the doctor-patient relationship. The sustainability of healthcare is argued as bound up in general economic wellbeing, and that the ever increasing costs of healthcare must be viewed within demands for other services, and in the effects of those costs on the economic activity needed to meet them.

Medical technologies contribute the major component to healthcare costs (Organisation for Economic Cooperation and Development, 2004, Australian Government Productivity Commission, 2005b, USA Today Editorial, 1998). Even if, as hoped by the editorial from USA Today (1998), technology becomes relatively
cheaper the increased demand for healthcare, especially by the aged, as noted by both OECD (2004) and the Productivity Commission (2005), will result in increased cost. Healthcare payers, i.e. insurance and/or government, by capping expenditure and/or passing elements of costs back to healthcare users can seek to control demand for healthcare technology. However these types of controls risk political and market exposure to a disaffected public. I submit that any restraint on the demand for healthcare can only occur as a result of collaboration between the users and suppliers of healthcare services.

Discussion on restrained demand in this chapter extends from the use of investigative pathology and imaging to augmentation plastic surgery and end-of-life care. Costs will be affected by moves to promote more community level care using technology usually kept within hospitals, as in the programs of hospital-in-the-home. These programs have been evaluated by reviews and editorials (Shepherd and Illife, 2005, Wilson and Parker, 2005, Shepperd, 2005) which, while admitting to the difficulties in combining results from disparate healthcare systems, and from varied clinical conditions and different program methodology, still conclude that the health and economic outcomes remain inconclusive. Many of these programs use hospital based home care systems (Leff et al., 2005, Davison et al., 2006) and are in the main directed towards the care of the frail elderly. The involvement of community level medical practitioners might be marginal, and poorly supported, as claimed by Wilson and Parker (2005). Any commitment by general medical practitioners to these programs may well depend on their closer integration with healthcare institutions, and with the enhanced social capital of the doctor-patient relationship advanced by this thesis.
4.2 Sustainability and Social Capital

‘Sustainability’, while concerned with local and planetary ecological wellbeing, is also a matter of a long-term view of human economic and social wellbeing; and equitably assured human health (Carley and Spapens, 1998 p. 72). The environment is of concern because it affects humanity; it affects our present and future survival; and it also affects our spiritual wellbeing in knowing that we have preserved its integrity (Suzuki and McConell, 1997).

If these ideals of sustainability are ever to be realised in a demand led healthcare system, and the healthcare ‘industry’ sustain the environment, encourage social wellbeing and support the economy, they will require healthcare consumers acting with trusted healthcare professionals. Such activity would be consistent with concepts of ‘social capital’ and community led sustainability practice (Productivity Commission, 2003). This situation of reciprocal trust could well affect the utilisation of healthcare technology, and the economic viability of high technology healthcare institutions. Robert Putnam, the principal advocate of the concept of social capital, decries the late twentieth century loss of community togetherness and produces evidence of its association with diminished health and wellbeing (Putnam, 2000) p. 326. There are now many publications on this association attempting to tease out the public trust of social capital from socio-economic deprivation (Kawachi et al., 1999, Kavanagh et al., 2006). ‘Social capital’ indeed defies definition that does not involve the context within which the term is used. It must however include reciprocal trust between people or peoples resulting in overall and mutual gain. This thesis is to
explore the particular social capital of the community level doctor-patient relationship. Eva Cox, likening social capital to the ‘Magic Pudding’ of Norman Lindsay’s children’s fantasy, observes its perverse and peculiar property in that it expands the more it is used (Cox, 1998). The social capital of the doctor-patient relationship, initially used to enhance community and hospital healthcare, will hopefully expand to encompass the general wellbeing of populations and their environment. However Eva Cox also notes the difficulty in giving numerical value to trust and social wellbeing. In her contribution to an international revue of social capital edited by Robert Putnam, she considers that Australia has undergone a similar reduction in social linkage in the latter decades of the twentieth century to that in the United States (Cox, 2002).

My questioning of healthcare consumers in Perth, Western Australia, contained in chapter five, revealed that these consumers do not see their relationship to general practitioners as a part of social capital; their relationship is a technological transaction. However the general medical practitioners interviewed in chapter seven would probably not acknowledge the consumers of chapter five as typical of their patients. They insist their patients appreciate a long-term relationship. They appear more hopeful that an insistence on continuity of care would remain a vital feature of long-term healthcare and remain of enduring community value.

The doctor-patient relationship has changed from the quasi-ecclesiastical reverence of past decades (Clark, 2002); but its replacement by valued social capital remains doubtful (Welsh and Pringle, 2001). Welsh and Pringle (2001) believe that the social capital of the British National Health Service has been undermined by economic
considerations. Patricia Illingworth, in the different socio-economic climate of the United States, and a vehement critic of the Health Maintenance Organisations of that nation, considers that society has “a moral obligation to protect the doctor-patient relationship from the cost containing mechanisms that compromise its ability to produce trust” (Illingworth, 2002 p.32). It is of significance that, in an even more contrasting socio-economic system, the enhanced community ‘connectedness’ of Cuban society is listed as one of the contributors to decreased levels of hospitalisation, and to other features of Cuba’s apparently successful healthcare system (Speigel and Yassi, 2004).

Miles Little, an Australian surgeon, noted the disturbed relationship between unhappy patients and similarly disgruntled doctors at a time of unprecedented population health (Little, 1995). He attributed this anomaly to poor communication on meanings and values and advocated education of medical students to remedy this confusion. I have already noted that John McKinley and Lisa Marceau (2002) and Patricia Illingworth (2002) claimed that the relationship is responding to changes in society and that outside forces have diminishing medical professional sensitivity. Hans-George Gadamer in a collection of lecture notes concerning nuclear weaponry, environmental awareness and cybernetics was also concerned with medical professionalism and the doctor-patient relationship within a changing society:

“doctor-patient relationship .-. ability of doctor to sense the demands of an individual .-. and to respond - in an appropriate way - blunted by economic, legal, and professional agencies”

(Gadamer, 1996 p. 138)
These matters impinging on the doctor-patient relationship and on quality of care will also be discussed after the conversations with general medical practitioners to be reported in chapter seven. At this stage I suggest that the doctor-patient relationship in Perth might need an element of supererogatory caring to fill the gap between primary and secondary/tertiary level healthcare. Supererogation is that expectation of doing more than one’s duty as an feature of medical professionalism; and is more than ‘beneficence’ (McKay, 2002, Torisky, 1998). Present beneficence would be the efficient, timely and proper referral to hospital level care; supererogation would extend that care to a willingness to be involved in ensuring appropriate and correct hospital care, and ensuring appropriate and correct discharge planning. The enhanced trust of the doctor-patient relationship and the bridge between high technology healthcare and the community will be an important element in community level social capital.

The prospect that social capital may be important to government policy decisions has been explored by the Australian government sponsored research of the Productivity Commission (Productivity Commission, 2003). While admitting the importance of a ‘contentious issue’ the researchers are troubled by its imprecision. Nevertheless in its ‘Overview’, and in the body of the work, it contains references to possible benefits to health and welfare:
“In relation to services such as procuring medical treatment or car servicing, trust in a doctor/mechanic (and trustworthy behaviour by the doctor/mechanic) may prevent or lessen overservicing”

“social capital - can generate benefits in several ways: through associated social spill-overs, such as lower health and welfare expenditure, and higher tax receipts”

(Productivity Commission, 2003 p. xi)

The Productivity Commission (2003) quotes Putnam, in its section on child welfare, as finding a

“composite indicator of social capital to be highly positively correlated to a composite index of child welfare in the United States, which includes items such as infant mortality and juvenile death rates, family structures and poverty rates, and data on teen births, high school drop-outs, youth unemployment and crime. Further, regression analysis showed that social capital ‘is second only to poverty in the breadth and depth of its effects on children’s lives’.”

(Productivity Commission, 2003 p. 38)

The importance of declining social capital to the sustainability of healthcare is apparent at a time of rising healthcare costs and concerns regarding the quality of healthcare services. Healthcare costs are now significant elements in private, public and individual economies affecting more than the present health of people and populations.
4.3 The ‘Non-Sustainability’ of Healthcare Services

‘Sustainability’ as a general term is used in many publications to elicit respect for the environmental, social, and economic consequences of human activity (McMichael, 1993, Suzuki and McConell, 1997, Nature and Society Forum and Sustainable Population Australia, 2003, Kluger, 2004). The sustainability of healthcare and healthcare programs is however generally derived from dictionary definitions of institutional sustainability, i.e. ‘sustain’ -to provide for by furnishing means or funds (Macquarie Dictionary p. 1741 7). Healthcare programs might be concerned with more than financial support for ongoing activity, and include political, institutional, workforce, and client based matters (Sibthorpe et al., 2005) but the outcome is the ability of the program to continue, i.e. to be sustained. There is minimal concern with the reciprocal effects of the program on institutions, or on social, economic and environmental wellbeing.

People in Australia and in other developed industrial nations are living longer and more healthy lives than at any time in history (Murray and Lopez, 1996, Australian Institute of Health and Welfare, 1996, Mathers et al., 1999). It is also true that Australia and other industrial nations are spending ever more on healthcare services (Australian Institute of Health and Welfare, 2003). A nation’s wealth, as determined by gross domestic product (GDP), has however been claimed as poorly correlated with health outcomes both historically (Szreter, 2003) and internationally (McGlynn, 2004). Cuba, already noted as an example of enhanced social capital, spends a much smaller per capita amount on health care in equal dollar terms than the United States

It is questioned that ever increasing expenditure on healthcare services is matched by gains in health and wellbeing (Scott, 2006). It is possible that growth in healthcare services could even be harmful, leading to over-investigation by over-funded facilities, and to over-diagnosis and over-treatment (Fisher and Welch, 1999).

The ever rising proportion of national wealth spent on healthcare occurs with increasing wealth in many nations (Organisation for Economic Cooperation and Development, 2003). Comparative figures of expenditure, both private and public, with demographic data for different nations are shown in Table 4.1. It is taken from OECD data contained in an article by Richard Southby, an Australian academic working in the United States, appealing for a change to the healthcare system in the United States (Southby, 2004). He uses Australia’s more equable and inclusive healthcare to show how much better United States healthcare could be. He however does not cite the data on the inequitable life expectancy of indigenous Australians noted in figure 4.1. This illustrates that the ratio between indigenous and non-indigenous death rates is as high as 7 to 1 for the economically most productive age group of 36 to 44.
Table 4.1 Comparative Health Systems Data Year 2001

<table>
<thead>
<tr>
<th>Country</th>
<th>% of GDP on health</th>
<th>Per capita spent on health</th>
<th>Life expectancy</th>
<th>Popn in thousands</th>
<th>% popn over 65 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>13.9</td>
<td>$4,887</td>
<td>79.5 - 74.1</td>
<td>284,797</td>
<td>12.4</td>
</tr>
<tr>
<td>Australia</td>
<td>9.2</td>
<td>$2,513</td>
<td>82.4 - 77</td>
<td>19,663</td>
<td>12.5</td>
</tr>
<tr>
<td>Canada</td>
<td>9.7</td>
<td>$2,792</td>
<td>82 - 76.7</td>
<td>31,111</td>
<td>12.6</td>
</tr>
<tr>
<td>Sweden</td>
<td>8.7</td>
<td>$2,270</td>
<td>82.1 - 77.5</td>
<td>8,898</td>
<td>17.2</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>7.6</td>
<td>$1.992</td>
<td>80.4 - 75.5</td>
<td>58,837</td>
<td>15.9</td>
</tr>
</tbody>
</table>

From (Southby, 2004) table 1 p.443 (OECD data 2003)

Figure 4.1
A comparison between the death rates for indigenous to non-indigenous Australians at different ages

![Figure 4.1](image-url)

Australia: Rate ratio of age and gender specific death rates, Indigenous vs non-Indigenous population, 1995–97

(Ducket, 2004 figure 2.8 p. 26)
There are reasons for differences between the health of a nation’s population not determined by the quality of healthcare services, e.g. geography, housing, educational levels, female emancipation, justice and policing, infrastructure and transport. However it is reasonable to note that the United States, despite an enormous expenditure on health care, does not achieve high healthcare status. This is a point highlighted in the comparison between developed English-speaking nations that investigated multiple indicators of healthcare quality (Hussey et al., 2004). Why this should be so has been discussed by Timothy Jost, and is likely to be related to a United States culture enamoured of, and demanding of, immediately available healthcare technology (Jost, 2004). This demand may be at the expense of doctor-patient relationships embedded in primary healthcare (Macinko et al., 2003). It is a situation illustrated by Eric Cassell in his story of a patient who, concerned with chest pain, attended a cardiac fitness centre for a self scheduled treadmill exercise test and subsequent consultation with the fitness centre cardiologist (Cassell, 1991 p. 159). Such a situation of immediate access to high technology and specialist care seems bizarre to doctors educated in the United Kingdom and Australia, even though the process of care was nonetheless logical and the outcome satisfactory.

Figure 4.2 shows Australia’s increasing expenditure on health care as a proportion of Gross Domestic Product (GDP) from 1990 to 2001 (Australian Institute of Health and Welfare2, 2004). The slope increases into the present century. Political efforts change the proportions of costs borne by governments, insurance and individuals but the total cost continues to increase (Hall, 2004). Despite efforts at containment, costs rise at a greater rate than national wealth.
Political efforts by government to shift costs to insurance and to individuals can have the effect of creating a division in society between those who can afford costly healthcare insurance premiums and those who cannot. This is so despite populations in Australia and, as will be argued later in the United Kingdom, making plain that healthcare is viewed as a common good (Leeder and McAuley, 2000). Stephen Leeder, earlier discussing sustainable healthcare at a conference dedicated to the issue, claimed that healthcare policy reflected the values of individual societies and hence had limited universal application (Leeder, 1999).
Jane Hall (2004), writing prior to the Australian federal election in 2004, affirms the threat to healthcare access from shifts of healthcare finances:

“Further expanding private health insurance, either by increasing the range of services it can cover, will shift more health care financing through the private sector and threaten the universality of entitlements to health care.”

(Hall, 2004 p. 2)

She goes on to state, in the same paragraph that:

“Unfortunately, the strategy that is most likely to encourage private insurance growth is to reduce the quality and accessibility of publicly funded services - I say unfortunately because that would further reduce the universality of the system”.

Australia has a particularly fluid though complex health financing system with private hospitals (partially government subsidised through taxation credits), publicly funded State hospitals (with a substantial Federal contribution), a Federal government publicly funded pharmaceutical service (with co-payments), and a fee-for-service medical cost subsidy scheme (again with co-payments). Adjustments to this system can be made relatively easily, and in tune with political requirements. This is a point made by Stephen Leeder (2000), and by Jane Hall and Alan Maynard in purported advise to a prospective United Kingdom government contained in the British Medical Journal (Hall and Maynard, 2005).

Healthcare costs borne by government are financed from taxation in one form or another; and funded in competition with other government activities. At a State level
the Reid report noted the increase in the proportion of the Western Australian government budget spent on healthcare (Reid, 2003). The report emphasised the effects of healthcare costs on other items of budget demand

“With Present Growth rate of WA health expense at 8.5% per annum the State Government would be faced with the options of:

Significantly increasing its revenue base (e.g. increasing the tax burden on the community by raising taxes and charges) and/or

Reducing expenditure on other essential public services such as police, education and roads.” (Reid, 2004 pp. 17-18)

A former government economics bureaucrat, John Langoulant, was reported as confirming that health expenditure threatened budgetary stability and, if not restrained to 5.5% of gross state product, would leave no possibility of government financial support for other activities (Taylor, 2005).

A report on South Australia’s healthcare system extrapolates data to 2051 and considers expenditure unsustainable and inequitable with indigenous Australian health care achieving standards of those expected in third world countries (South Australian Department of Health, 2003). John Menadue, a diplomat, who chaired the Committee producing that report, later considered that healthcare reform was a matter of debate between ‘insiders’ and that it needed to be more inclusive of community interests in setting priorities (Menadue, 2003).
Another Australian State, Victoria, also highlights problems of healthcare expenditure but is more explicit in forecasting an inability to meet future financial demands related to an aging population, decreasing fertility and a decreasing revenue base (Little, 2004). Little’s report anticipates a need to increase migrant population, workforce participation and productivity to compensate for an increased fiscal gap between expenditure and revenue. This conclusion of a serious economic impact from the health and related effects of an aging population is supported by publications concerning Australia as a whole (Committee for Economic Development of Australia, 2004, Department of Treasury Commonwealth Government, 2002) and from the Organisation for Economic Cooperation and Development (OECD) (Frenk, 2004).

Rising healthcare expenditure might be considered with Benjamin Franklin’s ‘death and taxes’ as one of modern life’s inevitabilities (Van Der Weyden and Armstrong, 2004) but why should the rate of increase be more than the increase in financial resources of apparently healthy countries? It is as if, given increasing disposable wealth, nations and people are choosing to spend most of it on healthcare. This claim is supported by Jost in discussing the United States (Jost, 2004) and by Butler in discussing Australia (Butler, 1998). Gentzen however points out that expenditure is always restrained by budgetary considerations, and notes that ‘expenditure’ records that which is ‘spent’ not that which is demanded (Getzen, 2001). Increased wealth enables increased expenditure to meet the demands of a voting public. However if increased funding becomes insufficient then something must be foregone in order for payment to be made: hence Reid’s comments noted above on the opportunity costs of healthcare.
Moreover the ‘choice’ to spend on healthcare is seldom phrased as implying the loss of funds for other causes. A case in point is the plan for hospitals in Perth, i.e. Health 2020: A Plan for Metropolitan Perth, (Health Department of Western Australia, 2000). That study based on an extensive phone survey of Perth householders found that, not unexpectedly, the majority wished for quality hospitals close to their place of residence. Questions were not phrased to determine what the respondents were willing to forego in order to achieve that end, or what combination of features including location influence decisions. A more appropriate approach might be that of the study of community preferences in regards to public hospitals in South Australia (Jan et al., 2000). In that study, while not specifying that a choice may involve an opportunity cost, choice is modeled within multiple preferences by a conjoint analysis that is more likely to reflect real consumer thinking. The authors found that travel time was not significant in choosing a hospital, while a known higher complication rate for surgery was; and ‘difficulty in parking’ was perversely considered a positive indicator for choice as possibly indicating a more popular hospital.

Some commentators have claimed that ‘sustainability’ applied to health care is a misnomer, as healthcare is a service not limited by available resources but by money (Battin, 1998, Browning, 1999). Money is claimed as a measure of society’s priorities and, if society chooses to spend on healthcare then so be it; the consequences will be those of opportunity cost, i.e. less money for some other activity, and not resource depletion, environmental degradation or social disruption.
Economic activity linked to healthcare has even been noted as a general economic ‘good’, a service activity without implications of social or environmental harm.

*Growth in healthcare expenditure expands the whole economy, and I am not aware of any evidence that spending in one area of healthcare necessarily depletes others. It could well be the reverse.*  
(Woollard, 2003 p.93)

Health care services do consume resources and affect the environment. I reviewed the use of water by the engineering department at King Edward Memorial Hospital in Perth and found that it was cheaper to leave a dripping tap for the two weeks of the hospital plumber’s holiday than to employ an ‘outside’ plumber. The significant factor was that the hospital as a public utility enjoyed cheap water rates even at a time of increasing concern about the diminishing water reserves for the city. Healthcare contaminates the environment, as anyone close to a hospital incinerator can confirm (Cihlar, 1972). Moreover the use and disposal of toxic compounds in hospitals can be a matter of occupational health and safety (The Lowell Center for Sustainable Production, 2000). However its main sustainability factors are in the economic activity needed to provide the finance, and in the requirement for human resources to maintain services. If it were only a matter of opportunity costs then exclusion from concerns on sustainability may be valid but healthcare services are drivers of economic activity.

An example is in the Victorian report of Little (2004) already mentioned in which he anticipates a need to increase the revenue needed to pay health and welfare by increasing migrant workers. Migrant workers not only increase present productivity
but also help redress the demographic change of an aging population. However this increase in population in turn leads to further debate on the consequences of population pressure on a fragile ecosystem (Flannery, 1994, O'Connor, 1998).

Economic activity driven by and for health care is more explicit in the United States with health care insurance linked to employment and company profitability. Fortune magazine, noting an expected 24% increase in United States’ worker entitled health care costs of the coming year of 2003, warned of consequential social and industrial instability (Stires, 2003). The following quotation is from a Bulletin (Newsweek) article on the viability of the United States automobile industry.

“The majority of Motown’s lost sales have apparently gone to “transplants”: foreign models (albeit, often with US design and engineering input) manufactured in US plants that aren’t tied to union agreements and WW II-era pension and health-care commitments. Last year, GM claimed that the cost of health care, averaging $US1525 per car built, was more than the steel”.

(Stahl, 2006)

If United States motor vehicle manufacturers remain uncompetitive, partly as a result of the cost of healthcare, this will contribute to a loss of employment as plants are closed down; and to the consequent loss of healthcare insurance tied to employment.

In Australia, and in other nations, government supported healthcare depends on taxation, and on the wealth created to pay taxes. Even at an individual level healthcare insurance premiums have to be met from profitable employment. The economic
activity of healthcare might be a service activity and even exchangeable for other services, but especially in Australia, economic wellbeing is ultimately dependent on mining and agriculture. These industries consume resources, produce waste, contribute to global climate change, pollution and environmental damage, and lead to biodiversity loss: points made by the Australian Medical Association but without reflection on healthcare’s contribution to non-sustainability (Kluger, 2004) (Australian Medical Association, 2004b). Without mining and agricultural activity Australia could not enjoy the healthcare that it does. This linkage between healthcare and possibly unsustainable economic activity is discussed elsewhere if not in Australia (Jameton and Pierce, 2001). That article from Canada explores the need to assure sustainability in healthcare as a Kantian duty to future generations, i.e. that financial and other resources used for present healthcare are in effect used at a cost to future generations. The Canadians also contribute to ‘The Green Health Center’ of the University of Nebraska which has organised multiple projects on the environmental consequences of healthcare (The Green Health Center, 2004). The ‘Center’ noted not only the ‘downstream’ and ‘upstream’ costs of pharmaceutical manufacturing, but also the responsibility of the public for both consumptive lifestyles leading to healthcare service needs, and for the 'ecological footprint’ of the United States healthcare system, a system which uses 40% of world healthcare finances for an overall poor outcome.

In many developing nations an investment in health can be economically profitable (World Bank, 1993, Bruntland, 2002). However there is no evidence for healthcare providing productivity gains involving the large majority of hospital bed users in developed nations. Many decades ago Stephen Enke pointed out the health economic
burden in developing nations of the less than five and over fifty-five years olds, and there seems little reason to question this cold and brutal assessment in this place and at this time (Enke, 1963). Some healthcare can increase productivity but cost-benefit analysis cannot be phrased in these terms for the large majority of healthcare users (Zarnke et al., 1997). Indeed the prevention of the principal cause of death can be demonstrated as increasing life-time healthcare costs (Bonneux et al., 1998), and that the cost benefit of healthcare interventions for a particular disease or condition should include the cost of survival and inevitable subsequent disease and disability (Blomqvist, 2002). Even improving the quality of healthcare and decreasing the incidences of adverse events, those events stated in chapter one to be so expensive, has been criticised as being economically speculative (Kilpatrick et al., 2005).

It is reasonable to question the benefits of wholesale investment into healthcare services as demonstrating minimal gain (Scott, 2006). Healthcare services are becoming more costly, threaten other human activities, and impinge on general social and environmental sustainability. Governments in most democratic developed nations risk public antagonism as they seek to restrain healthcare costs. The paradox is of increasingly successful treatment modalities with increasingly frustrated public expectations (Palmer and Short, 2000 p. 30). This point is emphasised by the report from the Australian Government Productivity Commission on Medical Technology (2005). I have also noted John Menadue’s comments in the report from South Australia on the non-sustainability of a demand led healthcare system (South Australian Department of Health, 2003).
On a world scale both supply and demand led healthcare systems can impoverish poor populations that fall prey to both the globalised blandishments of drug companies and the healthcare technology manufacturers of the developed world (Frenk, 2004). These lead to cost burdens that block development and, for those lacking insurance or government support, perpetuate the disease/poverty trap. Julio Frenk, chairing the OECD meeting in 2004 on ‘Health and the Economy’, commented on the burden of healthcare for developing nations:

“We all want better health systems but the effect on the economy should not be underestimated” (Frenk, 2004 p. 9).

The allocative efficiency of devoting financial resources to healthcare has been demonstrated as less effective as a means of improving health than dividing the same finance to both healthcare and to social and economic development (John and Abel, 2002).

Reports from Australian States and Commonwealth and the Organisation of Economic Cooperation and Development noted above refer to the effect of an aging population on healthcare costs. This is however questioned by investigations that reveal a complex mix involved in aggregate health expenditure for different age groups that included age, but also proximity-to-death, educational levels, gender, and available individual wealth at different ages (Zweifel et al., 1999, Chernichovsky and Markowitz, 2003). Table 4.1 above also indicated that in the case of Sweden an aging population does not necessarily lead to a higher cost healthcare system.
On the other hand, expenditure, as measured in the table of nations and national healthcare costs, may be an underestimate of demand. It does not show that expenditure is always limited by budgetary allocations. These may be mediated through channels that appear discretionary, e.g. doctors, but are nevertheless restricted (Getzen, 2001). Getzen claimed that the individual demand for healthcare might be inexhaustible but individually necessary, while per capita expenditure reflected available funding from various sources; and now becoming nationally ‘luxurious’ (Getzen, 2000). A luxury item in these terms is that purchased in increasing amounts from disposable wealth (Butler, 1998, Callahan, 1990).

Hence high aggregate health costs depend on numerous factors, and extrapolating high costs to a future dominated as never before by a high proportion of aged people will not depend on any single factor no matter how plausible such argument might seem. A future dominated by the health and welfare of an aging population will only be threatening to social, economic and environmental sustainability if the other factors involved are ignored.

These factors might include expensive healthcare technology employed without due consideration by those on whom the technology is to be used. It might include an aging population uninformed on their choices to employ expensive healthcare technology. It might include specialist healthcare providers employing expensive healthcare technology without information on the particular circumstances of recipients. The impact of technology is claimed as the most significant element in Australian healthcare costs by the Australian Government Productivity
Commission (2005), by (Dunne and Kelly, 2001), and by (Fett, 2000). Reports from around the developed world attest that most nations are similarly troubled despite varied healthcare systems (Ross et al., 1999).

A publication on future healthcare and public policy anticipated the expensive progressive redundancy of advancing technologies allied with ‘misdirected special interest consumerism’.

"Since the potential for increasing technological complexity is practically unlimited, judging the right level of technological sophistication in health care will be crucially important" (Peckham, 1998 p. 201)

The concern is that if new technology is being adopted there should be a concomitant discard of that technology no longer appropriate or found useful. The Australian Productivity Commission (2005) recognised this dilemma but, while encouraging objective measures of health technology cost-efficiency, admitted the necessity of financial incentives for the users and purchasers of technology. Hence, although assessment of pharmaceuticals and medical procedures will depend on government appointed agencies like the Pharmaceuticals Benefits Advisory Board and the Therapeutic Goods Administration, the recognition of individual variation will remain dependent on the individual actions of doctors dealing with patients; and hospitals dealing with doctors. The Australian Productivity Commission (2005) noted that public hospital’s use of technology is constrained by cost-efficiency; private hospitals however may well engage new technology to attract particular medical specialists. In
delivering ever more expensive medical technology the Commission advocated the exploration of community attitudes.

“There is a pressing need to explore what the community considers is an appropriate level of subsidised access to healthcare and the technology it embodies, and the institutional and incentive structures that will deliver it efficiently and equitably.”

(Australian Government Productivity Commission, 2005b Key Points)

I maintain that, given the opportunity, community level medical practitioners with their patients will express these attitudes from medical encounters, both within and without high technology healthcare institutions. Community attitudes will be recognised as the cumulative voice of these encounters; a measure less confused by other factors than that of the ballot box. The importance of community attitudes to restraint in the use of healthcare technology enabling healthcare sustainability is acknowledged by Stephen Leeder (Leeder, 1999).

4.4 Health Care Technology: Restraining the Unsustainable

‘Restraining the unsustainable’ is the title of a paper by a pediatrician (Silverman, 2003). He noted the cost in human, and eventually environmental, terms of the care of extremely premature infants. He referred, in the context of the American health care system, to the matters concerning my experience of decisions regarding these infants. He even quotes an Australian, Justice Michael Kirby, writing in a British newspaper, Guardian Weekly, in 1981 on the technological dystrophia of medical technology:
“My hope is that it won’t be the epitaph of our generation that people will say: ‘Here was a community which developed the most amazing, dazzling fields of science and yet proved themselves so indifferent or incompetent, that they didn’t address the serious social and ethical consequences of what they were up to.”’

Kirby in (Editorial, 1981)

However healthcare services are generally quarantined from discussions on sustainable human activity. It is legitimate to attempt a society of health and happiness but it should not cost the earth, and it should not be at the expense of others elsewhere. It is as if the drive to enjoy a long and happy life is to have no limits, and is to be achieved without reflection on costs to those less able to access basic health now or in the future.

Michael Carey and Philippe Spapens in their publication on sustainable living and global equity concentrated on human wellbeing (Carley and Spapens, 1998). Their introduction is specific in rejecting a ‘deep green’ perspective of local or general ecology divorced from human survival in favour of sustainable human development. In terms of this thesis and this chapter, it is notable that their subsequent discussion on sufficiency and consumerism did not extend to discussion on the sufficiency of a healthy human lifespan, or on the consumptionism of its intemperate prolongation. Alan Durning, an early commentator on immoderate consumption, while including a single line on the consumption of hospital care, omitted any further reference to healthcare for the rest of his book (Durning, 1992 p. 20). There are many commentators who have promoted environmental conservation by reducing human
fecundity, from Paul Ehrlich in 1968 (Ehrlich, 1968) and 1990 (Ehrlich and Ehrlich, 1990) to Bill McKibbon in 1998 (McKibbon, 1998), but the limiting or rationing of healthcare services as a sustainability factor was not discussed.

Implicit in the concept of the non-affordability of a demand led healthcare system, (that we can never afford all the health care we think we might need now or in our future) is that healthcare technology will need to be rationed or prioritised. It follows that some system will need to be approved to enable such decision making: or nations accept the present chronic tension between the lobbyists for particular healthcare programs and their governments, governments elected on short-term mandates to oversee healthcare regulation and budgetary allocation.

Rationing of healthcare services is demonstrated by the waiting lists for operative procedures in public hospitals, with procedures given rankings on an implied need basis. Those same procedures can however be performed much earlier in private hospitals which ranks ‘need’ by an ability-to-pay. Explicit rationing was attempted by the ‘Oregon experiment’ in the American State of Oregon. There, over a two year period, the public were offered information on 709 health care services including outcomes and cost effectiveness, before voting on the 587 services to be included in the state Medicaid program (Kitzhaber, 1993).

However the public given a task of healthcare rationing may well reflect current values and judgements in selecting those most sick, but with less chance of a satisfactory outcome, as against those deemed responsible for their own ill health in
not ‘preventing’ disease (Dunne and Kelly, 2001). Dunne and Kelly (2001) from the Federal Department of Health and Aged Care concluded that designated systems of prioritisation were unlikely to be successful and saw a reluctant reliance on slow incremental health policy changes more practical.

It is, of course, much easier to vote on the healthcare of ‘others’ than the healthcare of oneself. This is the point already made in regard to healthcare costs by Thomas Getzen (Getzen, 2000). Nevertheless individuals acting in concert with trusted healthcare advisors could influence the use of healthcare technology; given that the advisors receive no incentive directed to the use of the technology in question.

In chapter six general practitioners in the United Kingdom are discussed as reducing the rates of hospital admission, and hence healthcare technology, while operating within a fixed budget (Dusheiko et al., 2003). However patients of such general practitioners might have been conscious of their practitioner’s divided loyalties (Dusheiko et al., 2004). Similar problems exist with the health maintenance organisations in the United States (Wilton and Smith, 1997) and, again, are discussed further in chapter six.

The question put by this thesis is the degree to which the demand for specialist led technologically based health care for patients within institutions could, or should, be guided by community based committed general practitioners. It must first be considered in what ways health care technology could be considered over used or inappropriate.
4.5 V.O.M.I.T and ‘Excessive’ Healthcare Technology

VOMIT is an acronym for ‘Victims of Modern Imaging Technology’ coined by Richard Hayward in a provocative article in the British Medical Journal (Hayward, 2003). He is a paediatric surgeon and was commenting on the anxiety produced by reports of anatomical and inconsequential abnormalities discovered by new imaging technology.

The medical writer for ‘Private Eye’ (‘M.D.’) a British satirical news journal, criticised, in similar vein, a fellow journalist who lauded her own brain surgery for a lesion discovered by whole body scanning, a process promoted as a screening procedure for latent or presently asymptomatic, disease. ‘M.D.’ considered the matter as one of technological abuse (M.D., 2006). A more philosophical critique is that of Stale Fredriksen who saw the effects of screening for otherwise asymptomatic and undetected disease in Habermasian terms as a ‘lifeworld intrusion’ (Fredriksen, 2003).

Healthcare technology covers a much larger spectrum than diagnostic imaging to include pharmaceuticals, pathology, public health and the panoply of healthcare institutions with their staffs and infrastructure. It would be surprising if some of that technology were not applied inappropriately, and, occasionally, to the detriment of users. Indeed the first two chapters of this thesis dealt with adverse events following institutional healthcare technology. The assumption in the case of adverse events is that the use of technology was necessary but that either the wrong choice was made, or
the technology was omitted, delayed or applied incorrectly. In this chapter the question is put that healthcare technology would on occasions by better not to have been used at all, and that patients/consumers of technology might have benefited from advise to that effect.

In this context healthcare technology might be perceived to have an imperative of its own, a need to be used because it is there, an impression that one can never have too much of a ‘good thing’. It is the point raised by Federal Senator Tony Cooke in a short article in the West Australian (Cooke, 2004). He was generally happy to leave medical decisions to doctors but noted

"Doctors cannot be entirely trusted because, like most kids, they like new toys" and
he asked, "Can we really afford every piece of new technology on the street corner?"

(Cooke, 2004 p. 22)

He is echoing not only the concerns of Daniel Callahan and the Hastings Centre for Ethics, but also the plea of the neo-conservative Governor of Colorado, Richard Lamm, whose concerns were far from ‘ethical’ but fiscal

"We are inventing the unaffordable and the unsustainable"

Lamm in (Herring, 2002).

A different perspective on the use of unnecessary investigation is that seen as a professional, moral and ethical matter. The Charter, discussed in chapter two as the outcome of the Medical Professionalism Project (2002), made special comment on a professional duty to avoid unnecessary investigation to conserve resources, a laudable aim. The matter of ‘incentivisation’ and diagnostic testing in general practice was brought to the fore at a seminar on quality in healthcare reported in 1977 at which the
then Minister of Health Ralph Hunt threatened to limit Medicare subsidies to doctors (Medical Journal of Australia, 1977). This was shortly after the introduction of government funded subsidies for medical services and suspicions of finance based collusion between general practice and private pathology laboratories, i.e. GPs were suspected of ordering pathology tests at government cost from pathology laboratories in which they had a financial interest.

Diagnostic imaging has been noted as a cause of occasionally unnecessary anxiety and even surgery, and the use of wholesale pathology screening tests criticised as unthinking use of resources. However the patients of the forums described in chapter five were universally supportive of doctors who ordered investigations to support a diagnosis or to reveal latent disease. There were no doubts raised by participants that these tests may be occasionally superfluous, that they may not alter healthcare management, or contribute to information on healthcare status. When tests were suggested as being ‘overdone’ the consensus was that they were probably necessary for medico-legal reasons.

However in the context of this thesis, i.e. that the safety and sustainability of institutional healthcare would be improved by a more intrusive community general practice acting for patients, is the decision to forego healthcare technology for the treatment of disease. The appreciation that a disease is self limiting, or of such nature that any treatment is more of a risk than allowing the disease process to resolve without treatment, is supported by healthcare providers, healthcare funders, and by educated patients/consumers of healthcare (Dollman et al., 2005, Chang et al., 2006).
Much of that appreciation, however, is related to the minor ailments of general medical practice. This thesis is concerned with high technology provided in hospitals where the assumption is of a need for high technology treatment.

It is most pertinent in regard to end-of-life issues: that involved and caring general practitioners would offer advice as to the wisdom of medical treatment with, at best, short term benefit. It is this aspect of involved care that was raised by Ezekiel Emmanuel in his philosophical treatise ‘On the Ends of Human Life’. He proposed that a caring relationship would be characterised as:

"an attempt to minimise the economic and merely technical aspects of the physician-patient relationship by reclaiming the traits that make this relationship one between friends, albeit friends who have differences in knowledge, need and vulnerability".

(Emanuel, 1991 p. 247)

He specifically targeted medical specialists as inadequate to the task of ethical interpretation of the use of medical technology.

“This responsibility for ethical interpretation is threatened by professional specialisation focussing on technical skills: attention to ethical ends atrophies. The consequence is that the specialist ceases to understand and guard his professional ethics”.

(Emanuel, 1991 p. 31)

Many writers have commented on a need for medicine to be more than medical technological competence. They have insisted that the healing relationship between physician and patient recognise that patients are more than the repository of disease
processes (Cassell, 1991, Redding, 1995). They appealed for recognition that the socio-psychological aspects of the patient as a person contribute more than a complication of treatment but are central to that that afflicts the patient. The treating doctor must know the patient, the family, and the social setting to respond to the ‘suffering’ of their patients. ‘Cure’ for these commentators is then not only the restoration of physiological function but of a life of meaning and worth. However there are those for whom a medical consideration of non-medical social matters is outdated, and possibly even patronising, in dealing with an increasingly knowledgeable and sophisticated public (Radley, 2002).

Art Buchwald, a celebrated United States columnist, winner of the Pulitzer Prize, encouraged further debate on his life and works by refusing daily kidney dialysis as a means of prolonging a diabetic life already complicated by a leg amputation (Grossman, 2006). It is noted that in his most recent column he urged people to name a surrogate to speak for their health care decisions. In the Australian health care system one might hope that such a surrogate would be, or become, the patient’s family general practitioner. One of the general practitioners interviewed in chapter six noted his contribution to a patient and her family coming to terms with precisely the same decision as that of Buchwald.\footnote{Art Buchwald eventually died on 17.01.2007, much later than expected, and after writing about the process of awaiting death.}

A recent television broadcast by the Australian Broadcasting Commission program ‘Four Corners’ highlighted the fears felt by some elderly people that the onset of sudden disability would expose them to a medically sanctioned inexorable progression
from hospital to nursing home without recognition of their wishes (Cohen, 2007). Their wishes were however to suicide at some time prior to serious irrecoverable disability.

At the time of my writing the West Australian parliament is to debate legislation permitting patients to document their refusal to accept medical treatment aimed at prolonging their lives; and to nominate a surrogate to ensure their wishes are followed should they become unable to voice their own decisions (Government of Western Australia, 2005). It would however be wrong to confuse such legislation with attempts to limit health care costs, even though similar claims are part of opposition to the bill (Spencer, 2006).

4.6 Discussion: Healthcare Technology and a Doctor-Patient Relationship

I have argued that healthcare services are expensive and could be damaging to sustainable economic development. The purpose of healthcare services is to improve and sustain the health of people but if the gains in health are marginal and not framed in ways that reflect the wishes of people then any cost is unacceptable. Restraint on increasing use and cost of healthcare technology is part of the policy considerations of government, and/or healthcare insurance. Individuals divorced from immediate cost considerations will rarely limit demand; and not to benefit ‘society’, the ‘environment’ or ‘future generations’. Governments, following a policy of user-pay, have debated co-payment, i.e. the imposition of a moiety of the cost of drugs and other technology, on healthcare consumers. This has unfortunately been most ‘successful’ in initially
reducing healthcare usage in those consumers least able to manage restraint, i.e. the poor and the most sick. It has then perversely increased healthcare utilisation as the health of the poor and sick became affected by their inability to access healthcare at earlier more easily treatable stages of ill health (Mojtabai and Olfson, 2003, Anis et al., 2005).

In the early 1990s concern was expressed that supplier induced demand, i.e. by doctors, would continue the employment of technology and consequent costs (Mooney and Scotton, 1998). Both government and the profession anticipated benefits from a reduction in the number of doctors (Bollen, 1996, Australian Medical Workforce Advisory Committee(AMWAC), 2005). Reduced costs were also hoped to follow market driven mechanisms of competition between healthcare suppliers but without convincing evidence of either improved quality or quantity of service (Commonwealth Department of Health and Aged Care, 1999).

Chapter six concerns the incentivisation of medical practitioners by government, or health insurance, to limit expenditure. I have noted the moral dilemma inherent in such policy. However the exercise of choice by patients and doctors acting together, without suspicion of exploitation, might be more favorable. That choice would be based on reciprocal trust, a shared knowledge of healthcare quality and outcomes, and on sensitivity to the particular values and needs of individual patients and their families.
Healthcare consumers, patients and their families might then be guided to resist the ‘hidden addiction of medical consumerism’ (Frank, 2000). Frank (2000) used cosmetic surgery and penile enlargement as an extreme argument for a marketed consumer driven healthcare system, but extended the discussion to include the differing perspectives of doctors and patients on patients’ needs or demands. He saw chronic disease, disability, impairment and ‘death itself’ as legitimate targets of a ‘consumerist narrative’. He recognised that there can be no resolution of that which is ‘medically required’. However it is of interest that in discussing a surgeon’s response to patient’s requests he asked:

“*But family physicians are not surgeons – what is the role of the family physician in this tangle of consumerism?*”

(Frank, 2000 p. 209)

Although he continues his indictment by noting that ‘family physicians’ prescribe drugs within a market system influenced by consumer demands for the products of the pharmaceutical industry, the fact that he asks the question indicates that he considers family physicians as differently motivated. Surgeons are not part of a sales team but might be expected to promote the technology they have taken time to develop and become skilled in use.

The maintenance and sustainability of human health is largely bound up in costs, and because the needs for healthcare services are often unpredictable, and occasionally urgent, some form of insurance must anticipate the need for payment. Third party healthcare payers, i.e. government and insurers, faced with rising costs have attempted to persuade medical professionals to prioritise and restrain the costs of healthcare
services. General medical practice incentivised by government or insurers to operating within fixed budgets is the theme of chapter six. Whether or not healthcare consumers can restrain, or be persuaded to restrain, demand for healthcare is the theme of this chapter. The concept is that expounded by Daniel Callahan and the Hastings Centre for Ethics (Callahan, 1990, Allert et al., 1996). Daniel Callahan notes the problems of quantifying ‘wellness’, and questions both the morality of endless treatments with inevitable demise, and a medical concentration on the ‘conquest’ of disease. However reviewers of his provocative book referred to above, criticise his simplistic suggestion of a withdrawal of healthcare financing of the aged. They admit recognition of the problem but cast doubts on any solutions (Lammers, 1999, Battin, 1998). Another Report from the Hastings Centre (Allert et al., 1996) makes a plea for a redirection of medical professional values away from a contest with inevitable mortality towards honour, prudence, economic sustainability, social sensitivity and equitability. An editorial in Australia explores similar grounds but omits any reference to economics (Ashby et al., 2005).

Joanne Lynn and co-workers have promoted quality improvement in healthcare by recognising the different aims of people as their health declines in different ways as they approach the end of life (Lynn et al., 2002). Lately she and colleagues have expanded this concept to divide the whole United States population into eight groups separated by differing healthcare needs, different endpoints, different optimal health expectations expected from healthcare services, and different resource requirements (Lynne et al., 2007). People would inevitably move into those categories with inevitable decline and death but there is also recognition of chronic disability and the
treatment of acute conditions in those normally well. Maternal and infant healthcare needs exist as a separate group. Her advocacy is for recognition of this population segmentation by healthcare planners while emphasising individual healthcare needs. The disabled and declining health groups in her healthcare system are largely managed at home. I claim that an augmented primary healthcare system and community level general medical practice would evolve to use this system intuitively.

To discuss death and dying as issues in sustainability is grotesque, and to suggest that someone should die to benefit a government’s, a family’s or an individual’s economic bottom line is inadmissible. Nevertheless voluntary euthanasia is increasingly discussed as a human rights issue (Battin, 1994), and directives to refuse further medical care are to be incorporated into legislation in Australian States (Government of Western Australia, 2005). If voluntary euthanasia is ever accepted into public practice then the relationship between patients and general practitioners will become crucial to permit a process that while vehemently opposed to sustainability as an issue will nevertheless enable it in practice (Jackson, 2005). While advanced medical technology can maintain life in those who would ‘normally’ die it is denied that dying has now become a contest with technology (Illich, 1995). Ivan Illich, long-time critic of medical professionalism, argues that it is not medical technology but the “misplaced concreteness” of modern life and medical professional education that is the major obstacle to a “bittersweet acceptance of our precarious existence” (Illich, 1995 p. 1652). This ‘bittersweet acceptance’ will become part of a doctor-patient relationship.
Another analyst to realise that professional behaviour was most significant in defining and implementing the ideals of healthcare is the Australian health economist Stephen Duckett (Ducket, 2004). Duckett, though writing as a health economist accepts a limited capacity of financial incentives and regulations to promote change:

“Although financial incentives have an important role in defining goals and so on, so too do hierarchical relationships and professional norms and cultures. Strategies to move towards the ideal must therefore use all three instruments of change (financial incentives, hierarchical structures and regulation, and professional norms and cultures) and particularly the last, given the influential role played by professional norms and cultures in health”

(Ducket, 2004 p. 289)

It is the contention of this thesis that ‘professional norms and cultures’ should now be more sensitive to the needs of patients and provide a fourth ‘instrument of change’, i.e. the social capital of the primary level doctor-patient relationship.
4.7 Summary and Conclusions

In this chapter I extend the argument in chapters two and three that a closer relationship between general medical professionals providing primary level healthcare, and their patients, will provide the impetus to better healthcare in hospitals. The relationship founded on such an expansive continuity of care could affect healthcare costs, the sustainability of healthcare and even general sustainability.

I have used this chapter to argue for a consideration of healthcare costs as influencing more than healthcare, but also limiting those other activities and services that might have been funded were it not for those costs. Moreover the funding of healthcare cannot proceed without wealth that might have been obtained by means threatening to social, economic and environmental sustainability.

Increasing healthcare costs have been ascribed to healthcare technology that on occasions may be unnecessary, or inappropriate. Any decisions to limit technology will however require trust between doctors and patients and it is the argument of this thesis that that trust will be created by a willingness to extend the continuity of care espoused by primary level general practitioners into the hospital environment.

The core research of this thesis is to question both potential patients and general practitioners to determine if there are grounds for hope that a doctor-patient relationship can be created to support better and more sustainable healthcare technology. The next chapter is devoted to a focus group inquiry into the expectations
of patients for their primary level care general medical practitioner. The opinions of general medical practitioners are discussed in subsequent chapters.
Chapter Five

Research into the Relationship of Western Australian Health Care Consumers with their General Medical Practitioners: The Possibilities of a Contribution to Safer and Sustainable Medical Technology

5.1 Introduction

The previous chapters have contained the assertion that healthcare in hospitals can be substandard and healthcare services generally unsustainable, and that this is a responsibility shared between a maladapted medical professionalism, a professionally driven medical technology and an unrealistic and insatiable public demand (South Australian Dept. of Health, 2003, Menadue, 2003). Medical technology is understood to be more than high technology artifacts but the whole organisation of the management, investigation and treatment of human ill health (Fett, 2000). In chapter four I have discussed the concept of a sustainable medical technology and what a future of sustainable medical practice might be like. I implied its gradual acceptance by both society and the medical profession. This chapter is the first to discuss how this change might occur.

It is claimed that a technologically dominated medical profession is ill equipped to accept a responsibility for the policy direction of medical technology and health care: ”where rational automata take the place of the personal decisions of individuals and groups” (Gadamer, 1996 p.8). Other professions less wedded to a Cartesian view of
science and nature, e.g. philosophers, architects poets, may be more capable (Waltner-Toews, 2000).

It is however not only the profession’s adherence to a biomedical modernist view of medical science and technology that complicates its participation in sustainable healthcare policy. There is a philosophical conflict between a prime directive to care for each patient and a broader responsibility to society. This is discussed by the profession’s leaders (Schlesinger, 2002, Medical Professionalism Project, 2002, Weinstein, 2001). That broad social, environmental and economic considerations would replace the medical profession’s devotion to individual patient care is presently unacceptable (New South Wales Medical Board, 2003). That position however is not immutable and the need for a community focus for medical practice was noted as long ago as 1939 by rugby union representative, writer and surgeon Herbert Moran, “We have given our attention too much as single doctors to individual patients. “If the patient has a right to health, the community as a whole has also a right to protective measures. The State has intervened because we forgot the people as a whole.”

Moran as quoted by James Gillespie (Gillespie, 1991)

While agreeing that the medical profession is not singly responsible for the direction of healthcare, its leading influence is undeniable. The Australian Medical Association and many eminent members of the profession have supported the concept of sustainability as applied to industrial and agricultural activity (Australian Medical Association, 2004b). They have warned of the consequences to population health of
non-sustainable development (Kluger, 2004, McMichael, 1993). The profession cannot escape from deliberation on concepts of sustainability applied to its home turf of medicine, medical technology and healthcare.

The medical profession and its philosophy are discussed in chapter two, including the claim that its present existence is dependent on an implicit unwritten contract with society. That ‘contract’ reserves medical technology to an autonomous profession. However autonomous self-regulation in a more knowledgeable and critical world is no longer appropriate: and the exclusive possession of medical practice and medical technology by medical professionals unlikely to last (Britten, 2001, Philips et al., 2002).

This chapter is based on the other premise raised in chapter two: that increasing medical technology has required increasing medical specialisation and a consequent devaluation of general and community knowledge. Reciprocally this has enabled more weight to be attached to technology and specialisation. Lawrence Weed advocated information technology to remedy present professional inadequacy. However writing in the British Medical Journal he decried the power of specialisation:

“We should never have placed so much power in the hands of those who memorise knowledge, regurgitate it in examinations, forget much of it, specialise in a small part of it, and never fully integrate what they do with the details of patient’s needs” (Weed, 1997 p.232).

Strong criticism indeed, but as a former specialist I can only agree.
Specialisation encourages ever more technology and its cost. This cost might be ecologically and economically unsustainable. It is claimed by this thesis that a shift to a more sustainable healthcare system is dependent on an increasing role for generalist and community knowledge, and an evaluation of technology from a generalist point of view.

The question for this chapter is whether or not society as represented by healthcare consumers will accept a more intrusive role for general medical practitioners in the evaluation and control of medical technology i.e. the technology that might be relevant to their health. To this end healthcare patients/consumers might need to be willing to invest in a long term and trusting relationship with their general practitioner (Freeman et al., 2003).

It was necessary to develop a method to determine if healthcare consumers as patients are interested in long-term relationships with general practitioners and that those relationships are of a character that will permit patients and their general practitioners a greater role in the control, development and employment of medical technology. The opinions of health care consumers in Perth, Western Australia were determined by the qualitative evaluation of focus group discussions. The methodology was introduced and discussed in chapter one. Its detailed application is described below.

Further discussion relates to the future of an empowered general practice divided into that of relevance to the doctor-patient relationship, and that determining the present
and future role of general medical practice. It is possible that present patients are uninterested in an intrusive role for present general practitioners. Will this require a change in general practice, general medical practitioners or the whole medical profession? Or will the evolution of a sustainable healthcare system require a radical change in society?

5.2 The Value of a Long-term Doctor-Patient Relationship:

The Opinions of Healthcare Consumers in Perth, Western Australia

5.2.1 Detail of Method (Forum Group Discussion)

The Health Consumer’s Council of Western Australia (HCC) consists of both organisations and individuals. There are approximately 400 individual members. A random third were contacted by letter in August 2004 and asked to attend group forums approximately one month later. These were to consist of from three to ten members with a moderator from the HCC to discuss the future of general medical practice. Replies were received from 45, and 30 indicated a willingness to attend at specified times. As suggested in the previous section many potential participants in focus groups find set meeting times inconvenient. The participation rate of approximately 30% is not unexpected.

Those attending were sent details of nine hypothetical situations. The hypothetical scenarios that were discussed in each focus group were followed by questions, but it was emphasised that these were to be considered as guidelines for discussion and not
survey material. These scenarios are included below in that the responses of the groups can best be understood by immediate appreciation of those hypothetical situations.

**Hypothetical Situations to Encourage Discussions by Focus Group Participants**

**Scenario One**

A young man has ‘fainted’ in a city street and is taken to a nearby general practice. He is now conscious and sensible. He states he had not done this before.

From your experience, knowledge or intuition how would he be managed?

a) Briefly examined and then sent to a hospital emergency department OR
b) Examined and an appointment made with a hospital clinic

What difference would it make if he had a general practitioner that knew him and his medical history?

Do you think that in future young men will be more, or less, likely to have general practitioners who know them and their medical history?

Do you think that in future people should be encouraged to ‘register’ with a general practice?

What difference would ‘Smart’ cards; (i.e. computer-entry-data cards with individual medical histories) make?

**Scenario Two**

An indigenous Australian mother brings to the practice her young daughter aged five years who she claims has become tired and disinterested over two to three weeks. The mother thinks she has lost weight. She looks well. A clinical examination is normal.

Do you think that she will be reassured that all is well and told to come back the following week? Or

Multiple blood tests performed on the little girl and told to come back in a few days OR

Immediately referred to a specialist?

Do you think that different decisions would be made if the mother and child were well known to the doctors?

Do you think that indigenous Australians are more, or less, likely to obtain healthcare from doctors that they have chosen.

Do you think that in general GPs order too many, or too few tests?

Do you think that in general GPs are more, or less likely, to refer patients on to specialists?

Do you think that primary health care clinics would be better if general practitioners obtained specialist qualifications and were able to advertise their interest? Patients could consult with these ‘specialists’ without preliminary referral.
Scenario Three

A twenty-seven years old female and a seventy-year old male have suffered hip pain for six weeks. They visit their local medical officer.
Do you think there are likely to be differences in the degree to which they are known by their general practitioner?
Do you think that patients and their social and medical histories will be more or less likely to be known by their local general practitioners in the future? Will it matter whether or not their local doctors know them?
Do you think the doctor will give the patient a prescription for drugs and tell him or her to come back if he or she is no better, Or
Also arrange an X ray and see the patient again in a week, Or
Arrange an X ray and a referral to a specialist without seeing the patient again?

What difference will ‘Smart’ cards make?

Scenario Four

A thirty years old female, twelve weeks pregnant in her first pregnancy visits her local general practitioner. There are no problems expected.
Is this doctor likely to know her and her medical history?
Will he/she care for the pregnancy and deliver the baby? OR
Will he/she refer her to a specialist? OR
Will he/she refer her to a hospital clinic? OR
Will he/she refer her to a mid-wife?
How would these decisions change if she and her doctor lived in a city suburb or country town?
Do you think decisions will change in ten years? What changes do you think are likely? What changes do you hope will occur?
What benefits are there from GPs being involved in the obstetric care of their patients?

Scenario Five

An elderly woman eighty years of age is suffering early dementia. She cannot be left alone at home because she wanders off and becomes lost.
The local doctor arranges a visit from an assessment team for residential care of elderly patients.

Do you think the local doctor will be involved in the assessment? And be present for the visit?
Do you think he/she should be involved in the assessment?
Scenario Six

There is a road traffic accident and a young woman has suffered a leg injury requiring sutures. It is seven-thirty in the evening and she is taken to a nearby local general practitioner.

Do you expect the doctor to still be on duty and
see and examine the patient and suture the leg OR
see and examine the patient and refer her to a hospital emergency dept. OR
refer the young woman to a hospital emergency dept. without seeing her.

Would it make any difference if the young woman were a known patient of the doctors?

Scenario Seven

An Australian, originally from Iran, has a teen-age daughter who has been found guilty of assault. The local general practitioner has known her for five years.

Do you think the doctor should share responsibility for the outcome, i.e. a patient found guilty of assault?

Do you think anyone will suggest the doctor be involved in her assessment and care?

Do you think the doctor should be involved in her further assessment and care?

Scenario Eight

A sixty-year old man is a public in-patient of a teaching hospital. He has undergone major abdominal surgery but has suffered an infection and the registrar suggests that further surgery will be required to drain an abscess.

Do you think the patient will know what a registrar is?

Does he expect to be seen by the surgical specialist consultant?

Does he expect his own general practitioner to be informed prior to repeated surgery?

Or only after surgery and after discharge home?

If his GP were informed prior to repeat surgery would you expect his GP to call in to the hospital and see him? Would the patient want his GP to see him?

The patient asks a registered nurse if something went ‘wrong’. What do you think the nurse would/could say (i.e. if he/she thought an error had been made)?
Scenario Nine

A patient has a cancerous tumour. The specialist to whom he has been referred by his GP suggests major surgery will be required. The patient states that he would like to discuss the matter with his own general practitioner.

Why might the patient want to discuss treatment options with his GP?
How do you think the specialist would respond to the request?

The meetings were arranged to take two and a half-hours, which is longer than generally advised for focus groups but included a break for refreshments and relaxation. The taped conversations from multiple placed microphones were transcribed and, with written notes taken at the time, analysed for responses, persistent themes and what were judged significant omissions.

Meetings were introduced by discussing options for future general practice. Stark and improbable contrasts were made between potential primary medical care systems as in a), b), and c) below.

a) Largely supplied by nurse practitioners

It is possible that much of initial patient contact can be converted into computerised algorithms and then into protocols of evidence-based best practice (Nair and Hardie, 2003, Weed, 1997). Medical professional management can be reserved for complex or non-responding medical problems. This would take place at a secondary care level.

b) A ‘medical mart’ of a managed group of general practitioners

This clinic system of primary medical care would employ large groups of general medical practitioners on a sessional basis. They would have regularised work schedules and secured time off. Attending patients would be guaranteed
short waiting at convenient times. The clinics would be incorporated with adjacent diagnostic, pharmaceutical, allied health services, and visiting specialists. Patients could not be assured continuing care from the same doctor.

c) A small group of specially trained general practitioners

These doctors would be more dedicated to long term doctor-patient relationships. They would be trained in medical and behavioral sciences, and into the evaluation of medical technology. Their specialisation into primary medical care would equate to the specialised practice of secondary and tertiary level consultants. Their diagnostic skills would be allied with those of the ability to explain and evaluate medical technology.

The nine hypothetical clinical situations previously circulated were placed before the participants and questions phrased to reveal how these would be managed within these future options. All situations and questions were addressed but discussion allowed and extended to matters the participants wish to consider. No consensus or summarised conclusions related to the hypothetical situations was expected: the hypothetical situations were considered as vehicles for discussion.
5.2.2 Results

The 35 participants did not represent the general public, they were older and preponderantly female (68%). Many commented that their experience of healthcare was much more than their own, but also that of dependent family, friends and relations. (The only participant who wrote back with comments on the results of the research also noted this aspect.) Three participants were semi-retired nurses as well as carers and patients. Hence the term ‘healthcare consumer’ rather than ‘patient’ is appropriate. Participants as members of the Health Consumer’s Council were distinct in having an interest in healthcare reform.

Moreover although the ideal size of focus groups is noted as three to seven, the groups in this study because of preferences for certain times ranged from two in one group to ten in two groups and then groups of seven and six. All hypothetical situations were discussed although emphasis within the groups was different and in the larger groups some participants found it difficult to express a differing viewpoint from that of the majority, or from that of a dominant personality. Hence agreement with a viewpoint might be assumed from lack of dissent rather than expressed support.

All of the five focus groups found the future options of general practice too contrived and generally unacceptable. There was universal opposition to the concept of primary health care delegated to nurse practitioners. Option two, i.e. the medical mart of primary medical care with convenience and accessibility to ancillary services was generally considered ideal. The only questions were those of location, travel and
parking. There was no general support for the more traditional committed general practice situation as illustrated in c) above:

“Why are we making a backward move?”

This verbatim reaction from participants in two groups was not unexpected and as stated was the rationale behind the use of hypothetical situations in which I assumed long term relationships may be discussed as beneficial.

Themes will be noted in bold type and were extracted from the discussions in a necessarily arbitrary fashion. Direct quotes from focus group participants are noted in italised bold script.

In these meetings it was universally accepted that young men (and ‘young’ might be those less than 50 years!) would not form, or be interested in, a long-term relationship with doctors. This was not only because of the reluctance of young men to admit human frailty but also because of the present requirements for a more mobile workforce and the expectation of mobility in general. This later point also applied to young women, but their needs for gynaecological advice and childbearing was accepted as leading to an earlier and possibly more established doctor-patient relationship.
The concept of **registration** with a general practitioner, or with a general practice group, was reluctantly supported, and then only to enable assured and easier access to busy popular practitioners.

*“It’s part of the problem we have now”. “You get to see a GP who becomes popular and his popularity smothers him”. “And you can’t get to see him”*.17

There was no support for the sort of registration that would oblige patients to attend particular doctors, or that would certify a relationship. The majority of participants wished to retain freedom to change doctors and to obtain fresh views of their problems. Some expressed a fear that familiarity with a patient’s problems could lead to neglect of symptoms indicating a ‘different’ disease. This was presented as situations experienced by some participants and was so stressed that I concluded that it might have lead to their interest in the Health Consumer’s Council.

The benefit of a **long-term doctor-patient relationship** expressed by these groups was that of the holding of information on medical history, individual medical idiosyncrasies, and blood group. This sort of information could be contained in personally activated ‘Smart’ computer chip cards. All groups were specifically asked if general practitioners might have knowledge about patients that could not be included on ‘Smart’ cards. There was no support for the concept that general practitioners might acquire knowledge of individual psychological, social or cultural characteristics that might influence the management of their ill health.

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17 Gender neutral language was not expected from participants in these interviews.
Some participants rejected any such relationship. One stated that:

“I don’t want a cosy relationship with my doctor”. “What I’m looking for is a prescription or who’ll send me off to a specialist, and that’s all I want”. “I don’t want a cosy country doctor relationship”.

The ‘Smart’ card concept generated considerable discussion with as many for as against. Reservations were those of a general mistrust of information age technology. These concerns about confidentiality and the ownership of information were directed at government, bureaucracy and, less frequently, at general practitioners themselves. A few participants objected to general practitioners possessing information on patients’ medical histories to which patients did not have access; and which could be passed on to other doctors or to hospital staff without the patients’ knowledge.

The focus group participants accepted that a mother and child known to general practitioners would be treated differently dependent on what was known about them. However, as noted above, there was some suspicion that previous knowledge and assumptions could distort correct management. Hence the majority thought that blood tests should be standard and expected. None thought immediate referral to expert opinion likely. The concept of specially trained and experienced general practitioners, i.e. into diseases of children, was universally supported.

That the doctor-patient relationship may have psychological, social or community benefit was restricted to ‘others’ i.e. to indigenous or immigrant Australians. In one meeting other possibly disadvantaged groups e.g. the deaf, the disabled, were considered to need or benefit from this perspective, and one participant with working
experience of the situation noted a benefit to the elderly from socially involved general practice. No participant reflected on the benefit to himself or herself of a general practice with community involvement.

The groups had varied opinions on the **medical care of indigenous Australians** with only one or two participants having direct experience of their particular problems. The question on the ability of indigenous Australians to choose their own doctor was generally misunderstood. I wished to know if these Australians were making use of ‘routine’ general practice or being constrained by directed aboriginal medical services and the provision of hospital outpatient clinics. One group considered that only the medical school graduation of indigenous Australians would enable valid choice.

Most saw general medical practice as primarily an early diagnostic service. It was agreed that doctors did not treat without a search for diagnosis. They did not over-investigate:

> “Now rarely come out with a prescription”. “Now they really want to know what is wrong”.

Many used doctors who undertook routine tests for incipient disease, i.e. as part of preventive healthcare, and felt comfortable with the interest this revealed.

Any tendency for excessive specialist referral was felt to be a reflection of a concern with litigation. A few attendants made comments indicating the existence of financial or social connections between doctors driving referrals.
Most consumer/participants thought that females were now more likely to plan pregnancies, to attend general practitioners for pre-pregnancy care, and would therefore be known to the GP. However I noted that this often reflected advice from magazines that they concluded influenced young women rather than the personal experience or knowledge of these older people.

It was generally thought unlikely that GPs would now undertake obstetric care. They thought GPs would neither wish nor be able to refer patients to midwives. The groups thought this largely due to medico-legal matters and that this might change. They did not think the different forms of general practice would affect future midwifery or obstetric practice, a practice that would become a mix of midwives and secondary and tertiary level care excluding general practitioners.

Aspirations for a different lifestyle by general practitioners were not mentioned. A few participants noted some advantage to a general practitioner in being involved in obstetric care in that they would be able to manage post delivery parenting difficulties and initiate child-care programs. None anticipated this activity as founding the basis for a long-term relationship.

The majority thought that general practitioners would be unavailable for out-of-hours minor surgery, and especially if this was related to the potential legal complications of road traffic accidents. However four participants in different groups had personal experience of non-traffic accidents treated by general practitioners ‘out-of-hours’ and it did not seem in these individual cases that GPs treated only known patients. They
were also aware of an incident in which a doctor had refused care for an injured patient where there were now ongoing legal matters.

A few participants noted the influence of practice receptionists in controlling patient access to their general practice employers. It was assumed that these receptionists were reflecting practice attitudes.

Many felt that GPs would not attend at a home visit by an elderly patient assessment team. However in all meetings there were participants who had experiences of this event and could refute these general impressions. Focus group participants knew that the assessment team had general practitioner documentation prior to the visit and some could see little benefit to further contributions. Others noted that GPs involved in the family, and in the family’s difficulties in coping with their aged relative, could be most helpful.

The groups could see no relevance to a medical practitioner’s involvement in a teenager’s anti-social behaviour except if some family situation could explain the behaviour, and the doctor was contributing to a legal defense. Indeed there was general irritation that a GP could have any relevance to social situations. It was felt that general practitioners should stay with medical matters and those social problems were the purview of psychologists and social workers. They needed some reason for my choosing an immigrant Iranian family. It was necessary to explain that this was based on my belief that an Iranian teenage female would be the most unlikely to display anger and violence and hence there must be some complicated background.
One participant with a Moslem name was aware of the social prestige of doctors within rural and economically less developed communities.

A further extension of the reach and understanding of general medical practice is the main theme of this thesis, i.e. that GPs exhibit continuing interest in their hospitalised patients who have been referred on to specialists. Most focus group participants considered that general practitioners had no real function for in-patients in hospitals except in country or rural settings. No participant expected that a general practitioner would be informed of any events occurring during a hospital admission but only following discharge home.

Some participants, despite experience, were unaware of medical professional structures within hospitals and did not think it important. Most thought it unlikely that patients would meet hospital consultants when public funded in-patients in public hospitals.

There was no support for general practitioners acting as patient advocates in hospital settings. There were three separate responses that such activity would be “nice”. This is taken in this context to mean ‘pleasant but unnecessary and impractical’.

“Nice” “But not real” “If it did happen—Wow” “It would be fantastic”

A response to a suggestion that a GP would visit a patient in a tertiary hospital to review an adverse event.

There were comments that GPs would be too busy for such activity.
The position of a nurse faced with questions on the competency of medical treatment generated considerable discussion. Many participants knew of hospital protocols dealing with adverse events and two participants served on hospital committees dealing with such matters. There was general agreement that the nurse should offer no opinion and follow procedures linking medical staff to potential complainants. There was no comprehension that the patient’s general practitioner would or should be involved.

Participants found no difficulty with the thought that a patient referred to a specialist might subsequently wish to discuss diagnosis or recommended treatment with their referring general practitioner. They anticipated that patients might feel more comfortable with someone they knew, or obtain a referral for a further specialist opinion, or obtain a translation of technical complexity. However it was not because the general practitioner had special information on a patient’s personal characteristics, family or social situation. Only one or two participants considered that a specialist might be irritated or offended by the request to seek an opinion from a general practitioner.

This was the only situation in which a clear majority could envisage a distinct advantage to having a long-term relationship with a general practitioner.

There were persistent comments in all meetings that general practitioners had insufficient time for activities outside the strictly medical transaction. There was
awareness of the feminisation of the general practitioner work force and of the tendency for this to affect practitioner availability. Participants felt that the fear of litigation affected the way medical care was exercised.

The Australian peculiarity of **bulk billing**, in which doctors would limit charge for an item of service only to that amount recoverable from government funded insurance, was raised repeatedly at every meeting. It was not included or referred to in any hypothetical situations or in any questions to the meetings. In terms of priorities many **doctor-patient relationships** would be dependent on the willingness of doctors to forgo co-payment from their patients.
5.4 Discussion and Conclusions

The preponderance of middle aged and elderly females amongst the participants is that of those bearing the most burden of health care. These women are experiencing their own declining health and also caring for parents, husbands, children and even grandchildren. This situation and their exposure to general practice, admittedly in France, is eloquently described by Martin Winkler in his novel “The Case of Dr. Sachs” (Winckler, 2000). It is possible to argue that their views should receive added weight.

The use of health care consumers with a close experience of ill health is that followed by the Commonwealth Fund International Health Policy Survey, a respected survey of adults in five countries, questioning satisfaction with health services (Blendon et al., 2003).

There was reluctant support for a long-term doctor-patient relationship. Restraints to the formation of such a relationship were:

a) the doctor might have to forgo any co-payment (i.e. accept bulk billing),
b) the patient would retain the right of exit if he or she did not receive care of a type the patient expected, and
c) a substantial segment of the population might see little benefit from the relationship.
Health care consumers had little awareness of psychosocial or cultural matters that supposedly should influence health care management at all health care levels (Engel, 1977, Kleinman et al., 1978). There was minimal appreciation of the ‘lifeworld’ noted in sociological studies of doctor-patient relationships (Barry et al., 2001, Scrambler, 2001). This does not infer that these studies are mistaken but that subjects of care are possibly unable to reflect on their own psychological or social reality. Although it is assumed that a sustained doctor-patient relationship requires the general practitioner to engage in the ‘lifeworld’ of his or her patient (Safran, 2003) this study might also suggest that patients have other priorities, or that they have no experience that this depth of relational involvement is worthwhile.

It is evident that for these healthcare consumers at primary health care level in Australia the doctor-patient relationship has become that of the technocratic contract anticipated by Pellegrino; now no longer paternalistic and compelled by circumstances to circumvent holistic sensitivity (Pellegrino and Thomasma, 1981). This is not condemned by all (Radley, 2002). Some see this as welcome or inevitable and part of our technological future (Marinker, 2000, Holmes-Rovner et al., 2001). The priority commitments to diagnosis and advice as a function of general practice, rather than treatment, is consistent with professional expectations (Bitomsky, 2003, Charles et al., 2004).

The implicit contract between doctor and patient at primary care level includes commitment to the maintenance of health and the early review of disease and, although not part of the investigation, this was noted. It was activity triggered by the
age and medical history of the attendant at the doctor’s surgery. It is part of an incentives package in Australia (Sims et al., 2000). It was not part of any population review, and did not indicate a commitment to a long-term relationship.

It must be admitted that any hope for the sort of relationship required for an advocacy role will be unrealistic. Patients expect their general practitioners to care for them in their struggle with disease and disability but not if this opposes professional and institutional loyalty. Advocacy, eventually leading to hope for control of medical technology, would depend on a degree of trust not revealed by this investigation, and is a situation anticipated by others (Mechanic, 1995). David Mechanic, in discussing implicit rationing, considered that the erosion of trust was part of the increasing sophistication of patients. Susan Gould from the Hastings Centre noted that trust is considered part of moral duty rather than as part of the regulated contract that the doctor-patient relationship is becoming (Gould, 2001).

Healthcare consumers do not expect a community interest by their general practitioner that would either assist or hinder individual care. This contrasts with other views of primary healthcare that anticipate a psycho-social community impact from medically trained personnel (Cassell, 1996). In summary, and as demanded by professional codes of ethics, individual care remains of paramount importance (New South Wales Medical Board, 2003).

The other main point raised by the study was the reluctance of many participants to welcome ‘Smart’ card computer technology for the personal retention of medical
records. The question is what it would take to convince healthcare consumers that this technology would be beneficial: and, indeed, if it is to be beneficial. John Paterson, writing from a non-medical but an academic and administrative background, saw a patient held electronic record as the keystone to a better future healthcare system (Paterson, 2002).

The acceptance that general practitioners are not expected to participate in hospital care is an historical trend and was noted to be likely to contribute to the marginalisation of general practice over the ensuing decade by a federal government report in 1992 (Commonwealth Department of Health, 1992). The Report’s concern was the effect such change would have on primary medical care: there was no reflection on the effect such exclusion would have on hospitals. The absence of a general practitioner participation in the long term care of hospitalised patients is well illustrated by a qualitative review of long term hospitalised patients in South Australia (Johnson et al., 2005). Nineteen patients were asked about the effects of hospital care and their anticipated discharge. Patients expressed concern about their ability to manage. Conclusions were reached on the need for hospital staff to recognize these concerns. However no questions were asked on any expected involvement by primary care practitioners, and no discussions held on any interaction between patients, patient’s families, hospital staff and the patient’s general practitioners.

What questions arise as a consequence of this focus group research (this was one of the expressed advantages of this methodology)? There was the unexpected insistence on bulk billing and this raises the need to determine the priority for this measure.
Patient characteristic leading to bulk billing by general practitioners have been determined (Pegram and Valenti, 2004). However the characteristics of patients choosing bulk billing practices, or what they would demand in accepting a personal payment moiety, remains to be assessed.

Australian healthcare consumers in this study have accepted general practitioners as fulfilling a transactional contract to supply medical diagnosis, advice and treatment, and to act as gatekeepers to more advanced medical technology. Any intrusive role to pursue governance and sustainability will have to depend on a reconstituted general practice mandate. This can occur as a result of professional restructuring and development of general practice: the creation of the superior ‘renaissance’ generalist. This development is that claimed by Marshall Marinker, Visiting Professor of General Practice at the University of London, as a necessary replacement for what he considered to be a moribund general medical practice (Marinker, 1995).

An assessment of the quality of institutional care could occur as a result of general practitioners given finance to purchase secondary care services on behalf of their patients (Maddox, 1999). The presumption is that GPs would purchase services from hospitals prepared to offer the best quality of healthcare. This might have occurred as a consequence of general practitioner fund holding aimed at reducing waiting lists for secondary level care in the United Kingdom in the early 1990s. This is the subject of the next chapter.
The themes explored in this chapter,

a) the benefits of an established doctor-patient relationship, possibly certified by registration,

b) the provision of electronic medical records, and

c) the possibility of a general practitioner leadership or advocacy role in caring for their patients,

will be returned to in questioning a number of general practitioners in chapter seven.
Chapter Six

Experiments in the Empowerment of General Medical Practice

6.1 Introduction

This thesis is based on the proposition that the better governance of hospitals will support sustainability of the health care system. Moreover, those most affected, the hospital’s patients, should participate in enabling the outcome of governance, the quality of health care. It is suggested that presently there exist a minimal ability for patients to influence hospital management and that it may be necessary to encourage an agency role by, for example, the patient’s general practitioner.

In chapter two I have discussed the problem of progressive specialisation for hospitals and the medical profession. In that chapter I have suggested that there are risks that progressive abstraction from long-term whole patient involvement deprives hospital based healthcare of an important component of caring. That is not to imply that specialists and hospitals cannot be caring individuals and institutions, but that, without some continuity of care, human relationships important to reassurance and healing are difficult to establish.

The previous chapter however indicated that patient consumers of the Australian healthcare system anticipate a general practitioner as providing efficient, competent basic health care as and when required, and at minimal cost. They have come to accept that a need for the more complicated investigation and treatment at a specialist
level within hospitals would mean no further participation by a general practitioner in their immediate care. Moreover they do not think of continuity of care involving social and psychological factors required by such a general practitioner as a significant and important component of primary medical care.

To establish that patients through their general practitioners can influence the governance of hospitals would require a research program with some agreed endpoints and run over an agreed long time period. Such a program involving changes in the attitudes of patients and their doctors is, at this stage, unlikely. However it may be possible to point to ‘experiments’ conducted elsewhere that would possibly support the hypothesis. In most cases these experiments were not directed to the governance of hospitals but to the empowerment of general practitioners within healthcare services and, by inference, in respect to that of healthcare institutions. ‘Empowerment’ implies that those given powers were previously, in some degree, repressed, dominated or marginalised.

Since the beginning of a state recognised medical profession and a structured healthcare system general medical practitioners have represented the lowest rung of the profession. In 1992 a Commonwealth Health Department committee investigating general practice in Australia came to the conclusion that general practitioners were treated as inferior:

"supports view of GPs as subordinate to specialists, as managing only simple problems, or as doctors who failed to become specialists"

(National Health Strategy (Australia), 1992 p. 38)
In chapter two I have described how this attitude might have been different if the British and, later, the Australian medical professions had evolved differently. General medical practice, rather than general medical knowledge, became the base from which specialist practice was created. This has changed and general medical practice has become a ‘special’ practice with special requirements (Choong, 2004, Royal Australian College of General Practitioners, 2005). In chapter seven all general practitioners I interviewed considered that continuity of care, although not restricted to general practice, was and would remain its defining mode. I anticipate that general medical practice, recognised and respected as a ‘specialty’, might evolve to have a different position within the hierarchy of the medical profession. Moreover, and of crucial importance to this thesis, is that the medical consumers, the general practitioners’ patients, would anticipate the advantage of that changed position to their health and care.

However in chapter five it was revealed that some interested and involved healthcare consumers accept that the present professional relationship between doctors would be more significant than any relationship between doctor and patient; and that that would be so notwithstanding the length of time that the doctor/patient relationship had lasted. They have no confidence that ‘their’ general practitioner could influence care within a healthcare institution dedicated to specialisation. Professional reticence apart there has also always been the fear that patient knowledge of inconsistency between doctors would adversely affect patient care and compliance.
Government, a significant stakeholder, and in some nations the principal funder of healthcare, has at different times and places, sought to empower general practitioners in respect to the other parties to healthcare. The most significant experiment in this regard was the granting to British general practice of finance to purchase secondary and tertiary level care on behalf of their patients. Other governments, including that in Australia, have attempted similar reforms both to restrain or cap healthcare costs and to improve healthcare for particular groups of patients. Nevertheless the body representing Australian doctors, the Australian Medical Association, has condemned the holding of capped finance by doctors as possibly distorting medical values (Australian Medical Association, 2004a). This condemnation is much to do with capped remuneration and the control of an expenditure that should relate to patient needs, but it is relevant in this chapter to determine if this investment in the United Kingdom changed medical professional relationship and affected hospitals.
6.2 The British National Health Service 1990 - 1999

6.2.1 Introduction

The British National Health Service (NHS) registers patients with general practitioners in their geographical area. This is necessary to enable the remuneration of general practitioners by the number of patients registered under their care, i.e. they are paid ‘per capita’. It is in the interest of doctors to retain patients, and NHS general practitioners are in effect ‘regulated’ to provide continuity of care for patients while they remain in their locality.

They also act as ‘gatekeepers’ to specialist care: patients cannot obtain an appointment to see a specialist in the health service clinics of hospitals without a prior referral from a general practitioner. Many countries including Australia use GPs in this way to avoid unnecessary, excessive, and expensive specialist and hospital clinic use. It is also considered medically unwise for patients to have immediate access to specialists whose focus for care is possibly distorted by their special professional interest (Wright et al., 2003).

It might have been expected that GPs in Britain, despite continuity of care being imposed, might have evolved an advocacy role. It has been shown that this did not happened and general practitioners became established as the poor relations of the profession (Jeffreys and Sachs, 1983). Patients referred to hospitals or to specialist care did not expect any further involvement by their general practitioner. It was even
difficult to ensure the exchange of prompt and proper information, a matter raised in interviews with present Australian general practitioners in chapter seven.

At the start of the NHS in 1948 public hospitals were centrally funded but, as quasi-independent trusts, later became dependent on Local Health Authorities for their commissioning. Specialists in public hospitals were, and still are, employed on a sessional salaried basis; i.e. they are paid for each half-day, or nominal half-day, that they work. Hospitals, as for any public service, could be closed down in areas where population changes reduced their workload. They were not as protected as inferred by David Wilkin in his review of fund holding in 2002 (Wilkin, 2002). He noted that, at the time of general practice fund holding, hospitals were still commissioned by Area Health Boards for four-fifths of their budgets, and as monopoly providers could not be closed down. However, as illustrated later by conversations with general practice finance directors, individual departments could be very sensitive to any threat to reduce patient numbers, and their employed specialists could find their sessional allocations affected.

Competitively selected hospitals in the United Kingdom have now been allowed to devolve to community–owned Foundation Trusts operating under locally elected Boards with the anticipation of performance scrutiny at a patient level. However the degree of community accountability has been criticised (Day, 2005). It is interesting that this is comparable to the situation long established in Sweden and follows similar reforms in New Zealand (Howell, 2004, Barnett and Barnett, 2003).
The internal pseudo-market that was general practitioner fund holding (GPFH) was part of a policy initiative of a Margaret Thatcher Conservative government convinced that a competitive market would resolve many national problems including healthcare. This situation was a characteristic of market based neoclassical economics promulgated in the 1980s as a means to social wellbeing guaranteed by wealth creation, rather than as rights based welfare. However a National Health Service, that embodied cherished rights to healthcare funded by the nation and administered as a responsibility of government, could not be abandoned. The creation of funded ‘purchasers’ of healthcare would hopefully ensure that competition driven reforms would, if not reduce costs, at least curb further increase and improve healthcare standards.

From 1991 this purchaser-provider split was extended to include progressive numbers of general practitioners given funds to purchase district nursing assistance, pharmaceuticals and some elective (non-emergency) secondary and tertiary health care services on behalf of their patients. The ‘market’ incentive for participating general medical practitioners was that they would be allowed to retain unspent funds for discretionary spending on their practices.

This model of primary medical care being used to drive other levels of healthcare has been developed in different ways up to the present time, but now involves committees of other stakeholders with GPs represented (Wilkin, 2002). The original fund holding model was the only time doctors were provided with a purchasing role of their own. The degree to which this financial empowerment of committed general medical
practitioners affected the clinical and corporate behaviour of hospitals and their specialists is the matter for investigation in this chapter.

6.2.2 The Impact of General Practice Fund Holding on Hospitals

Surprisingly little effort was taken by government to determine the benefits of such a radical measure and it was not until the British Audit Commission surveyed both fund holding and non fund holding general practices in 1994-1996 that any widespread concerted attempt was made (Stewart-Brown et al., 1996). Comparisons by this time were difficult, as fundholders were self-selected, possibly differentially motivated, and there were no objective outcome measures in place. Moreover the practices tended to occur in different social circumstances as noted by Majid et al. when analysing hospital admission rates in economically poor areas of London (Majid et al., 2000).

There is some suggestion that funded general practitioners managed to curb cost increases, and that funded general practices referred patients less often for secondary healthcare services (Dusheiko et al., 2004). The bureaucracy necessary for such a radical initiative made the administrative costs very expensive, and these remained so despite gradual acceptance and familiarity (Dean, 1997).

The general practitioners involved became imbued with a better sense of direction and purpose in their contribution to national health: their status improved (Maddox, 1999). However the satisfaction of patients was equivocal with some patients probably conscious of their GP’s attention to avoiding referral (Dusheiko et al., 2004). Others
were more aware of better service (Sargeant and Kaehler, 1998). It will be noted later however that many patients were unaware of the fund type of their particular practice. Fund holding general practitioners were able to obtain more ready access to secondary/tertiary care for their patients (Stewart-Brown et al., 1996, Popper et al., 2002, Dowling, 1997), even though as stated the numbers referred to this care were reduced (Dusheiko et al., 2003).

Notwithstanding the quite radical and probably disturbing changes to the infrastructure and administration of a large service organisation it is difficult to find any evidence in the literature of consequences to the health of the British, or of their hospitals. Julian Le Grand, from the Kings Fund policy unit, both in 1998 and in 2002, considered that minimal changes occurred despite these profound redirections of health care policy (Le Grand et al., 1998, Le Grand, 2002). The new Labour government, in reforming these funding arrangements following election in 1997, did not withdraw from the concept of a general practitioner led health service. ‘New Labour’ considered that the future should be more collaborative between primary and secondary level service rather than be one of a market competition to which it still had lingering ideological aversion (Pollard, 1997).

The Audit Commission in 1996 did criticise fund holding GPs for limited use of evidence based clinical practice guidelines, and noted a lack of involvement of patients in decision making. It was considered that fund holding made little difference to the way doctors practiced, Stewart-Brown, Gillam et al (1996). ‘Audit’ and ‘practice guidelines’ are however managerial tools and were minimally established in
healthcare between 1990 and 1996. Julian Le Grand by 2002 was better able to considered that these ‘top-down’ administrative controls might be psychologically resisted (Le Grand, 2002). He postulates that the lack of any change in outcomes from policy variation in the NHS is due to inadequate numbers of healthcare professionals (1.7 doctors per 1000 people – compared with 2.5 in Australia and 2.7 in USA) combined with poor professional incentives. In my discussions on medical professionalism in chapter three it was proposed that this lack of change is part of the resistance of a complex adaptive system.

The British Medical Association, like its sister organisation in Australia the AMA, opposes the holding of capped budgets by doctors. In an editorial in its journal, the British Medical Journal, it comments on a publication by the Royal College of General Practitioners noting philosophical dilemmas with fund holding (Fugelli and Heath, 1996). That publication makes the point repeated by others that a doctor’s primary duty of care to an individual could be incompatible with political cost-effectiveness dictated by government.

6.2.3 Conversations with Fund Holding General Practitioners

Finding it difficult to believe that such a radical measure as the purchasing of health care services by health care professionals had had such minimal effect I decided to replicate George Maddox’s ‘field trial’ of fund holding (Maddox, 1999) by conversations with colleagues in and near Liverpool. I had considered that a general practitioner able to ‘purchase’ care for a patient should have been able to determine
the hospital care with the best results, and the most convenient location. A general practitioner should have been able to bargain for the most cost-effective care, noting the hospitals’ need for his, or her, further purchases of healthcare.

Questioned in July 2004 were four financial managers and four general practitioners. The conversations were recorded. However their experiences were too diverse to indicate any persistent themes and represent variation in response to a significant event in the history of a health service. They included a GP (Rob) who was not involved in fund holding but was involved in subsequent piloting of total health service commissioning. He was opposed to the operational aspects of fund holding and was the secretary of the local British Medical Association (BMA). Two GPs (Ian and Mick) were from one moderately sized group practice that relegated much of the bargaining for patient access to a health service manager (Terry). One GP (Colin) and a financial manager (Neil) were from a practice that sought to exercise the potential of general practice leadership in local health service reform. The opportunity was also taken for discussions with two financial managers (Kate) and (Joy) from more distant general practice groups.

Colin and Neil probably demonstrated the way that government hoped fund holding would influence healthcare services. Colin was able to obtain the trust of other general practices to produce the combined patient numbers necessary to influence government and secondary healthcare providers. His combined practices took on a part-time research worker to investigate the journey through a local hospital of a patient and were able to demonstrate poor management. This, in its turn, influenced
specialists at that hospital to develop outreach services and to guide primary healthcare into early care protocols, preventative care and follow up systems. He considered that he and his colleagues contributed to the general avoidance of hospitalisation and of the re-admission of patients for a relapse of the condition requiring their original admission.

His combined practices were also able to build a minor surgery unit employing interested GPs to conduct operations cheaper than that provided at hospitals. It seems unlikely that he and his finance manager took part in competitive bidding for secondary level services, but were able to enhance primary level care and the viability of their local hospital by collaboration rather than threatened competition. Colin and his colleagues’ efforts to improve hospital based healthcare, and not merely to increase the access of more patients for more healthcare procedures, was very special and was the only example I could find where this occurred. It is discussed further in chapter seven when the question will be asked why it was necessary to create an ‘artificial patient’ to determine hospital care standards when ‘real’ patients are so available.

Joy, at a later interview, made the point that it should not have been necessary to launch fund holding to achieve the better care demonstrated by Colin and his GP colleagues:

“Quite ironic really; I was commenting before about practices grouped together which gives you a bigger power base, then you have the ability to destabilize things greatly, but on the other hand if its in a locality and you can improve things across practices technically, why couldn’t that have
happened without fund holding?” “Which goes back to the consultants/GPs situation where could the whole thing have been talked through - and managed, rather than potentially having a destabilizing situation, because in my opinion it definitely destabilized the trust (hospital) for a couple of years”.

Terry, a fund manager with GPs Ian and Rick, enjoyed the contest created by fund holding. He considered that the friction between GPs and hospitals enabled better care:

“Once it became fund holding the consultants were relying on the GPs, you could send them anywhere you wanted. And that caused a bit of friction. And its often described now that that’s the only time the NHS worked properly”.

Terry and Joy were interviewed together. Joy noted that the need for accurate costings by hospitals and GPs encouraged the rapid accumulation of financial sophistication and the utilisation of computer generated data. They noted the need for GPs to become computer literate following the computerisation of practices by those uneducated into information technologies. Terry commented on newly arrived computer power:

“It was like being given a Ferrari on your seventeenth birthday there would be an accident somewhere along the line”

They both anticipate patient held ‘smart’ card technology.
Terry especially used his ability to manipulate previously dominant hospital authorities. He gave colourful accounts of patients being moved away from local hospitals to those some distance away:

“That contract that they did on Christmas Eve I spoke to the local hospital first and they said “We’re not intellectually disposed to that sort of thing” exact words. Fair enough! Moved everybody out - they lost thousand upon thousands of pounds out of the trust. And the directors rang me up at New Year and said “You could close us down if you do that any more”. “What have we got to do to stop you doing it?” And my quip was “Are you now more intellectually disposed to doing it?” And what they had to do - to get the consultants to say “yes we’ll do more sessions”. Because the opposite to that is if they don’t do more sessions we’ll move them (patients) off and then there’s no need for the original sessions”.

Ian and Rob, however, pointed out the anomalies of the system with local hospitals having lost local patients and now, having extra bed capacity, able to contract with more distant areas. These may well be in the areas that had agreed to treat Terry’s original patient groups. Hence patients were being somewhat ludicrously moved about the country to comply with local political machinations. Rob also noted game playing on the part of hospital consultants taking on fund holding practice patients at times supposedly devoted to NHS patients.

Rob, although not in favour of budget holding by GPs did agree that hospital consultants were forced to improve certain standards of practice, mainly communication. Ian, moreover, noted that these standards had declined since strict fundholding was abandoned:
“The fact was that yes they could communicate very quickly with fund holder’s practices but they did nothing for the overall system.”

“It was highly selective then. And once fund holding disappeared, believe it or not, things went back to what they used to be.”

Rob was very conscious of the effect of fundholding on the whole health service. He considered that it was both administratively very expensive and inequitable. With no extra clinical resources made available, those patients not in fundholding practices were disadvantaged with longer waiting times and poorer coordinated care than would otherwise have been the case.

It was evident that financial managers enjoyed the ability to influence hospital practice. General practitioners themselves took little part in bargaining but were courted by hospital specialists demonstrating the type of service on offer. While this was of benefit to all concerned it did not extend to a critical appraisal of individual patient care. These general practitioners of many years of experience were unable to recall any occasions in which any parties expected them to become involved in reviewing episodes of individual patient care.

There was general agreement on three points. One, that patients were aware because of media exposure that a two-tiered system of care had been created between those in or out of fund holding practices. Two, patients within any practice were unaware of the nature of their particular practice, i.e. that it did not intrude into the day-to-day care of those patients. Three that at that time and possibly even now, consumer groups
was irrelevant to the health care system. One practice manager referred to them as “ancient hypochondriacs”.

Individual patient needs were not part of the bargaining process. General practitioners needed large numbers of patients to influence hospital practice, eventually leading to purchases by groups of practices. Hence although GPs were empowered to influence hospital and departmental policy, e.g. willingness to form outreach clinics, more patient convenient operating times, better communication, this did not extend to individual patients. For those patients able to access hospitals as patients from fund holding practices their waiting times were reduced but there was no effort to ensure better care. The governance of hospitals was unaffected.

The frustration of general practitioners engineered to reflect a technologically dominant healthcare system is well expressed in the editorial of Fugelli and Heath (1996):

"Modern fragmented technomedicine induces unrealistic and dangerous expectations while at the same time promoting dependency"
"Biological variation and the stresses and misery of human life are converted into diagnosis with consequent demands for specialised investigation and treatment".

(Fugelli and Heath, 1996 p. 457)

It remains to be seen if a different general practice and a different healthcare consumer could influence the ‘technomedicine’ of healthcare institutions. I suspect that ten years later this position of concerned general practice is worse, not better.
Health services in different countries reflect both national and professional characteristics, and it would be wrong to assume policy development on one country would have the same effects in another. Certainly the implementation of healthcare policy in a centralised healthcare bureaucracy like the NHS would be impossible in a federal system like Australia. Nevertheless the general practitioner fund holding ‘experiment’ in the NHS, operational from 1990 to 1999 though partially abandoned in 1997, has been observed by many countries concerned with both rising healthcare costs and a dispirited healthcare work force.

6.3 The Empowerment of General Medical Practitioners in Other Nations

No other developed nation has attempted the radical experiment of the United Kingdom in providing primary healthcare with potential control over other levels of healthcare. Two former Soviet republics have replicated the British experience with reported benefit (Borowitz and O'Dougherty, 1997). However there are examples of the preferential diversion of finances to primary care from secondary and tertiary levels. Sweden has elevated the professional status of generally trained doctors and ceased their role as essential gatekeepers to specialist practice. The United States, on the other hand, with a traditionally much diminished status for primary medical care, has tried to engineer such a gatekeeper role within Health Maintenance Organisations.

Australia and New Zealand have utilised funds for more restricted special purposes involving general practitioners. However the coordinated trials for the management of
chronic ill health in Australia have tried to objectively and quantitatively assess both the role of GPs in their management and the benefits of fund holding. Cuba, the last nation discussed, is special in achieving high healthcare status from relatively low cost. This has been attributed to its very involved general practitioner service.

### 6.3.1 Sweden

Sweden has a different healthcare structure to that of Australia. It has a long tradition of local government with 73% of health care provided from local taxation, 16% from central government, and 16% from user charges (Diderichsen, 2005). These local authorities have considerable power to choose the healthcare system under which they operate. For many years care was provided from the out-patient clinics and operating theatres of district general hospitals. However in the 1980s, in common with many other countries, including Australia, problems with the cost of welfare and healthcare led to radical change.

Data from the Organisation for Economic Cooperation and Development (OECD) showed only Japan and Germany as increasing in-patient beds per population between 1985 and 1996 (Organisation for Economic Cooperation and Development, 2004). Most nations decreased bed allocation but Sweden reduced theirs from over 14 per thousand of its population to less than 6 per thousand, a substantial change compared with other OECD nations.
According to Diderichsen (2005) there was a 25% fall in employment by healthcare services. There was thus a concomitantly greater emphasis on primary level care. However only 20% of doctors are general practitioners (40% plus in Australia) and much primary level care is provided by district nurses (Swedish Institute, 2003). There is no compulsory gatekeeper role by general practitioners although co-payments, which are a feature of Swedish healthcare, do provide an incentive to use GPs.

Thors, reporting to the European Union of General Practitioners in 2003 (Thors, 2003), noted both that the referral rate from GPs to specialist was less than 10%, and that GPs required the same time in training as specialists. Thors now considered that general medical primary health care would now be the natural first choice of healthcare consumers because of competence, and not as a result of regulation.

However Swedish healthcare is characterised by a mandatory co-payment by patients for services provided and, having at one time modeled change on a British NHS system, has now become similar to that of Australia. Diderichsen (2005), for example, noted an increasing tendency to private beds (20%) and a tendency for doctors to seek private practice; and he feared the consequent loss of local loyalty inherent in the decreased use of public local hospitals. He considered that this loyalty was such a part of the Swedish healthcare system that its loss would threaten service sustainability.

Lately the ‘Esther Project’ has provided an example of GP coordinated patient access to appropriate technology (Institute for Health Care Improvement, 2006b). Specialists
act at the direction of Swedish primary care physicians who with home nurse practitioners can also take over hospital type care. ‘Esther’ is a representative 88-year-old patient whose journey through the Swedish system illustrated deficiencies in care. The ‘present’ system is predicated on a care plan from ‘Esther’s viewpoint.

6.3.2 United States

A characteristic of United States (US) healthcare is the diminished importance of primary medical care. General (family) practitioners, in a largely private health care system, were not required to act as gatekeepers to specialist care. The lack of primary care has been argued with some evidence by Barbara Starfield and her co-workers to be a significant factor in the sometimes less than satisfactory US healthcare system (Shi et al., 1999, Starfield, 1996).

The United States of America is the main consumer of healthcare amongst the nations of the world. Almost 15% of its gross domestic product is spent on healthcare (Organisation for Economic Cooperation and Development, 2004) and, in such a large and prosperous population, this represents a large proportion of all worldwide financial resources consumed by healthcare. Yet 40 million of its people have no financial provision for ill health, and its population health statistics are only average (Southby, 2004). Encouraged by such poor returns on investment into healthcare services attempts were made to place ceilings on expenditure and to impose cost-efficiency by the use of Health Maintenance Organisations (HMOs).
These private organisations, paid by industry, insurance companies or individuals, employ healthcare professionals, and negotiate with secondary and tertiary level healthcare institutions for the best price and outcome for patients admitted to them. There is a financial incentive to avoid expensive specialist and institutional care and HMOs found it profitable to employ family doctors both as substitutes for cognitive specialists (i.e. those not performing surgical procedures, e.g. cardiologists) and as part of a more integrated healthcare structure. They are then similar to the NHS general practitioner groups funded by government, and there has been speculation that GP fund holding or its successors will evolve into HMOs (Cresswell, 1997, Beilby and Pekarsky, 2002).

However Eliot Freidson, writing for medical administrators at the time of Bill Clinton’s proposals for healthcare re-organisation (Freidson, 1993), feared a simplistic ‘prolaritarianisation’ of medicine with doctors becoming cogs in an administrative machine. His comments of an elimination of complexity to enable cost-savings fits with the views already expressed in chapter three of complex adaptive systems as a basis for understanding healthcare systems in general (Martin and Sturmberg, 2005, Plsek and Greenhalgh, 2001).

Health Maintenance Organisations may have slowed the rise in healthcare costs but these costs now threaten the economic viability of healthcare payers (Stires, 2003). While there is some relationship between the sort of continuity of care provided by
family physicians and patient satisfaction (Saultz and Albedaiwi, 2004) there is becoming less emphasis on these doctors acting as a break on specialist use (Kazel, 2003). The decreasing emphasis on this role by Sweden and other OECD nations has been noted (Organisation for Economic Cooperation and Development, 2001).

Moreover population health statistics do not improve (Sloane, 2004); reflecting not HMOs as such, but the basic inequity of the United States healthcare system. The HMOs have, indeed, been favourably compared to the British NHS (Feacham et al., 2002). In that paper Feacham et al noted more ready access to specialist care, with reduced need for emergency admission, and less waiting times at all stages. He claimed to demonstrate that costs were no different\(^{18}\).

Comments by leading healthcare analysts Alain Enthoven and Donald Berwick, contained as an appendix to the paper by Feacham et al (2002), noted the results of better care with equivalent costs. Alain Enthoven considered competition in the USA to be the significant factor in the apparent better care; Donald Berwick, supporting the theme of this thesis, noted the importance to patient satisfaction of an integrated care pathway before, during and after hospitalisation. He claimed, in addition, that American patients, in a less diffident culture, were more likely than the British to be insistent on better care.

\(^{18}\) These findings and the methodology on which they are based has been questioned Talbot-Smith, A. (2004) *The British Journal of General Practice*, 54, 415-421.
6.3.3 Australia and New Zealand

New Zealand was similarly affected by a competition led economic policy to rein in health costs in the 1990s (Barnett and Barnett, 2003). Independent Practice Associations of GPs, and some secondary care specialists, could purchase drugs and laboratory services from Regional Health Authorities. The contrived purchaser-provider split did not extend to the purchase of health services as in the UK. Again expectations of cost saving were dissipated by transactional cost as occurred in the United Kingdom. Barnett and Barnett (2003) also found difficulty in relating any health policy changes to the health of the population.

New Zealand is also included in this section because of the action of Sandra Coney from the Women’s Health Action Trust, a consumer organisation, in raising claims of service decline that would follow fund holding by NZ general practitioners (Coney, 1997). She feared a loss of patient autonomy with restricted access to expensive medication and specialist treatment, and the use of nurse practitioner phone consultations. She saw any increased status of general practitioners as becoming a distinct disadvantage to New Zealand patients.

Australia with its mix of private and public health care historically enabled an influence of primary care professionals on secondary and tertiary level standards of care. This has been referred to in the introduction to this thesis. However, as certified
and experienced technical prowess became established as a requirement for providing in-hospital care, general practitioners became excluded from these institutions.

Australia also evolved an idiosyncratic and peculiar split between primary and secondary level care in that payment and control of general practitioners became a Federal responsibility while public hospitals remained a State matter. There would be no opportunity for general practitioners to be financed, even in large groups, to purchase secondary and tertiary level care. Funding from pooled sources was eventually used for the coordination of chronic disease management. Funding was made available to organise Divisions of General Practice, reflecting the comments of Joy, the finance manager in the United Kingdom noted above, but they were to be devoted to better primary level care and had little part in secondary or tertiary level care. These blended payment incentives for general practitioners could have little direct impact on high technology healthcare except to avoid institutional care by better primary level management.

The General Coordinated Care Trials (GCCT) initiated by the Commonwealth government in 1999 are in effect a fund holding exercise dedicated to a choice between strengthening the role of GPs to manage chronic and complicated ill health, or to ‘add-in’ a non-medical coordinator to achieve better management. Despite criticism directed towards the design and evaluation of the trials (Stoelwinder, 2001, Esterman and Ben-Tovim, 2002), the use of a trial mechanism in policy research is commendable. It was possible that ‘clients’ felt happier and more secure with the help provided, but without that help being provided by medical professionals.
(Commonwealth Department of Health and Ageing, 1998, Esterman and Ben-Tovim, 2002). Esterman and Ben-Tovim make the point that the trials demonstrated unmet needs rather than any cost containment from avoided hospitalisation.

Mabel Chew, in editions of the Medical Journal of Australia dedicated to general practice and general practitioners, described both depression amongst GPs in 2001 (Chew and Williams, 2001), and the confusion of multiple demands without professional gratification (Chew, 2003). She noted the requirement for coordination in chronic and complicated care, and this formed a key to general practice as described by Beres Wenck in 2005 (Wenck and Lutton, 2005). The Medical Benefit Schedule, which supports fee-for-service funding in Australia, now contains arrangements to support general practitioners in coordinated care plans for chronic conditions.

Hence in Australia fund holding supports primary and complicated care at general practitioner level but has not encouraged the sort of redefined role implied in the United Kingdom.

6.3.4 Cuba

It is questionable that general medical practitioners in the socialist republic of Cuba have been empowered in regard to other members of the medical profession. Indeed they remain most under-privileged and poorly remunerated. If they have been able to influence health care it is because of their embodiment within the structure of Cuban society. The use of the Cuban healthcare system in this chapter is because of the
general assumption that the remarkable cost and medical effectiveness of the Cuban system is dependent on primary healthcare and on the social capital engendered by low patient numbers per general practitioner.

The following charts have been extracted from Speigler and Yassi (Speigel and Yassi, 2004). They illustrate population health statistics of a developed industrialised country from an economic base characteristic of a “Third World” developing nation.  Cuba in 2000 had a mean per capita income of $2,712 as against the United States of $34,637.

Even data from outside the usual parameters of population health are exemplary, like the Quality-of-Life in mental health (Vandiver, 1998), and wellbeing in elderly nursing homes (Gordon, 2001).

**Fig 6.1 Healthcare outcomes per GDP  Cuba and United States**

![Graph showing children under 5 years old (female) Mortality rate vs GDP for countries in the Americas.](image)

**Source:** Data from World Development Report, 2003 (4)

* GDP=Gross Domestic Product per capita in International dollars (WHO, 2001)
Schnitzger and Romero, feminist reviewers of Cuba’s healthcare system were expecting to find a dictatorial regime as responsible for these results (Schnitger and Romero, 2003). They note Cuba’s per capita expenditure on healthcare of $186 compared with $4,500 in the US. Moreover they express surprise in determining the system’s sensitivity to abortion, reproductive health and sex education.

Special characteristics of the Cuban healthcare system are the very high proportion of doctors per population, approx. 6 doctors per 1000 people, and the use of general practitioners housed by the State within poor as well as affluent neighborhoods. These GPs are able to become intimately involved in their patients’ social as well as curative and preventative medical wellbeing. Cuba’s doctor surplus is exported and has
enabled this pattern of care to been extended to other poor nations in Latin America, and even to Venezuela (Ceaser, 2004). Venezuela is significant in having adequate numbers of doctors (2.5 per 1000 people; almost exactly the same as that in Australia), but apparently poorly motivated to pursue primary level care (Wallerstein, 2000).

Speigler and Yassi (2004), who spent some ten years on fieldwork in Havana, considered that Cuba’s health was bound up in the totality of its primary health focus. They note education, housing and employment but also the integration of the healthcare services and the social cohesiveness of Cuban society. They note a significant part played by community organisations in Cuban healthcare both to determine healthcare priorities and to encourage policy compliance.

**Fig 6.2 Healthcare modeling in Cuba**

![Conceptual Model of the Influences on Health in Cuba](image)

(Speigel and Yassi, 2004)
It would be difficult to anticipate a healthcare system similar to that of Cuba in Australia, or any other free market economy, and some have anticipated that its healthcare system will not survive economic or political change (Garfield, 2004).

6.4 Conclusions

The empowerment and promotion of primary level healthcare has produced change in healthcare systems and in healthcare outcomes. These have the potential to improve the sustainability of healthcare systems. However the special purchasing power allocated to British GPs, while improving access to secondary healthcare and furthering communication between primary and secondary care did not influence the quality of care at secondary and tertiary level institutions. Patients while able to be treated more promptly could not be assured that they were treated well.

The promotion of primary level healthcare has not necessarily involved medical doctors, and one might suggest that the use of nursing and allied health professionals be enlarged to cover primary care not requiring medical skills. This would permit the more incisive use of doctors for the healthcare of patients exposed to the sometimes less individually sensitive care of healthcare institutions, noting again the comments above from the paper by Fugelli and Heath (1996).
District nurse practitioners and part-time general practitioners could replicate some of the features of the Cuban system and full time generalist physicians could gainfully be employed within the second tier of the polyclinics developed for Cuba. However, notwithstanding Cuba’s successful primary care dominated healthcare system, there is no evidence that any effect is transmitted to the quality of care in hospitals.

The Swedish ‘Esther Project’ outlined above involves research on a patient journey not dissimilar to that undertaken by ‘Colin’ and his research assistant in Liverpool. The resultant healthcare planning enabled better care while reducing the hospital admission rate and is continually focused on the needs of the mythical ‘Esther’. As the project co-director states the change is as more cultural than technological:

"Concentrate on what patients value, not on what professionals value".

"Involve all suppliers and caregivers in prioritizing those patient values”

Goran Hendricks quoted in (Institute for Health Care Improvement, 2006a)

However the promotion of primary level care does not translate to more empowered patient consumers. If healthcare consumers are to use general practitioners to be assured of proper and sensitive care within high technology institutions healthcare consumers will need to be convinced of the benefit of a profound change in professional behaviour. They will then need to insist on a service of this type from general practitioners providing more personal care. In turn general practitioners will need to be convinced that that this effort will be rewarding in personal, professional and monetary terms.
How general medical practitioners see the divided nature of present Australian healthcare is the subject of the next chapter in which experienced GPs in Perth, Western Australia are asked to discuss this and other aspects of their work.

Government and other third party payers will in their turn have to be convinced that any outlay of finances to support general practitioners in a patient advocacy and leadership role will decrease both hospitalisation and re-admission, the chance of costly error, and, ultimately, improve the satisfaction of healthcare consumers.
Chapter Seven

The Value of Continuity in Healthcare:

Conversations with Western Australian General Practitioners

7.1 Introduction

This thesis concerns the separation of healthcare that occurs when patients are admitted to hospitals or hospital clinics. Patients transfer, when necessary, from community level healthcare under the care and supervision of primary level general medical practitioners, to different levels of specialised medical and technological expertise. There have been concerns that government and community regard for secondary and tertiary level expertise risks progressive marginalisation of primary level general medical practitioners and general medical practice, and that general medical practitioners have, as a result, become professionally diminished (Commonwealth Department of Health, 1992). A recent ‘Position Statement’ from the Australian Medical Association emphasises the effects on total patient care:

“In spite of the benefits for patient care to be derived from GP-hospital integration, the barriers to improved communication and cooperation have continued to grow. Over the past decades, GPs have increasingly been excluded from the provision of hospital based care.”

(Australian Medical Association, 2006)

However in this thesis I question the converse, that high technology healthcare as provided within hospitals has become affected by the absence of the influences of general medical practice and general medical practitioners. I ask if the special doctor-
patient relationship at primary health care level can and should influence the quality of healthcare delivered in secondary and tertiary level healthcare institutions.

In chapter two I noted the evidence that healthcare in hospitals is occasionally flawed, and some impairment related to medical professional dysfunction. In chapter three I further discussed the possibility that those efforts to remedy inadequate healthcare by management initiatives and clinical governance measures alone would be ineffective without sensitivity to patients’ concerns. An insistence that patients and patient representatives should be involved in improving hospital standards has been argued (Vincent and Coulter, 2002). However those recommendations usually involve representational contribution to management based clinical governance. I have suggested that general medical practitioners, acting at the request of their patients, might accept a more intrusive supportive role for both their patients and their hospital based specialist fellow healthcare professionals, and obtain a more immediate effect on healthcare standards. Those standards will be more than the current measurable clinical outcomes but include those dictated by a patient insistence on compassion and understanding.

I have further argued in chapter four that a more involved general medical professional bridging the gap between the general community and high technology healthcare would contribute to both the sustainability of healthcare and the restoration of general social capital. However, for all these lofty aims to be realised general medical professionals would have to be willing and able to accept this task. Moreover the doctor-patient relationship at community level would have to be enduring and durable. The research questions posed in chapter two are directed to determine if this is so in
Perth, Western Australia at this time. It is hence significant that the healthcare consumers involved in the focus group discussions in chapter five when asked to discuss their present and future relationships to general medical practice indicated that the doctor-patient relationship had become more transactional, more technocratic, and less personally involving. Moreover they might prefer it so.

In this chapter some experienced general medical practitioners are asked about their views on a place for a primary medical practitioner-patient relationship in the care of patients requiring hospital and specialist secondary and tertiary level care. Do they consider that there is an inevitable fragmentation of healthcare between primary and secondary/tertiary levels to be compensated by ever better communication systems? Is there an incongruity in an espousal of continuity of care, the long held hallmark of general practice (Freeman et al., 2003), while being willing to relinquish patients, when they are possibly most sick, to the alien environment of hospitals (Hill, 2003)? As a result will Australian general practitioners become suborned to an ‘officist’ role in the bizarre situation described for the Unites States (Manian, 1999); becoming unable to take any part in the care of their most sick patients?

Do some have a vision of general practitioners as whole-of-care managers of the now more complex health care needs of people and populations (Wright et al., 2003, Martin and Sturmsberg, 2005)? Is attention to non-technological aspects of wellbeing now outmoded within the hospital environment (Radley, 2002)? Finally are some Australian general medical practitioners able, willing and, moreover, available to undertake a more intrusive role in high technology healthcare institutions?
Hospital based healthcare professionals were not involved in discussions on an intrusive or intermediary general practitioner role, in that if patients and their primary level practitioner acting together insist on access, then, with the present emphasis on patient sovereignty (O'Connor et al., 2001, Ford, 2001, Planning and Workforce Group, 2003, Hillman, 1999), it will occur; without their agreement it will not. The vital step in any policy change will be within the doctor-patient relationship at community level.

The following are accounts of semi-structured interviews with selected general medical practitioners in Perth, Western Australia. The interpretation of these conversations and subsequent discussion will attempt to answer some of these questions.

7.2 Methodology for Conversations with General Medical Practitioners

The opinions of primary level doctors on the nature of the patient-doctor relationship in Perth, Western Australia, were sought using the qualitative research technique of semi-structured interviews. The underpinnings of the research methodology were noted in chapter two in which the research question and hypothesis was introduced.

Forty general medical practitioners (GPs) were contacted between August and September 2006 through the Yellow Pages of the Telephone Directory in Perth, Western Australia. The Yellow Pages lists general practitioners as such and by location. There was little attempt at randomisation and GPs were targeted by my impression of their length of service, background, location and gender. The
proportions of males and females were approximately those of the general practitioner population. I wished to interview those more experienced general practitioners with a reasonably easy geographical access to hospitals. It was hoped to obtain representation from those known to be politically active, those working for salaries in company owned practices, and those in more traditional general practices of varied sizes. Prospective participants were provided with written information on the nature of the research and with an idea of questions leading to discussion. They were phoned later to determine their wish to participate.

Twenty general practitioners from the forty originally approached finally agreed to participate in these conversations. Because these GPs were informed on the nature of the thesis being explored it is possible that those consenting to be interviewed may represent those more likely to be sympathetic to the general theme of the research. Moreover it can be argued that selecting older and more experienced doctors would deny the opinions of younger professionals reflecting more recent attitudes.

The opinions that have been sought are deliberately those of more experienced doctors, and those with access to the larger hospitals of inner metropolitan Perth (see Figure 6.1). It was anticipated that those occasions of patients expressing present anxiety with hospital care to their general practitioners would be infrequent and require years of professional exposure.

By selecting GPs from diverse professional backgrounds it was hoped to obtain wide and varied opinion but this research was not aimed at a statistically representative sample of Perth general practitioners. I wished to know whether some GPs would be
willing and able to act in an advocacy or intermediary role for their patients. I anticipated that there might be opposition to what could be seen both as a further extended general practitioner workload and also as an encroachment on professional limits. I was interested to find out from those with most professional experience and confidence whether the proposed changes were supported conceptually, and what problems there might be in implementing such a change.

Figure 7.1  Map of Perth
with approximate location of practices of interviewed general medical practitioners shown by a red cross

The interviews were conducted under a standard semi-structured format with participants allowed to take the discussion outside that format. The transcripts were studied, colour coded to determine positive and negative responses, and to detect underlying themes and contradictions.
Signed consent was obtained with an agreement to return the transcripts of the taped interviews to all participants before analysis, and to enable participants to review any material prior to its use. No comments would be ascribed to individual doctors. Participants were asked if they would wish to be listed as participants in any subsequent publication. A majority wished to be so listed. All participants were assured that they could withdraw from the study at any stage. No participant decided to do so.

Information on the nature of the research and of the proposed discussions with these general practitioners sent to them prior to interview is contained in an appendix to this thesis.

Confidentiality was assured and the study conducted under the auspices of the Human Research Ethics Committee of Murdoch University. It was agreed that tapes and transcripts would be secured for five years.
7.3 Results of Semi-Structured Interviews with Experienced General Medical Practitioners in Perth, Western Australia

Out of the twenty general medical practitioners who agreed to take part in this research (from the forty initially contacted) eleven were males, nine females, thirteen from inner suburban practices and seven from outer suburban practices. Eighteen had more than twenty years of experience in general medical practice; the other two had approximately fifteen years of experience.

I did not question participants on the nature of their income, or their involvement in matters of medical politics, so the ‘diversity’ of their practice circumstances is my impression of those backgrounds. Similarly, practice size is neither measured nor defined. Notwithstanding these subjective impressions the participants included one academic general practitioner and four GPs of varying political involvement. Four of the participants were salaried employees of primary care medical companies, with eleven of the remainder working in large group practices with on-site pathology collection agencies, and nearby, or on-site, pharmacy facilities. Four practitioners worked in smaller practice premises of a more traditional stand-alone configuration. The large majority of the participant GPs therefore worked in the combined primary healthcare facilities of the sort preferred by the healthcare consumers interviewed in chapter four.
Most of the interviews were conducted in the general practitioners’ consulting rooms but some participants preferred to meet in their own homes, others came to the interviewer’s residence and one arranged to meet at a university site.

The rest of the results are presented within arbitrarily selected themes of

a) a fragmented healthcare system,

b) the importance of continuity of care, including care in end-of-life situations,

c) the future of general medical practice and the general practice workforce and

c) ‘trust’ in doctors.

These sections contain extracts from the transcripts of interviews with the participants’ contributions italicised in bold typescript, and the interviewer’s, where included, in normal italicised typescript. Explanatory comments are in normal bracketed typescript. ‘A’, ‘B’, and ‘C’ at the beginning of extracts indicate different interviewees.
7.3.1 The ‘Importance’ of a Divided Healthcare System

The interview conversations were initiated by discussion on the importance of any ‘divide’ between primary and secondary/tertiary level healthcare. This elicited a very varied response in that it was unclear as to whom, or to what, ‘importance’ related. To general practitioners only a small number of their total patient contacts result in hospitalisation, but to patients entering the hospital system any ‘divide’, e.g. by the presence or absence of important information between community and hospital care, may be critical. Even with appreciation of this situation any ‘importance’ varied between ‘minimal’ and ‘great’ depending on the hospitals involved, the nature of any disease, and, over time, as staff changed within the hospital environment.

“It varies enormously, from hospital to hospital, even from unit to unit. “Even from time to time?” “Exactly”. “You can notice when they change jobs from registrar to registrar in the middle of the year”.

All participants agreed that communication between the sectors of care was a significant problem, but half of the doctors interviewed noted that fragmented care was an integral part of a sectional healthcare system. Many doctors illustrated their experience of communication problems with case examples. All noted that communication problems, although still significant, were considerably better than a few years ago. There had obviously been a recent determination to remedy any shortcomings.
A) “So I think it’s very important that there is at least a very good communication and I have to say this I think there has been a great improvement in the communication between the GP and the tertiary hospitals in recent years.”

B) “And it is a lot better than it was. It was great (importance of ‘divide’) two years ago and extraordinarily great five years ago. I want to say that it is improving but there is a long way to go.”

There were accounts of fragmented care resulting in repeated investigations, and some inference that whatever had been previously performed was discounted at hospital level because of a general disparagement of care carried out at primary level.

“I don’t think they often think there is wealth of information that could be made available to those doctors from the GP but we’re never asked. I think it’s almost a given that they think we don’t know very much and can’t contribute.”

Half of all participants noted episodes of changes in medication by hospital medical staff that were both arbitrary and also poorly explained to GPs and to patients when discharged from hospital.

It would seem that much of the fragmentation of healthcare was bound up in the serious problems of a failure to communicate from one sector of healthcare to another. There had been changes made to address these problems with varying degrees of success. However I wished to know if fragmented healthcare needed a human element to fully overcome defects, and if there were limits to communication technology. One
participant was not impressed by discharge communication technology, describing it as largely ‘gobble-de-gook’ and wished for a reversion to personal communication:

“The biggest constraint - variously - for an hour - ideally on a day-of-discharge if they could give a quick phone call and, like our practice, we have a nurse - answer the phone - could take down the relevant stuff and type it, it could be in lots of ways better, or you could quickly speak if you needed to. The constraints in the communication were income driven - and the residents? I don’t know how busy they are now.”

7.3.2 The Limits of Communication

The general practitioners were then asked to discuss the degree to which any ‘divide’ in care could be overcome by electronic or telecommunication technology, e.g. computers, phones, mobiles, and facsimile machines. Some insisted that they experienced minimal problems communicating to and from hospital staff, while others were very disparaging. It was evident that much depended on switchboard staff and the expectations of those involved. The possible future use of patient held computer chip ‘smart’ card technology, either containing individual medical records or with access to centralised data banks, was anticipated to solve many problems. However participants recognised the needs for record updating, and some knew of considerable difficulties before this type of technology could be implemented.

“I imagine a central registry of data to which you lock in would be a somewhat hypothetical future which will take some years to arrive”.

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However my main interest was the degree to which a general practitioner’s more complete knowledge of a patient could be transferred to ‘smart’ cards.

“Well, the relationship; you can have all the information, but you might not have the confidence, and all those sort of things that go with it.”

Most practitioners questioned on this point noted the inability to transfer social, psychological, human or ‘holistic’ details to a medical summary. Two or three mentioned confidential social, psychological or medical problems that they feared might distort future medical assessment and management. One doctor used a coding system to avoid the placing of some details even within her own medical files.

“I think that relates to medical records in general that occasionally you will hear things from people that you would rather not include in their notes: for their own personal good”.

It is interesting that this replicates fears expressed by some healthcare consumers from the focus groups in chapter five concerning ongoing medical records, usually in regard to psychological problems, that they feared would diminish the attention given to present symptoms of disease. Participants expressed the inadequacy of biomedical details to provide biographical factors that might be important in healthcare. Given that GPs might know more about their patients, and that there are personal details not appearing within medical records, I wished to know whether or not they would be willing to intervene in hospital care should that be necessary.
7.3.3 General Practitioners and Concerned Hospital Patients

A spectrum of responses was obtained by the direct questioning of these medical practitioners on the degree to which they would respond to a patient’s or a family’s concern(s) with their hospital treatment. Some said that this had occurred on a few occasions over their professional life and others, despite many years of experience, denied that this had ever occurred. A third of the doctors involved, contemplating the patient’s concern within the context of what might be considered proper professional behavior, said they would contact the hospital and the hospital medical staff to acquaint them with the patient’s fears. One respondent placed the context of possibly critical professional conduct within a legal frame. Others insisted that they never discussed patients’ problems by phone and, as a matter of principal, would insist on face-to-face meetings. Some doctors in this situation would insist that the patients request the hospital doctors to phone the general practitioner, but they did not mention that this had happened. It seemed to be a ploy to divert the patient’s expectation of action from the general practitioner. However some doctors had contacted hospital medical staff at times in their professional life on behalf of patients to insist on a review of the patient’s care.

“I have certainly had patients ringing me and asking me: they’re not happy with what is going on in hospital, and I’ve rung up and taken some measures to intervene. I think that’s really important; because we know them better than the hospital doctors. And sometimes they want a second opinion.”
One doctor with a very busy practice understood a supportive role for general practitioners in this context.

“I think there is, to some degree, a patient’s view, and often because they are fit as well, that once they are in the hospital that the GP plays no role. Whereas patients have often said it would have been lovely if I could have called you to say, you know, to tell you of my fears about what is happening, or just to update you about what's happening to me, etc. Often there is so much trust that lies between a patient and their clinicians particularly the family doctor; and so sometimes it’s lovely to have it validated, that that is the right course of treatment: the hospital is doing the right thing. And half the time it’s not putting us into a God-like position, and I certainly don’t believe that, but sometimes when the family doctor turns around and says ‘You know they really are on the money here, etc’. Instantly their fears are allayed and they are much more comfortable then with what’s going on”.

One doctor admitted to visiting a patient at the time of the patient’s concern with their hospital care. Some GPs, especially those with hospital appointments, would ‘call in’ to see patients; making sure that the patient understood that they had no official position in visiting them. They noted the pleasure of patients in the caring role displayed, and one general practitioner, who frequently phoned to inquire as to a patient’s welfare, always asked the ward staff to mention to the patient that she had called.

All participants considered that visiting patients in hospital would be inconvenient, difficult, or even impossible as a use of limited and expensive time. There would be problems with parking vehicles, locating patients and obtaining access to clinical material. None emphasised medical professional inhibitions on visiting patients but,
as noted above, such restraint was expressed in regards to discussions on a patient’s concerns with their hospital treatment.

If, as it seems from these discussions, general practitioners seldom (if ever) took any part in hospital care when their patients were under the care of specialists, I wished to know how this matched with the rhetoric of continuity of care. First, what was their general attitude to continuity of care, and secondly, what was their impression of its importance to their patients? Was the absence of continuity of care in hospital care a concern, and were any participants aware of any contradiction in an espousal of continuity of care by general medical practitioners?

7.3.4 General Medical Practice and Continuity of Care

All participants emphasised the importance to general medical practice of continuity of care. Many of these doctors stressed that longer-term relationships were what made primary level general medical practice the career attraction to them that it was. In view of my findings from research into the attitudes of healthcare consumers contained in chapter five I was interested in what general practitioners might think their patients’ perspective on continuity of care might be. I emphasised the psychosocial aspect of the relationship in defining continuity:

**Continuity of care: defined by a relationship over time in which a GP has knowledge of more than a patient’s medical history, e. g. social and psychological wellbeing.**
Without exception they all thought that their older patients and those with chronic medical conditions valued continuity of care.

I asked participants if they believed patients were aware of ‘continuity of care’ in the terms stated.

“Very much so! Perhaps some of our younger generation is not as aware of it. They are very often well, and so they see each little event as just an event, or they come in for a minor medical and they just have nothing continuous? But if you have young people with chronic illness they see seeing the same GP as very relevant. Even mothers with little children seeing at least one or two GPs, not just anybody, gives them that feeling of continuity.”

Many expected younger people to be less interested in continuity of care, and some noted that those of less education and of less socioeconomic status were more likely to seek medical help from a conveniently located practice rather than from a doctor with whom they had a long history. However the diminished relationship was not one-sided and continuity was becoming less valued as the nature of general practice changed.

Again asked their opinion on the value patients place on continuity of care:

“I think so. I think patients do. Not all patients but many do. That’s why they prefer to have their own doctor. That is a little bit of the problem about where we’re heading; that the traditional family doctor - probably that is their main forte. I think the more modern larger practices tend to have less in the way of continuity. The records might be all there but the actual doctor-patient relationship isn’t quite as strong.”
Some participants accepted and welcomed the changed nature of general practice. They considered that continuity of care between a patient and one doctor could be replaced by continuity of care between a patient and a group of doctors sharing properly recorded information. However this question, i.e. the future of general practice, demonstrated a very diverse approach to general medical practice. This ranged from one practitioner who considered that the previous one-to-one relationship could be demanding and dangerous to the long-term mental and physical health of doctors, to those roundly condemning corporatised medical practices paying doctors as salaried employees with no incentive to establish long term relationships. One critical practitioner claimed that, in these practices, doctors who were starting to form ongoing relationships with patients would be ‘moved on’ to other practices as closer relationships with longer consulting times might threaten practice profitability.

Participants were asked if patients valued continuity by being prepared to pay for continuity of care: in effect if patients would insist on the absence of a co-payment in order to continue with a particular general practitioner. The responses were very difficult to assess as practices varied on their policies in this regard. All participants noted that some patients were prepared to travel long distances and to wait to see them if a close relationship had developed. Some doctors made the point that patients would value continuity of care if they had experienced the benefit that a relationship over time would confer.

A) “Certainly there’s a big proportion of people who don’t have GPs at all. And I think they’re the ones that don’t understand the continuity of care issue. And if they did they would have a GP.”
B) “If they haven’t any experience of it – no: but if they’ve had a taste of it they will know they’re not getting it.”

C) “I think those who have experienced what it meant and how it would benefit. You have to show patients what are the benefits of it to show value.”

This last response was from a general practitioner that considered that only twenty per-cent of patients valued continuity-of-care in the terms described. This doctor, medically educated in the United Kingdom, thought that Australian GPs did not understand ‘continuity’ in the same way as their UK counterparts.

However I still found it difficult to unravel the medical history of a patient from the personal ‘knowingness’ that the traditional general family medical practitioner acquired over time. The majority of these general medical practitioner participants still phrased ‘continuity’ in terms of medical history; just as the healthcare consumer respondents in my focus groups described in chapter four.

7.3.5 The Continuity of Care in Public Hospitals

I stated to all participants that patients admitted to public hospitals had minimal opportunity to acquire continuity of care and asked if its absence mattered. All but four participants separated the need of patients for continuity of care into whether or not the patients were suffering from an acute or chronic medical condition, i.e. that those suffering chronic conditions were those who would suffer from a loss of continuity of care in hospitals.
All considered that the absence of continuity was an unfortunate but expected reality of hospital admission. The four participants not stressing the divide between acute and chronic care noted the general practitioners’ role in providing the continuity element lost in hospitalisation.

“Hospitals are not really about continuity of care, or historically they haven’t been, although it could be argued that it should be. The hospital (staff) needs to see themselves as a care provider to a specific passage of person’s life and medical history, which required that level of specialised intervention. But they should realise, I believe, that they must integrate and work with the providers who have been looking after that patient up to that point. And who the patient will be going home to when they leave. I think the hospital focus should be outside this particular episode of management. And contextualise the patient’s stay in hospital as just a particular part of that continuity of long-term care. A lot of the things that they see in fact are acute complications of chronic diseases. Whether they were elective or non-elective admissions.”

I asked if the absence of continuity-of-care in hospitals matters:

“It does matter. But if they have that anchor person on the outside like the GP who stays across all of what is happening in the patient’s healthcare then the patient can come back and we can provide the underpinning of the continuity.”

Those participants emphasising the importance of chronic diseases as requiring continuity in hospital care noted that they would try to mitigate the absence of continuity by referring patients to the same specialist or specialist teams. They admitted, however that, with changing hospital staff, this was unlikely to be effective in enabling contact between doctors and patients who were known to each other.
A few general practitioners stated that this aspect of public hospital care was that which emphasised to patients the benefit of private hospital insurance in providing ‘continuity’ through specialists ostensibly chosen by the patient.

### 7.3.6 The ‘Contradiction of Continuity’

Only two participant general practitioners commented on the apparent contradiction of their espousal of continuity while being unable to take part in the care of patients when the patients were sick enough to require hospital care\(^{19}\).

One general practitioner when asked about the ‘availability and readiness of general practitioners to attend patients in hospital concerned with their hospital care’ responded in a reflective way:

> “That is a difficult question. It goes to the issue of continuity of care. It goes to the issue of differences in approaches and standards.”

The other practitioner initially considered the topic as practitioners employed by the hospital to be responsible for their own patients within hospitals.

> “I think there are many doctors who would really like that situation as part of the continuity of care.”

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\(^{19}\) I did not phrase this question as such but hoped that the conversation would lead to such reflection.
When the question was put that the matter was to do with concern that hospital treatment may be causing harm because of a lack of particular knowledge or insight possessed by the GP, the response reflected intra-professional concerns.

“I think it could lead to problems actually. You don’t play against the other person and it really would be much better to be in the team player arrangement where specialists talk to GPs while their patients are in hospital.”

From these interviews with GPs it would appear that there are anomalies in regard to how continuity of care is conceived; not only that between its importance for patients and doctors but also in regard to how doctors perceive its importance to be for patients. This important finding will be discussed later, and its consequences on any policy changes based on this thesis will form part of the subject matter for the next chapter.

That some practitioners were prepared to challenge professional barriers on behalf of their patients maintains the theme of this thesis. As expected this happened rarely and supports the decision to interview experienced general practitioners. With the finding of high levels of error in hospital care (Wilson et al., 1995) general practitioners must be aware that mistakes happen in the care of their patients. Why GPs appear to take such little notice of the risks of hospital error, and why the consumers of healthcare do not expect them to take action, will be discussed in the next chapter.
If continuity of care were of significant benefit to patients and the community then the third party payers such as government and health insurance would find a means to encourage continuity, as in the use of bonus payments to doctors in Californian HMOs found to increase patient satisfaction (Jackson, 2001). In Australia incentives are explicit in the MBS rebates for GPs to coordinated the care of those with chronic and terminal illness (Commonwealth Government of Australia, 2003), and as used to promote the use of practice nurses and information technology by general practitioners (Harris and Mercer, 2001). Indeed the Organisation for Economic Cooperation and Development recommended economic incentives to promote continuity of care by general practitioners (Organisation for Economic Cooperation and Development, 2001). I asked these interviewed general practitioners if some system of financial incentives promoting registration of patients with general practitioners would be of benefit. This is discussed in the section to follow.

7.3.7 The Registration of Patients with General Practitioners

The majority of interviewed GPs did not support the concept of registration of patients. They stated that a freedom to choose their doctor by patients was of paramount importance. I stressed that under this scenario the choice would stay, the incentive would only apply to continuing with that same GP. Again a majority considered that this largely occurred in Perth now and extra incentive would achieve little.
“It might be more to administer preventive things. You are responsible for a block of patients who are registered with you. Can you then get at them because you have a list of YOUR patients? Would that be of benefit or not?”

“I think it would be of benefit but I guess to get to the political, if they had the right to choose their GP, rather than being forced into a practice that they don’t want to go to - I think that’s the difference in England - they are done geographically.” “Assuming choice.” “Assuming choice, I think it would be good idea because we know already with doctor shopping or patients with personality disorders, that see a doctor on a regular basis, they are less likely to go elsewhere, and get into all sorts of other medications, tests etc. There is, in particular, those difficult patients, but in general it would be good thing but I think a lot of our patients recognise that for important issues they have their own GP that they are comfortable with; and if its not so important they will go round the corner.”

A situation with a strong connection to continuity of care, and to compassion and psycho-social awareness is that of the process of dying. General practitioners with long term relationships with their older and most sick patients would have to become included in the provision of care at this most sensitive time. Nevertheless I was aware that some general practitioners had become involved in the special provision of palliative care for the terminally ill, that they had become de facto specialists. I wished to know how the participant general practitioners dealt with demands for continuity of care and family management in this area, and if there were any parallels with institutional care, i.e. a surrender of care at a demanding time in a patient’s life.
7.3.8 Care for the End of Life

I asked if general practitioners felt they were equipped to deal with end-of-life issues. Again the responses were very varied.

One doctor considered that the process was a matter of management, while another using the same resources, demonstrated a degree of involvement more expected of involved caring general practice.

\[ A\) “I think we are really well equipped for the planning aspect and then I find the palliative care services really good. Yes, I do. I find that’s a well-organised service and the doctor there that I liaise with. The patient can still come and visit me. But I don’t do the house calls. I have one today “Can you come to see me?” I’ve liaised with the palliative care doctor and they’re going to look after her at home. But the planning as the patients don’t have much idea, and, depending where they’ve gone to, sometimes the oncologist, they haven’t done much directing either. I find the GP is very well placed for that”.

B) “It depends on the GP. I mean personally, I think I know someone is slipping towards that stage of life and I’m reasonably good at it. I bring in the troops, harness the resources, but again it requires continuity of care, being able to speak to the daughter, being able to speak to the son, who you may have known for many many years. I have a patient recently. She had chronic renal failure, her creatinine was 500\(^{20}\), and I said to her “You have two choices – dialysis, or allow nature to take its course”. In came the daughter, we all had a chat, we made a decision – no dialysis for Mum.”\]

\[^{20}\] The GP is referring to the serum creatinine level indicating severe renal failure, normal value is less than 150.
Other doctors were far less confident.

“I think poorly. That’s the appropriate word. I think very poorly. Nothing prepares you for that. It depends on your personality. I think general practitioners are trained very poorly. It’s something I don’t enjoy. I feel I do it because I have to do it. It is one area in my overall skills that I feel inadequate for.”

One doctor was able to reflect on the emotional involvement of a caring general practitioner.

“Or we have more emotional involvement I think, we’ve got continuity of care, known them for long time, and maybe it’s a bit like bringing up these issues when we don’t really want to lose our patients. It’s not that easy a topic to bring up. Whereas, if somebody’s got a cancer and dying and in palliative care, it’s obvious that they are going. It’s probably not as hard for those doctors (palliative care doctors) to discuss it. But if you were my patient sitting here now it’s not easy to discuss that. Maybe we shouldn’t have continuity of care!”

The majority of participants felt that they had evolved to be able to deal with terminal care issues over their years of experience. Half had been involved in hospice and palliative care programs. With the development of these special programs general practitioners had evolved a coordinating role which was noted by many participants. One general practitioner commented on the relinquishment of family involvement as part of change.

“Years gone by families used to do it, families would do the nursing, now families just won’t do that. And it requires hospice and Silver Chain\(^\text{21}\) to come in and provide all those sorts of things. Sometimes that’s provided by GPs but a lot of GPs value the addition of palliative care specialist, many of whom are GPs anyway”.

\(^\text{21}\) Silver Chain‘ is an independent home nursing organisation
General practitioners have different personalities, different life experiences, and, with different degrees of emotional involvement with their patients, it is not surprising that this is reflected in different attitudes and ease in dealing with death and dying. I was more interested in the degree to which they were willing to maintain a controlling influence in the management of care, and their use of special guidance from palliative care advisers who would not have the professional distance of hospital based specialists. The majority of interviewed general practitioners are quite able to accept an overall coordinating role in end-of-life matters. This team leader role could well transfer to other clinical situations.

A reconfigured professional relationship will however also depend on the general future of primary level healthcare, and the next section deals with the participant GPs’ views on this future. I questioned participants on the workforce availability for general practice and how introducing non-medical clinicians might modify this in future. Without the ability to release general practitioners to act in new ways a future as part of institutional care cannot be realised.

7.3.9 The Future of General Medical Practice

One general practitioner noted that there was a greater variety of interests and competencies within general practitioners than occurred in specialist practice and this inherent diversity would be reflected by the wide variety of responses to be expected in their hopes and aspirations of the future.
Many participants claimed to be content with their present situation and would not anticipate change. All but one of those interviewed would be reluctant to lose the wide medical interests of general practice, and that primary care sub-specialty interests were for ‘others’. Some were able to forecast change including group practices of multiple primary care sub-specialty interests and a senior practitioner grade that would include attributes of general physicians that all agreed were now becoming subverted to their own sub-specialty interests. The change to a senior physician general practitioner might be by insistence on work of higher professional standards, or by years of experience.

A) “Just to come back to the GP thing. I mean a GP is now a ten year trained doctor, well that ten year trained doctor ought to be functioning at a much higher level than most of them are functioning.”

“As you say replacing the general physician.”

“Well there are no general physicians.”

B) “Basically I think with age there should almost be a graduation from when you first graduate that you’re a base-line medical practitioner, and then, over age and with experience you become a senior consultant. I think we should have a senior GP where you become a senior physician. That’s the senior physicians of old.”

While many were keen to see a greater percentage of their workload taken over by practice nurses and three could envisage a future of general practitioners as leaders of health professional teams at primary care level containing nursing and allied health professionals. One could anticipate that these teams would include specialist medical advisors.

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The two speakers are noting the progressive sub-specialisation of previously more generalist specialist physicians.

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“Leaders. That’s in short what I have said already. Very much the team-care leaders. And team players as well, and well rewarded for what they do well, but I do also think that there is going to be increasing sub-specialisation within general practice. Why shouldn’t they choose what they like and what they are best at? But within group practices you should have a variety of the expertise available.”

This team care leader concept is very similar to that already made in regard to end-of-life issues.

Notwithstanding the idea of access to healthcare institutions it is evident that some practitioners aspire to more demanding professional roles and the majority assumes that change in their professional roles will occur. However the present workload of general medical practice coupled with an increasing insistence on a balanced lifestyle, i.e. between work and leisure, means insufficient numbers of general practitioners to serve present needs (Skinner, 2006, Australian Government Productivity Commission, 2005a).

7.3.9 The General Practice Workforce

One female practitioner commented:

“We have a workforce shortage that has been talked about for billy-o and it’s partly because we didn’t have enough graduates in the past and partly because fifty percent of our workforce is female; and they don’t want to work full time. We have a real-time shortage because of the gender of the workforce. That’s not going to get any better for a long time to come; so we’ve got pressure.”
There was wide acceptance that some of a present general practitioner’s workload was a waste of expensive training and could be delegated to non-medical clinicians. However there was little agreement on how much and how far delegation could go. Some were only willing to permit practice nurses to undertake simple monitoring roles.

“I don’t think there’s a lot that I would be happy taken over by non-medical staff. Other than very basic, somebody having his or her weight, blood pressure checked. I wouldn’t want to be into prescriptions - there’s some talk of nurses doing Pap smears and all that that means. I wouldn’t like that.”

A general practitioner working in a large general practice did not support delegated primary healthcare but was the only practitioner to note that nurses may not wish to accept greater workloads. She was also very disparaging on non-medical staff undertaking cervical cytology smears.

“Well we have work here that is managed by supervised practice nurses, basically vaccinations, at the moment here we have the right balance. There are certain other minor things that they could do but they don’t want to. I certainly don’t see them taking over, say for instance, family preventative health care.” “Or front line curative stuff?” “No, sometimes in emergency there is a triage - for management.”

At the other extreme, however, there were general practitioners that would welcome nurse practitioners acting in a semi-independent primary care capacity. There was within this group of general practitioners experience of working with nurse practitioners in various situations, from rural practices and the military in Australia to
experience overseas. None of these had any poor experiences to report but one had some misgivings.

“Now in the UK and in the USA nurse practitioners are acting as screens before you see patients.”

“Yes they do. I am familiar with that. I’ve actually experienced it already”.
“What do you think of it?”
“I don’t think I’m qualified to answer that because I wouldn’t like it for myself”.
“But you’re uncomfortable with the concept?” “Yes, that’s right. And in today’s sort of atmosphere.”

Another practitioner was less subjective in evaluating his experience in Canada:

“that was called the nurse practitioner’s practice that became a quite famous practice and it consisted of five doctors and seven nurse practitioners and the quality of their care of the things that they did and the outcomes were just the same”.

A general practitioner with experience of remote rural Australia was complimentary.

“And it does happen, let’s face it, there are lots of country towns, remote communities where there is no doctor, there’s a sister there, and I’ve done work with the Flying Doctor in North Queensland in the past and I’ve worked with them - absolutely fantastic. So there is no reason why they can’t find a niche”.

There was great variation in the tasks of general practice that these general practitioners might wish to relinquish. The nursing duties of recording weight, blood pressure and urinanalysis would be supplemented by tasks stemming from mental

23 I took it to mean an exposure to litigation.
health problems, drug addiction, administration and bureaucracy, and the health education of the practice patient population.

One thing was very evident. There was no support for the idea that other members of the general practice ‘team’ could substitute for doctors in dealing with any concerns patients might have with hospital care.

I discussed the possible general practitioner-patient ratio and whether or not these general practitioners would welcome increased or decreased recruitment to their ranks. There was again wide diversity of opinion. Many were ‘content’ with their present practice situation and the number of patients they were expected to manage within the working day. Others noted that the numbers of patients seen by them had decreased but the intensity of care expected had increased, both as regards the patients’ expectations of care and the complexity of chronic and preventive health measures.

I asked what the ratio of GPs should be to the population of potential patients in their area. I stated that I estimated that in the suburban areas in which these GPs worked the ratio would be one general practitioner to from 500 to 1000 potential patients. I asked if they would like more or fewer GPs to service their area.

“I don’t know what the correct number is. Years and years ago and when things were less complex it was something like 1 in 1500 or 1 in 1200 or something like that, but now that things are more complicated with diabetes, cardiovascular management, these days you really see anything more than 600 or 500 as too much of a work-load.”
In all conversations I mentioned the very low ratio of general practitioners to patients in Cuba (1 GP to 120 families (Speigel and Yassi, 2004)) but all considered that that situation would be quite impractical in Australia. This was largely linked to the remuneration likely from small numbers of patients but also with the reduction in interest and experience from very small workloads.

Given that general practitioners could be made available for a role within healthcare institutions it still requires that patients would need or trust a newfound relationship. Any change in the trust of patients in their doctor affects the doctor-patient relationship and all that it depends upon, including aspects that are important to this thesis. If a loss of trust in institutional medical care is to be replaced by trust in the long-term relationship of primary level care then I wished to know the beliefs of the experienced general practitioners interviewed in the question of trust levels between patients and doctors.

### 7.3.11 Trust in Doctors

Most of the general practitioners questioned considered that trust in doctors generally had decreased. A third of them thought that this did not apply to the patients’ own doctors but to medicine in general; and one doctor believed that diminished trust was general throughout society.
A) “I still think the average person likes their doctor. They may have a poor general overview.”

B) “I don’t think it’s declined, but people are more willing to criticise people, and they are more savvy in terms of consumerism and what they want out of the relationship.”

One participant denied any reduction in trust but phrased in such a way that it seemed to be an insistence that trust must not be threatened. She did not enlarge on her denial.

“Has this declined? Well I don’t think it has. We should never do anything to jeopardise that trust.”

Another considered ‘trust’ as paralleled with ‘status’ and was under no doubt that that had fallen. It is possible that this was the reason he was the only general practitioner that made the point that the public regard for general practice was decreased in respect to specialist practice.

“There is absolutely no doubt that the status of the medical profession has diminished appreciably”.

“So in terms of the standing of the medical profession as a whole I think it is diminished, diminished appreciably, I think general practice is diminished more appreciably than specialties.”

It is possible the association of ‘trust;’ with ‘status’ is an assumption that one led to the other; that the public’s trust of doctors was inevitably linked to status. However patients and the public might trust general practitioners but still recognise diminished

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24 I took this to mean the general trust level in the community
status arising from other aspects of their professional position, including progressive exclusion from technical skills, exclusion from high technology institutions (National Health Strategy (Australia), 1992) and decreased relative earnings (Relative Value Study Group, 2001)\textsuperscript{25}.

These conversations covered the fragmentation of medical care and the inability of general medical practitioners to influence the care of their sometimes long-term patients within hospitals. They have exposed some anomalies in an espousal of continuity of care. The interviews revealed some general practitioners as wishing for recognition of a more exacting professional role while others resist the surrender of primary care roles to non-medical professionals.

It is now necessary to discuss how these results accord with generally held opinions in Australia and elsewhere. Are there anomalies in these results that need to be explained? Do these results support a future of general medical practitioners as more assertive in the care of their patients within healthcare institutions or as supporting concepts of healthcare sustainability? From these results what problems can be anticipated in encouraging a more assertive general medical practice?

\textsuperscript{25} The Relative Value Study (RVS) by government and medical organisations eventually agreed to value GP consultations at approximately twice the then rate. The RVS has never been implemented.
7.4 Discussion

7.4.1 General Practitioners, Patients and Hospitals

There may be much that is unsatisfactory and unsatisfying in community level general medical practice but these conversations and current discussion are concentrated into those aspects of general medical practice which impinge on hospital based care; and through that aspire to influence the healthcare system generally.

In the Australian healthcare system a patient’s general medical practitioner, who in the United States might be termed a ‘family physician’ ‘primary care physician’ or simply ‘physician’, is often unable to take part in the hospital care of his or her patient. The exceptions are in rural or district hospitals and occasionally outer metropolitan hospitals when the doctor concerned has obtained admitting rights to that hospital. In that situation, more prevalent forty years ago, general practitioners admit patients to the hospital under their own care. They can treat patients as and how they think fit within the boundaries of their own clinical skills and experience. The hospital retains the right to enforce those boundaries, to set limits on the doctor’s treatment modalities. However with political and technological change, Australian doctors cannot now admit patients to public hospitals under their own care. Patients under State care without their own hospital insurance cannot access doctors of their choice; i.e. the doctor treating the patient is employed by the hospital. Patients with hospital insurance can be admitted to public hospitals under the care of doctors of choice providing the doctor is on the clinical staff of the hospital. As pointed out in the
results above a patient’s general practitioner with many years of experience and with special knowledge of the patient concerned must usually attend as a routine visitor without special recognition by the hospital.

If the hospital is a private hospital and the doctor has admitting rights he/she can attend and charge a fee for that visit. Less than 45% of Australians pay premiums for hospital insurance. In the case of a public hospital any visit by a general practitioner cannot attract a fee as listed by the Federal Government Health Insurance Commission Medical Benefits Schedule (MBS) unless for the purpose of conferring on discharge planning.

Even in this latter capacity Australian doctors were unwilling to claim payment even though more than 80% considered the matter of discharge planning of importance; and that GPs were insufficiently involved (Preen et al., 2006). One conclusion of that article was that: "it (an unwillingness to claim for payment) may indicate an undervaluation by some GPs of their role in hospital driven processes." (Preen et al., 2006 p. 90)

It is important to re-emphasise that the discussions with general practitioners in this chapter cannot be seen as representing the views of general medical practice as a whole. However opinions held by all, or nearly all participants are probably expressive or indicative of the majority of Australian general practitioners. Hence the views that:
a) problems between primary and secondary level healthcare are those of communication between one and the other,

b) continuity of care is the abiding virtue of primary level healthcare, and that
c) continuity of care is understood and appreciated by most patients,

are opinions held by the majority of general practitioners.

It is also valid that if there are differences of opinion stated by these practitioners on subjects then there will be differences of opinion held within Australian general practice as a whole. It will however be invalid to express these differences in numerical terms. Moreover, important issues raised by any participant, even if not supported by all, can provide an avenue for debate.

This discussion will first address the apparent anomaly regarding the differing opinions expressed of the doctor-patient relationship and continuity-of-care by the consumers and providers of healthcare. Without a close doctor-patient relationship based on some continuity of care at a primary healthcare level much of the arguments of this thesis, and I would hold, the hopes of a better healthcare system, will founder. It is evident that continuity of care as a concept is unclear, and for it to contribute to a working doctor-patient relationship some further clarity will be necessary. In particular do patients appreciate or need their general medical practitioner having a special knowledge of their personality, or social circumstances, and would GPs be hampered in a contribution to the hospital care without that special knowledge of their patients?
I will also argue the place for a more personal contribution in bridging the gap between community and institutional healthcare, and claim that technological advances will need to be ‘personalised’ by widespread telecommunication to address the defect. If primary level general medical practitioners are to become more involved in resolving the fragmentation of healthcare then issues of the expectations of patients and GPs for one another become raised. This will lead to discussions on the healthcare workforce necessary to pursue the mutual objectives of community level healthcare.

7.4.2 The Lack of Clarity and Consistency in Continuity of Care

Continuity of care, i.e. that healthcare is better in many regards if patients attend one doctor over a period of time for their healthcare needs, is widely endorsed (Organisation for Economic Cooperation and Development, 2001). There was no question that continuity of care is an integral part of the type of healthcare that doctors participating in these conversations wished to promote for primary healthcare. They did however recognise some reservations to its appeal for a number of their patients.

They insisted that older patients valued continuity but that younger patients would not establish a relationship because of the likely limited nature of any medical requirement. Older patients, those with recurrent problems and, as noted above, some young mothers with children, would return, sometimes from quite long distances. However these doctors were conscious that some patients would only choose doctors willing to accept basic payment, i.e. continuity of care was framed by a willingness or ability to pay. Moreover there was very limited support by these GPs for a system of
incentives to promote registration of patients with one practice. The British NHS registration by place of residence was universally rejected as limiting patient choice, and it was difficult to engineer discussion on alternative systems.

It was continually stressed in these conversations that continuity of care was to include more than knowledge of a patient’s healthcare record. All participants recognised a psychosocial component of their relationship with their patients. However the emphasis placed on the needs of chronically diseased patients with their longer and more complex medical histories denied the need of the acutely ill to require care directed at concomitant complicated emotional and social problems. All participants recognised that public hospitals could only rarely supply continuity of care and, as in the acceptance of fragmented care, this was considered largely inevitable and, in the context of acute and emergency care, unimportant. Doctors wishing to access specialist-based technology for their patients have usually had to trade off its benefits against the loss of continuity.

However the absence of continuity of care and its consequences in hospitals is not accepted as inevitable by all. Norwegian researchers condemn its acceptance and point out that there are consequences for patient care and patient satisfaction and for the working conditions of hospital based healthcare professionals (Krogstad et al., 2002). They appeal for more research to be directed towards its investigation and management.

Continuity of care at primary care level is also not to be seen as an unqualified ideal for doctors. There was some reservation in a dedication to patient care if the level of
dedication were to be dictated by patients. This replicates concerns about patient exploitation of the doctor-patient relationship made by Freeman and Hjortdahl (Freeman and Hjortdahl, 1997). Hence the insistence by some participating practitioners that phone discussions on care are replaced by arranged appointments, and that continuity of care be a matter of a relationship with a group of doctors rather than an individual responsibility. This latter point was also an outcome from debate by focus groups of Australian general practitioners published in 2000 (Sturmberg, 2000).

George Freeman and Per Hjortdahl writing from academic general practice in Norway and Britain noted the advantages and disadvantages of an undertaking to continuity of care (Freeman and Hjortdahl, 1997). They saw their GPs as caught between the rhetoric of continuity and patient demands, and with empowered patients capable of exploitation by demands for different and preferential care. Nevertheless leading proponents of primary healthcare outside Britain such as Jan de Maeseneer, Barbara Starfield and Per Hjortdahl later combined to condemn proposals to change the British NHS commitment from registration with a single general practitioner (Maeseneer et al., 2000). They considered that long-term care was of such benefit as to outweigh risks of abuse or the loss of choice in healthcare provider.

A further insight into continuity of care is provided by the study by Tarrant et al (Tarrant et al., 2003), who explored ‘personal care’ as a entity distinct from ‘continuity’. They found that in many circumstances, e.g. acute illness, or busy lifestyles, continuity, i.e. longer term relationships, was not as important, but the empathy and communication skill of ‘personal care’ were. These researchers
emphasise that “it is clear that patients do not always regard an ongoing relationship as essential to personal care” (Tarrant et al., 2003).

The concept that a one-to-one continuity-of-care could actually be harmful to general practitioners, as expressed by one participant, has been confirmed by studies in the United Kingdom (Chew-Graham and May, 1999, Chew-Graham et al., 2004). In those qualitative investigation carried out into the doctor-patient relationship involving chronic disease, doctors became depressed at dealing with intractable disease and/or patients unwilling to help themselves. Because the doctors felt they were duty bound to maintain the relationship they were drawn into collusion with patients in sustaining an illness dependency and chronic incapacity. This reaction to ‘heartsink’ patients may also be a factor in the rejection by interviewed general practitioners of registration of patients with GPs in the Australian healthcare system. These GPs might wish to retain the ability to engineer the movement of some patients to other medical practices, avoiding the geographical registration trap of the UK system. ‘Choice’ is not just a matter for the patient, but also for the doctor.

Collusion within the doctor-patient relationship in maintaining a medical treatment seeking behaviour is also condemned as a ‘hidden addiction’ by Arthur Frank (Frank, 2000), but his concern was with the effect on the patient, and on society, of a consumerist orientated healthcare system.

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26 ‘heartsink’ refers to the emotional reaction felt by some doctors on the entrance of patients for whom they can do little, usually because of the patients’ personality problems.
Longer-term relationships may have other benefits than that of better patient care. It is considered to increase a doctor’s sense of responsibility for overall health (Hjortdahl, 1992); and is positively correlated with patient satisfaction (Saultz and Albedaiwi, 2004).

Given the widespread endorsement of continuity of care and long term doctor-patient relationships the puzzle is why there should be such discrepancy between the expectations of general practitioners and the healthcare consumers interviewed in chapter four. Those focus groups of healthcare consumers are in the main the very patients that the participant GPs of this chapter would expect to support long term relationships, i.e. middle aged to elderly females involved in their own and their families’ healthcare problems. That these ‘consumers’ are unrepresentative in being those self-selected and interested in healthcare reform is possible, but the views of these GPs are so certain and overwhelmingly confident that this group would value long-term relationships. It is more likely that there is a different perception of that which is involved in the continuity of care of a doctor-patient relationship.

I believe that many patients see a visit to a known GP as a convenience, as a means of avoiding repeating a medical history and possibly risking important omissions. They may prefer a general practitioner as a trusted confidant, and eventually as a knowledgeable friend, but I doubt the awareness of a ‘lifeworld’ of sociological significance. Neither they nor their doctor would see their symptoms as meaningful extensions of their ‘lifeworld’ as claimed by Paul Redding (Redding, 1995), or that medicine risks colonisation of a patient’s ‘lifeworld’ in Habermasean terms (Scrambler and Higgs, 1998, Barry et al., 2001).
It is also plausible that these older general practitioners are unrepresentative of younger general practitioners. This is consistent with a replacement by younger GPs of a component of the social capital of a trusting relationship by a technological contract; and a technological contract that is now becoming accepted by all parties without experience of a different relationship.

The concept of continuity of care being valued only after experience of its benefits was made by a few participant general practitioners. It is possible that an impressive evidence of the value and benefit of continuity, and of a long term doctor-patient relationship, might be a willingness to take part in assuring hospital based care; and, as stated by one participant’s patient, to reassure the patient when most anxious and most vulnerable. In that sense the advocacy role of general practitioners in hospital care would be the cause of a long-term relationship and not its result.

In recognising the deficiencies of hospital care some of the participants in this study suggested that hospital staffs appreciate the special position of general practice in providing continuity of care. They anticipated general medical practitioners as being the coordinators of whole-of-life as well as whole-of-person healthcare. A future role for some of these general practitioners is as team leaders coordinating the activities of nursing, allied health practitioners, and medical specialists. This role might well encompass hospital-based care.
Sturmberg’s focus groups of Australian general practitioners (Sturmberg, 2000) also expected a place for general medical practitioners within the hospitals of the healthcare system:

“the patient goes somewhere and you can either have input into what happens with them or you are at least following what is happening with them - you may want to come along and have the option to input, be it in hospital, be it psychological referral, physiotherapy or whatever”

(Sturmberg, 2000 p. 19)

However it is difficult to be confident of the doctor’s participation in coordinated care plans. The Coordinated Care Trials of management for long-term chronic ill health conducted in Australia from 1997 had as their theme a choice between that of an enhanced GP role or the creation of trained ‘coordinators’. So far no firm conclusion are available (Commonwealth Department of Health and Ageing, 1998, Esterman and Ben-Tovim, 2002, Wenck and Lutton, 2005). It was stated that patients were happy to have a devoted care coordinator from any source. However the trials were designed to have a quantitative evaluation of evidence-based-medicine that may have decreased their value by focussing on trial design rather than on patient outcome in patient terms, as indicated by (Esterman and Ben-Tovim, 2002) and by Johannes Stoelwinder (Stoelwinder, 2001).
7.4.3 The ‘Fragmentation’ of Healthcare

All participants agreed that those problems of ‘division’ between community level care and institutional management were those of communication. ‘Communication’ meant the exchange of information on the care and investigation of patients when at different times under the care of other sections of the healthcare system. It also meant for general practitioners more than that care programs were changed, but that those changes should be explained and explicable both to them and to their patients.

However there was no sense that general practitioners were to be involved by hospital staff in care programs; they were not sought out for advice, not even on the wisdom of the discharge programs already noted as being part of the MBS. Problems were those of the transfer of information and not those of impaired care from the fragmentation of responsibility. These experienced general practitioners probably accepted the inevitability of a divided system to be most effectively bridged by increasingly sophisticated communication technology.

This is similar to the views of the general practice educator Linda Mann who although emphasising the need for a breakdown in the ‘silos’ of community and institutional care considered the solution to be better information technology and joint funding arrangements (Mann, 2005). J D Zajac, however, discussing the Australian hospital of the future (Zajac, 2003), noted inefficiencies arising from fragmented care to be partly resolved by the use of generalist trained special hospital based doctors, the so-called ‘hospitalists’, and again stressed communication technology to inform ‘outside’ general practitioners.
The fragmentation of healthcare systems has been noted as a contributing factor in the mal-distribution of Australian human and financial resources at both state and federal level (Planning and Workforce Group, 2003, Australian Government Productivity Commission, 2005a). However these and other reports seldom note that fragmentation could contribute to dysfunction in patient care. The Reid Report from Western Australia (Reid, 2004) is specific in noting impaired healthcare consequent to fragmentation:

“Poor coordination and communication across the primary care/acute care interface contributes to avoidable admissions, adverse events and poor health outcomes. Care coordination is particularly important for those with chronic and complex conditions, those with mental illness, and the disadvantaged such as Aboriginal people and those from lower socio-economic groups.”

(Reid, 2004 p. 21)

The interviews with general practitioners noted in this chapter did provide anecdotal evidence of poor communication resulting in potential but not actual harm to patients. There could be no discussion of harm caused to patients in view of the medico-legal implications of recording such evidence.

The concept of the hospital based generalist, as taken up in the United States, and discussed as a possibility in Australia (Hillman, 2003) has been described as leading to an ultra-fragmentation of care (Manian, 1999). In that article clinical responsibility is progressively deflected as the patient passes from ‘screenist’ nurse practitioner, to
‘officist’ general internist, then, following hospital admission, to a ‘hospitalist’ generalist, and possibly an ‘intensivist’ generalist within the hospital’s intensive care units (ICU). The patient then passes back down the line; all for the single episode of clinical care. In Manian’s derisory review the patient relates to none of these general medical practitioners; and no one accepts overall responsibility.

The enhanced responsibility from an effective doctor-patient relationship might cross the divide between community and institutional healthcare but will require a degree of trust. There will be the need of doctors from different sectors of medicine to trust one another, but of prime importance will be the need for patients to trust doctors.

7.4.4 Trust in Doctors and Hospitals

The subject of ‘trust’ is very difficult: it is difficult in being an essential component of the doctor-patient relationship and other forms of social capital, but also being immeasurable and unquantifiable (Cox, 1998, Productivity Commission, 2003). I discussed ‘trust’ in chapter three with different opinions on its apparent decline. These general practitioners expressed confidence that trust in a personal doctor was still present despite levels of distrust in the community as a whole. It appears reasonable to ask if patients might be more likely to trust their general practitioner than an institution like a hospital; or to trust doctors perceived as being institutionally employed.

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27 Equivalent to a general medical practitioner in the Australian and British context
Pellegrino and Thomasma in discussing a fidelity to trust as one of their ‘virtues’ make the point that one trusts a pilot on boarding an aircraft without knowing the pilot but trusting the ‘system’ to provide a technologically trustworthy person (Pellegrino and Thomasma, 1993). Can a healthcare institution or a medical profession be such a system? Pellegrino and Thomasma argue that ‘system trust’ is insufficient for doctors, and that patients’ commitments to doctors involve a more profound and personal submission than that of a passenger in an aircraft. Nevertheless for public patients in the Australian healthcare system a faith in institutional integrity is essential. However, in chapter two of this thesis I showed that ‘system trust’ has been found defective and deficient in many circumstances and in different healthcare systems.

Doctors, proven to demonstrate technological competence, labeled as specialists, were considered by one general practitioner as having a higher status than general practitioners. This aspect of a diminished general practice is supported by many other reports and writers (National Health Strategy (Australia), 1992, Del Mar et al., 2003, Chew, 2003, Allen, 2002, Kamien, 2002). Different general practitioners in this study referred to undervaluation of their work as a concern, and this opinion is upheld by the Relative Value Study of 2001 (Relative Value Study Group, 2001). That study, involving government and organised medicine, attempted to determine a financial basis for evaluating the cognitive function of a consultation as against the technological function of a surgical procedure. It eventually determined a value for a primary level GP consultation at approximately twice that then currently accepted (Pearn-Rowe, 2003). This policy document remains to be implemented. It is notable that the United Kingdom’s National Health System is attempting to reverse the trend
and to reward general practice relatively more than procedural specialists (Weller and Maynard, 2005, Dickinson, 2004).

I have made the point that status and trust are distinct but may be connected. The question might then become one of whether or not a technologically equipped but newly met specialist is trusted more than a general practitioner with whom one has developed a long-term relationship. The question is however without substance in that in any clinical situation trust is multi-faceted. There is a trust to be technologically competent and to be abreast of recent developments. There is a trust to be compassionate, and to take time to know and to understand a patient’s fears and values (Cassell, 1991). There is a trust to be trustworthy and a ‘fidelity to trust’ (Pellegrino and Thomasma, 1993).

The matter of trust with specialists and general practitioners is not that one should dominate but that both can be employed; and certainly in referring patients to a specific specialist a general practitioner is trusted to do so in the patient’s interests. It is however of concern that in public hospitals the supposedly knowledgeable patients interviewed in chapter five did not expect to meet a consultant specialist and had very little idea of the rankings applied to hospital employed doctors. It is of even greater concern that, as I discussed in chapter two, many patients of KEMH were unknowingly dealt with by doctors of experience much lower than the degree of clinical difficulty would warrant.
It is then reasonable to conclude at this stage that ‘system trust’ in healthcare is under threat but there exists no mechanism for its enhancement by the personal trust of an established doctor-patient relationship. Both patients and general practitioners have become inured to a fragmented healthcare system and change will be difficult.

Moreover in noting that primary medical practice is seen as possibly injurious to doctors, and that there exists the potential for exploitation by patients of the relationship, it is relevant that trust is now seen as a two-way matter (Entwistle, 2004). This change from a unidirectional psychometric ‘trust in physician scale’ in 1990 (Anderson and Dedrick, 1990) to Vicki Entwhistle’s editorial (2004), in an edition of the relatively new journal of Health Expectations dealing with ‘trust’, has occurred over fourteen years.

Certain general practitioners in this study do aspire to a change. Some have occasionally sought to interfere in hospital care on behalf of their patients. Some see a future of general medical practitioners as experienced specialists in personal and family medical care, and with cognitive and clinical management skills to be respected by the community, by hospitals, and by government.

However general practice workloads have been indicted as a cause of depression, ill health and poor motivation amongst doctors in Australia (Schattner and Coman, 1998, Kamien, 2002) and elsewhere (Chew and Williams, 2001). To anticipate the ‘new kind of GP’, the renaissance GP of Marshall Marinker (Marinker, 1995), and perhaps that aspired to by some of the participants, would require that many of the present
tasks of general practitioners be delegated to others just as capable of their performance. Without such a redefinition of general practice any hopes for a role in secondary and tertiary level care will be impossible.

7.4.5 Workforce Issues in General Medical Practice

There is considered a present and an immediate future shortfall in general practitioner numbers (Australian Medical Workforce Advisory Committee (AMWAC), 2005). Moreover a report of the demographics of present GPs shows an increasing preponderance of female and older practitioners, both categories taking longer times with consultations (Australian GP Statistics and Classification Centre, 2006) p. 100, and hence exacerbating the shortage. That same report noted a decrease in the number of sessions, i.e. half-days, worked in 2005-6 as against five years previously. The present workforce needs to adapt to maintain even its present output, a situation admitted by the participants in the interviews reported in this chapter.

It was evident in these conversations with general practitioners in Perth that there is a dichotomy between those GPs content with their present situation and those anticipating change. A few of the interviewed GPs would welcome nurse practitioners to share the clinical workload, a few more anticipate practice nurses taking on recording and observational functions, and some who would hope for allied health workers, e.g. psychologists, to bring their particular expertise within the primary healthcare team. There was however a majority who would only relinquish nursing type duties to practice nurses if the practice was large enough to employ a special
practice nurse and that, in a government supported fee-for-service system of remuneration like that of Australia, adequate funding was guaranteed\textsuperscript{28}.

This attitude has been condemned by some as defeating aspirations for a worthwhile job (Coote, 2003). However valuation inevitably has a financial component and, as stated, general practice awaits the implementation of the Relative Value Study conducted five years ago (Relative Value Study Group, 2001). A further problem would be that if nurse practitioners were to be shown to be equally competent in many respects to present general practitioners, and easier and cheaper to employ, then the economic security of present general practitioners could be perceived as threatened.

In these conversations with general practitioners most respondents expressed doubt as to the competence of nursing educated clinicians but overseas experience is supportive. In 1983 Donald Right quoted 22\% of all medical services as capable of being performed by nurses (Light, 1983) and that, in the American primary care setting, nurses and GPs performed equally well.

By 1995 Doug Banbow noted a Gallup poll that showed 95\% of Americans in different States would accept nurses as their primary healthcare giver (Banbow, 1995). In the United Kingdom the profound changes in the relationships between the sectors of healthcare starting with the fund holding described in chapter four have now resulted in nurse-led primary care services (Wilkin, 2002). A meta-analysis of studies performed on care provided by nurse practitioners in the UK and United States

\textsuperscript{28} Practice nurse funding is now part of government subsidies to general practice and their activity is now measured.
showed that in some respects the care was better than that provided by general medical practitioners (Horrocks et al., 2002).

However the focus groups interviewed in chapter five totally rejected the concept of nurse-practitioner primary healthcare clinicians, and it is of interest that one of the participant GPs asked to comment on the subject disapproved on the basis that he “wouldn’t like it for himself”. There is evidently a strong subjective element to the demand for a medically trained clinician.

In 2006 the Health Workforce Innovation Conference in Australia heard of physician assistants and nurse practitioners from the UK and USA (Brooks and Ellis, 2006). A comparison of the costs and efficiencies of the NHS and a large Health Maintenance Organisation on the USA has already been noted (Feacham et al., 2002). In that study the more extensive use of both nurse practitioners and physician assistants in the USA was associated with better and, in equivalent terms, cheaper healthcare. Martin Van Der Weyden, editor of the Medical Journal of Australia, noting the many influences leading to a replacement of medical professionals by non-medically trained personnel, saw the process as requiring not opposition but adaptation to the inevitable (Van Der Weyden, 2006).

However Donald Light, writing in 1983, noted an absence of non-medical personnel willing to train, and there may be similar difficulties in Australia, and at this time. Furthermore the health care consumers questioned in chapter five were adamant that they would not accept nurse practitioners as front-line primary care clinicians; and in New Zealand a patient care representative has already been noted as publishing
warnings to patients on both the use of nurse practitioners and on an increased status for general practitioners (Coney, 1997).

Despite many of these interviewed general practitioners’ satisfaction with their present working conditions some views of Australian general medical practice are of a bleak future facing multiple conflicting and confusing influences (Chew, 2003, Lipscombe, 2003). These range from professional and financial under-recognition to a public expectation of ‘quick-fix’ technology. Some have claimed that it may be better to enlarge the horizon of general medical practice into areas of population health, evidence-based-medicine, information technology, clinical governance, disaster medicine, preventive women’s health, and some to undertake Master’s training in cognitive behaviour therapy (Trumble and Glasgow, 2003). Trumble and Glasgow (2003) also point to the much quoted report from Canada (CanMEDS, 2000) which locates professional aspirations within the needs of society, in contrast to the physicians charter noted in chapter three of this thesis (Medical Professionalism Project, 2002). The CanMEDS (2000) report notes GPs as collaborators with specialist physicians and surgeons and accepts a need for their particular professional expertise. I can see no reason why this cannot be expressed within high technology healthcare institutions.
7.5 Conclusion

The research contained in this chapter was predicated on the notion that an increased influence by patients and their general medical practitioners would be beneficial to the functioning of healthcare institutions and to the sustainability of healthcare services. In order for this benefit to be obtained general medical practitioners would have to be willing and able to take part.

Twenty general medical practitioners from the Perth metropolitan area were asked for their opinions on matters related to an increased and potentially intrusive role for GPs in hospitals. There was general agreement that the main problem with hospitals and general community level healthcare was that of communicating details of the healthcare record between the different sections of the healthcare system. The majority assumed that this would be eventually overcome by progressively sophisticated communication technology.

There was also common agreement that a main function of general medical practice was the long term care of patients. Some had the ambition that this should extend to a leadership role for general practitioners in the coordination of patient care within both primary and secondary/tertiary level healthcare. This coordinating role has been accepted for the care of the terminally ill.

A few of the interviewed general practitioners had intervened in the care of patients under the care of hospitals and specialists but this was very uncommon. All agreed that there was no present ability to attend their patients in hospitals. This was
prevented by practical details of time availability, parking and patient location. It would be uneconomic, professionally unsupported and require changes in the way general practitioners were recognised by larger metropolitan public hospitals.

Many of these interviewed general practitioners are content with their present professional life-style and would not welcome intrusion into clinical care by non-medical clinicians similar to nurse practitioners. Others anticipate a more professionally demanding role as whole-of-life and whole-of-care coordinators; and as senior physicians adopting a position foregone by specialist consultant physicians.

No interviewed general practitioners would have expected the middle-aged women making up the preponderance of healthcare consumers forming the focus groups interviewed in chapter five to have had reservations in their support for long-term doctor-patient relationships. This anomaly may have implications for the future of general medical primary healthcare.

The next chapter contains discussion of, and suggested resolution of, the difficulties in implementing a policy change opposed to the entrenched positions of many healthcare consumers and providers. This chapter shows some general practitioners as willing to challenge those professional mores that devalue wide-ranging perceptual ability in respect to technological proficiency.
Chapter Eight

Resolution and Conclusion

8.1 Introduction

The hypothesis of this thesis is that much of the main challenges in healthcare services, including rates of error and ever rising costs, cannot be resolved by government measures or institutional governance alone, but also require support by patient/consumers aided by trusted healthcare professionals. The background to the hypothesis is the proposition contained in the second chapter that mistakes made in the care of patients admitted to hospitals are those of medical professional values concerned with protecting the profession as much as caring for its patients. This distorted professionalism wishes to protect its right to train its members and fellows in ways it thinks fit without scrutiny, and to manage error without accountability to the wider public. Moreover in a healthcare system like Australia, where almost half of the population pays hospital care insurance for treatment in private hospitals and the other half is treated in wholly public funded facilities, there remains the suspicion that the medical profession supports different standards of care based on this difference.

However mistakes in care, termed ‘adverse events’, occur in all hospitals (Wilson et al., 1995), private and public, and with multiple causes (Wilson et al., 1999), technical, systemic and human, that have led to attempts to design feedback systems analysis and fail-safe mechanisms to repair the damage (Australian Council for Safety and Quality in Health Care, 2003). In chapter three I discussed the concept of linear
relationships, of cause and effect, in resolving complex issues, with the development of the hypothesis that patients and their primary level clinical professionals should be involved in the assurance of high quality high technology care at a more individual and immediate level.

The argument is taken further in chapter four by proposing that that same close relationship based on willingness by primary level clinicians to mediate for their patients in both secondary and tertiary level hospitals can also serve to restrain healthcare technology that might contribute little to patient care. Healthcare technology is also indicted as contributing to rising healthcare costs (Fett, 2000). Those costs both compromise other demands for individual or governmental funding (Reid, 2004), and also demand industrial mechanisms for wealth creation that might be socially, economically, and environmentally damaging (Winner, 1986).

The hypothesis, that a better and more sustainable healthcare system is dependent on a reciprocally trusting relationship within primary level healthcare, is however dependent in the motivation of both parties to engage in such a relationship. The research noted in chapters five and seven does not show present support for the hypothesis from either patient/consumers or general medical practitioners in metropolitan Perth in Western Australia. It may also be relevant that this same research shows difference in attitudes by healthcare consumers and doctors to long term doctor-patient relationships.
Any support for policy incorporating this hypothesis will depend on the outcome of confusion over the value and meaning placed on continuity of care by both doctors and patients. Also involved will be the questions of the longer-term direction of both general medical practice and of hospitals, and of the future organisation of the profession of medicine.

In this chapter I further analyse the information from the research carried out so far, together with a search of the literature, to determine if a different working definition of the present doctor-patient relationship would be more appropriate for the future direction of healthcare. I then explore the use of this fresh concept in addressing first the rate of error in hospitals and then the overall sustainability of healthcare.

8.2 ‘Personalised’ Patient Care

The healthcare consumers participating in the focus groups, and reported in chapter five, provide a bleak view of the future of primary care general medical practice. That future is of consumers using GPs as a diagnostic vehicle for access to drugs and specialist care and little else (I will maintain the convention of quotes from research participants in bold type):

“I don’t want a cosy relationship with my doctor”. “What I’m looking for is a prescription or who’ll send me off to a specialist, and that’s all I want”. “I don’t want a cosy country doctor relationship.”
This view is consistent with a future of general medical practice expressed by Marshall Marinker as “essentially episodic, and the relationship into a kaleidoscope of brief encounters” (Marinker, 2000 p. 123)\(^{29}\).

Alan Radley (2002), a social scientist working in healthcare, also agrees with Marinker (2000) that the long held belief in a necessary psychotherapeutic component to general practice, based on Michael Balint’s work in the 1950s (Balint, 1957) is now outmoded:

“Inasmuch as patients feel that they have more control over their health agendas, it is likely that they will expect less of their general practitioner in respect of advice about life in general.”

(Radley, 2002 p. 702)

He sees patients as informed by support groups and the Internet; and coping with disease as a moral requirement. However the general practitioners interviewed in chapter seven, all devoted to the concept of continuity of care, would find these opinions difficult to accept and possibly reject them as uninformed by exposure to the ‘real’ world of clinical care. Indeed Radley (2002) admits that his views do not cover the spectrum of clinical experience. Nevertheless the previous chapter did note concern within the rhetoric of ‘continuity of care’ regarding both the content of continuity, involving potential exploitation by patients, and its impact on practitioner lifestyle.

\(^{29}\) Marinker, however, makes the point that he is anticipating a future not welcoming it.
A pointer to the future is possibly that of the work from Manchester in the United Kingdom on ‘personal care’ as being that aspect of the primary care relationship that is most valued (Tarrant et al., 2003). That qualitative study revealed that patients welcome recognition by their doctors of their individuality, as well as their medical record, but that it did not necessarily arise from a long relationship but from the doctor’s interest and communication skills. Personal care is easier in an established relationship but the patients in the study by Tarrant et al. (2003) claim that it can be absent in the British NHS despite repeated encounters over long periods.

A similar result but from a post visit survey accompanied by confidence limits as to the relevance of associations between a ‘personal’ relationship and health promotion, confidence in health outcomes, and needs for further referral, is that of Little et al (Little et al., 2002). Again the conclusion was of the importance of a patient centred doctor able to convey a personal interest.

Patients in the Manchester study wished their previous healthcare records to be acknowledged as part of personal care, but this could be obtained by efficient and complete record systems and does not need to reside in one person. Hence the wish expressed by some general practice participants in Perth, and the focus groups of Australian GPs studied by Sturmberg (2000), that the doctor-patient relationship could be replaced by a relationship with a group of doctors, and it understood.

A future doctor-patient relationship at primary level care could be a brief episode, or ‘even a kaleidoscope of brief encounters’, but still preserve a personal perspective that
patients can value. A doctor-patient relationship may now be considered as that between an informed patient and a group of doctors with access to records of the patient’s medical, social, occupational and psychological history. In managing the patient’s present problem, or problems, a doctor or a group of doctors would recognise and be sensitive to that history, and be able to relate to the patient as a person. ‘Personal care’ as a term relates to the quality of the relationship and not to the number and frequency of encounters. Moreover the patients’ need-to-be-informed becomes a shared duty with the general practitioner guiding the patients’ sources for information (O’Connor et al., 1999, Coulter, 1999, Akerkar and Bichile, 2004).

The Perth general practitioners’ insistence on the worth of continuity of care becomes explicable with the realisation that, in a choice based system, like that of Australia, continuity is the result of a more personalised care program and not its cause. Those patients willing to travel long distances or wait hours to see particular general practitioners are doing so not only because the patients have a long history with those practitioners but because the long history stems from a personalised service. It is the personal service that is crucial. The ‘experience’ of continuity of care claimed to be important by participant Western Australian general practitioners might be the experience by patients of a doctor willing to use his or her awareness of medical and personal features of the patient to moderate and direct an encounter.

Per Hjortdahl, a long time commentator on the concept of continuity-of-care, claimed in 1992 that for general practitioners to know a patient might take from one to five years, or 4 to 5 visits in one year (Hjortdahl, 1992). However in 1997 he and George
Freeman admitted that longitudinal continuity was not as important as a personal commitment from both patient and doctor (Freeman and Hjortdahl, 1997).

It is then possible to resolve the conflict between the opinions of the consumers of healthcare noted in chapter five with those of general practitioners voiced in chapter seven. If the questions had been framed to discuss ‘personalised care’ as a feature of the doctor-patient relationship, rather than continuity of care involving social and psychological issues, there might have been greater agreement.

How might this concept of a doctor-patient relationship requiring personal care support the hypothesis of a more intrusive general medical practice in contributing to better institutional healthcare? ‘Personal’ may not always involve continuity, and may not infer a special psychosocial awareness to which hospital clinical staffs are not privy. If so, then it also follows that a ‘personal’ relationship can be managed by hospital clinicians given the time and willingness to do so.

Conceptually an adaptable personal relationship accords with experience. The healthcare consumer quoted above from one of the focus groups in chapter four as rejecting a ‘cosy relationship’ suffered from the genetic disorder, haemophilia, and it would be probable that he would have had a personal relationship, not with a GP, but with a specialist clinical haematologist. Patients and specialists with long term commitments to long term chronic medical conditions usually have similar associations. It has even been suggested that, in contrast to the usually expressed opinion of the special need of a coordinating general practitioner for the care of those
with chronic diseases (Commonwealth Department of Health and Ageing, 1998), they may be better cared for by specialist led teams dealing with that chronic disease (Moore and Showstack, 2003, Burden, 2003).

Moreover, if ‘personal care’ can be replaced by an efficient and reliable records system, then the transfer of those records and that knowledge to institutional care might be argued as sufficient to ensure proper care. This is the case put by Linda Mann (Mann, 2005). The general practitioners interviewed in the previous chapter, however, made some relevant comments. There was the GP interviewed in chapter six who quoted his patient as valuing his GP’s reassurance that all was well with the patient’s hospital care; and there was the response from one GP to the question of what might be absent from a ‘smart’ card:

“*Well, the relationship; you can have all the information, but you might not have the confidence, and all those sort of things that go with it.*”

It is the argument of this thesis that patients need ‘confidence’, a confidence that their care and values will remain paramount at times of political, professional and institutional change. They need, moreover, a confidence that faced with the fear of technological and human error, or the risk of receiving advice that may not accord with their particular needs, they can enlist the support of a trusted medical professional. That trust is itself a matter of confidence. Consumer/patients need to trust that clinical professionals caring for them as persons have the professional confidence to mediate on their behalf at all times and in all situations. That trust and that confidence will need to be earned.
From the conversations with general practitioners in the last chapter there was the affirmation that an experience of continuity of care will convince patients of its benefit. Replacing ‘continuity’ with ‘personal care’ will not change that conviction. In terms of professional confidence there was the wish by some GPs to assert a leadership role in the management of chronic disease, a situation that is already present, to some extent, in terminal care. I propose that were general medical practitioners to assert a role as a mediator of high technology healthcare, and to insist on quality healthcare for their patients, this in itself would act as the catalyst for a more emphatic doctor-patient relationship. The program would be reciprocally self-supporting. This leadership role for general practitioners in a teamwork concept of primary healthcare has been condemned by some who decry the loss of individual care involved in such a situation (Fugelli and Heath, 1996, Troop, 1998, Greenhalgh and Eversley, 1999). However both Les Troop (1998) and Greenhalgh and Eversley (1999) consider that an individualised approach could obviate any risk of depersonalisation:

“\textit{objective of primary care should not be teamwork per se but personalised care from a single practitioner coupled, where appropriate, with task-focussed activity by ad hoc groups of staff with specific skills}”

(Greenhalgh and Eversley, 1999 p. 44)

I will review its potential effect on error and substandard healthcare in hospitals.
8.3 Error in Hospitals

The sub-standard care revealed by the Inquiry into King Edward Memorial Hospital discussed in the first chapter (Western Australian Government (KEMH) Inquiry, 2001) has led to the appointment of full time specialists to replace sessional part time consultants. This has enabled proper supervision of specialists in training and the assumption of responsibility for clinical care by specialists remaining on-site without the diversion of interest to private patients elsewhere. It was discussed in that chapter that clinical dysfunction may have had much to do with an outmoded medical professionalism, but planned resolution is more related to the allocation of funds for the hiring of full time specialists.

Nevertheless the creation of full time staff also has enabled the setting and auditing of standards of care and an assurance of accountability. My assertion is that this will be insufficient to redress real or perceived deficient standards of care, and, in terms understood by the patients of the hospital and by the public, has yet to be proven. That claim is however supported by an in depth ethnographic study of a hospital in the United Kingdom in which medical staff subverted managerial imposed ‘reforms’ directed at safety and quality issues (Waring, 2007).

In that study it was contended that medical staff were insistent that medical care could only be assessed by medically qualified professionals, an opinion that was a feature of the Inquiry into KEMH noted in chapter one. This thesis makes the point that those
medically qualified professionals need not be employed by the hospital but by the patients, i.e. their primary level general practitioners.

If approximately one in ten patients in hospital is harmed by the healthcare system (Wilson et al., 1995, Brennan et al., 1991) then it must be expected that other sectors of the healthcare system are aware of this rate of error. A hypothetical general practitioner with a patient load of 1000 may expect 100 or more patient hospital admissions in one year. One GP from the interviewed group considered his ‘admissions’ to be 200 per year so the estimate is conservative. A GP with 100 admissions and an ‘error rate’ of 10% therefore might be aware of mistakes in care occurring to his or her patients involving hospital admission to, on average, ten patients in each year. Those mistakes may or may not result in long term harm; and then there are also failures in providing care with the compassion demanded by healthcare consumers (Australian Medical Workforce Advisory Committee(AMWAC), 2005, Breast Cancer Network Australia, 2004); the rate of which may be increasing (Chew et al., 2003). General medical practitioners should be aware, or be informed, of mistakes and substandard healthcare associated with their patients’ admissions to hospitals.

That does not infer that all these mistakes are preventable. The original article, Wilson et al (1995), noted 50% of errors as having occurred before the admission analysed in the paper, some from a previous admission, and only 50% of those were deemed preventable. In only a small number would the ‘event’ have been ‘preventable’ by some action initiated by the patient, by, for example, an appeal to his
or her local general practitioner. Nonetheless an awareness of an adverse incident, even after the event by a patient’s GP, and some action taken by that GP at the time to inquire as to cause and consequences, might be of immediate benefit both to the patient and also to the hospital, and to the GP, in ways a delayed retrospective audit would not.

The disclosure of the incidence of error as described by Wilson et al (1995), led to a determination to affect improvement that, understandably, was to be preceded by analysis and measurement, and a cause determined. Hence there is a proliferation of committees dealing with Adverse Incidents Monitoring Systems (AIMS), consumer reporting mechanisms and assessment of sentinel\textsuperscript{30} events, rooted in the Australian Council for Safety and Quality in Healthcare (Australian Council for Safety and Quality in Health Care, 2003). Similar programs have been created elsewhere (Bagain et al., 2001). Many of these mechanisms are concerned with a retrospective search for causes in systems of care that can, hopefully, be corrected. However they contribute little to the individual patient with their present fears of that which has happened, or is yet to happen.

Investigating United States patients’ reactions to incidents causing sufficient harm to lead to legal action, Stephen Fielding emphasised preventive mechanism, but also found a need to provide an individual human response (Fielding, 1995). He criticised a medical system reducing patients to commercial consumers, and, in support of this thesis, saw a need for a re-affirmed doctor-patient relationship at primary care level:

\textsuperscript{30} individual events that reveal background defects in care
“medical care is reduced from the status of a humanistic institution to a commercial commodity .... The most effective way to control malpractice claims is to emphasis prevention, provide more humanistic primary care, and to re-evaluate the social policies that mould the health care system”.

(Fielding, 1995 p. 53)

The interviewed GPs in the chapter seven, however, rarely responded to concern about hospital treatment by their patients, and the healthcare consumers interviewed in chapter four did not expect them to do so. Some of those healthcare consumers would have had a long-term relationship with their doctors associated with an expectation of continuity of care, an expectation that did not extend into institutional care. The question that needs to be asked is, why not?

The answer lies in the professionally and publicly accepted hierarchical division of healthcare. There is little expectation by the profession or the public of an influence of community level primary care upon high technology healthcare. As one GP participant noted:

“I don't think they often think there is wealth of information that could be made available to those doctors from the GP, but we’re never asked. I think it’s almost a given that they think we don’t know very much and can’t contribute.”

There is an appreciation that general knowledge medical care may be valuable and lacking in acute-care specialist driven hospitals (Hillman, 1999), and hence the discussion of the employment of generally trained and experienced ‘hospitalists’ based on the American model (Hillman, 2003, Zajac, 2003). Although proportionately fewer
in number United States GPs retain admission rights to hospitals and engage specialist help in a way that was more common in Australia 40 years ago. However letters to the New England Journal of Medicine, responding to an article on ‘hospitalists’, referred to visiting GPs as visiting by routine with little contribution to patient care (Freer et al., 1999). Some writers even anticipate that ‘hospitalists’ will contribute to a further decline in recruitment to primary level medical care (Moore and Showstack, 2003). It is claimed by them that medical graduates in the United States see little benefit to a professional role in general practice diminished by ‘hospitalists’ at one end of the technology spectrum and nurse practitioners and physician assistants at the other.

However this hypothesis is not referring to general medical knowledge as such but to the special doctor-patient relationship that is hopefully a special feature of primary level healthcare. While Western Australian healthcare consumers interviewed in chapter four seem unimpressed by any special relationship it might be argued that they have accepted a loss they might sometime regret; a point made by ‘Fred’ Dainton, a distinguished ‘patient’ in the United Kingdom

Lord (Fred) Dainton, was asked to introduce a joint British and American conference at a time of changing economic systems and how those changes might affect healthcare (Daiton, 1990). However he was not a medical professional, trained health system bureaucrat, or health economist; he was a distinguished chemical scientist, and it is reasonable to assume he was speaking as a representative of the patients/consumers of healthcare:
"What the patient needs to feel absolutely secure about is that his 'doctor of first contact' will always be accessible and act solely in the patient's interests, that is, be his advocate in all matters pertaining to his health including that of dealing with hospital doctors, bureaucrats and those who administer the social services"

(Dainton, 1990 p. ii)

Why, however, do so few patients feel able to use their ‘doctor of first contact’ in a way suggested by Dainton? In an interview with one general practitioner in Perth the practitioner quotes his patients’ regret at being unable to access his reassurance

“Whereas patients have often said it would have been lovely if I could have called you to say, you know, to tell you of my fears about what is happening, or just to up-date you about what’s happening to me, etc.”

Questioned as to their attitudes to a general practitioner visiting a patient in hospital, even to a patient that had suffered an ‘adverse event’, the participants in the focus groups of chapter five considered that such activity was superfluous to the proper role of such a GP. They did not even think it likely that the GP would be informed that the ‘event’ had occurred until long after the patient’s final discharge home.

It is possible that the advance of medical technology has left general medical practitioners with nothing to contribute to healthcare in hospitals as is claimed by Marinker (2000). He discounts any present day contribution from GPs as having special knowledge of their patients; and that they and their patients can,
“no longer expected to pay lip service to concepts of beneficence, empathy, and holism in a future of genomics, robotics and electronically democratised knowledge.”

(Marinker, 2000 p. 123)

Moore and Showstack (2003), referred to above as noting a decline in recruitment of medical graduates to primary level care, considered that an advocacy role could no longer be expected following the relinquishment by GPs of an unrealistic 24 hour, seven day week commitment to patient care.

It must be admitted that if the present patients/consumers interviewed in chapter five are a guide as to the future there is no possibility that policy promoting an interventionist primary level medical professional will succeed. It would only succeed if primary level medical practitioners can demonstrate a benefit to the process, and this can only occur if they, in their turn, have an incentive to do so.

Such an ‘incentive’ is referred to in chapter six. That chapter discussed the funding of general practitioners to purchase healthcare for their patients with the idea that this would galvanize hospitals to improve healthcare standards in a market environment. However the end-points of healthcare standards then and now are made the quantity of healthcare services, e.g. waiting times for surgical procedures, rather than their quality. The York Centre for Health Economics published data suggesting that fund holding might have led some patients to avoid surgery and institutional healthcare (Dusheiko et al., 2003). However, this might have been seen as being motivated by a perceived doctor’s self-interest, i.e. the doctor ‘saving’ monies allocated to patient
care, that affected patient satisfaction (Dusheiko et al., 2004); if so, fund holding would affect the trust necessary for success in a more intrusive role.

However in the interviews with ‘Colin’ in chapter six some influence on the quality of hospital care was revealed. He and his research worker had followed patients through the system of their local hospital to demonstrate defects of management and care programs. In terms of this thesis could not all patients act as their own quality surveyors with reporting mechanisms to their own doctors? The problem is that patients would have to anticipate a benefit from so doing.

It is apparent from the interviews in chapter six that, given access and time, some general practitioners could provide the sort of reassurance, review and intervention that would support the hypothesis. They aspire to a renaissance of general medical practice in which their “ten year trained experience”, to quote one participant, contributes to significant professional wisdom and knowledge that both improves the healthcare system and provides a more rewarding career for themselves (Coote, 2003).

A position as a physician/general practitioner equips them to deal with specialists on a more than equal professional footing. They can insist on a place in all plans for the care of their patients, and not only on ‘discharge planning’ when the problem for the hospital is to clear the hospital bed for the next patient while avoiding re-admission from a too early return to the community.
It is possible that the public, the present or future patients of the healthcare system, need to be told that in a personalised healthcare system they have a right to inform their ‘personal’ doctor of their concerns with their institutional care. If this hypothesis is valid, and the process of an intrusive primary care professional becomes of value to patient care, then hospitals might see an advantage to informing patients of their rights in this matter.

Patients are already informed of a responsibility to ensure their own safety (Office of Safety and Quality in Health Care, 2003). In that publication from the Department of Health in Western Australia, taken from the Australian Council of Safety and Quality in Health Care, patients are told of 10 tips including, to ‘be involved’, to ask questions, and to talk to their doctor about options for treatment. They are however told little about what to do if they are concerned about their care.

Hospitals in the late 1990s following, but not necessarily in consequence of, the disclosures of substandard care revealed in chapter one, have created whole departments dealing with patient disquiet and dissatisfaction similar to complaints departments in retail stores and services. The staffs are, however, employed by the hospital and, over time, and, despite the best of intentions, they will identify with the other employees of the hospital. These departments should, in appropriate circumstances, act as links between patients, their GPs, and hospital clinical staff.

It is evident from the meetings and interviews carried out in this research that, in bridging the gap between primary and institutional healthcare, the major problems will
be those of entrenched attitudes, not only those of professionals but of the public, that will take time to resolve. The advantage of time is the opportunity to develop technology to help processes of change. In this context that technology may well be telecommunications involving face-to-face encounters that will obviate the need for personal visits by patients’ ‘personal’ clinicians.

However many GPs are content with their present position dealing with both preventive healthcare and also a heavy workload of problems that individually may not be too demanding. The current GP workforce is insufficient to meet present and future expectations (Australian Institute of Health and Welfare 2, 2004) and the prospect is for the increasing use of practice nurses, then nurse practitioners and medical assistants (Harris and Mercer, 2001, Australian GP Statistics and Classification Centre, 2006). If, as was stated by some participants in the interviews in chapter seven, many tasks in primary healthcare can be managed by non-medical clinicians then the expectations of those medically trained will change. However most general practitioners interviewed supported only limited functions for practice nurses and did not support nurse practitioners, and the Professor of General Medical Practice from Edinburgh warned of further marginalisation of general practice from the employment of nurse practitioners (Weller, 2006).

In summary it is unlikely that the sort of doctor-patient relationship that could influence healthcare services will occur without concomitant change in general medical practice in Australia. While some general practitioners could offer and
welcome a superior professional service, a fee-for-service system that rewards the volume of patient contacts and turnover does not encourage such change.

8.4 A Future of General Medical Practice

The experienced GPs interviewed in chapter seven could be unequally separated into those more or less content with their present professional position and those that envisage a more demanding future for primary level practitioners. Some saw themselves as team leaders in patient care, some as taking on a semi-specialised role within general practice teams, and others aspiring to become recognised as yet-to-be-defined senior physician/general practitioners. This is consistent with the opinion of one participant that multiple expectations of general practice would reflect the very varied abilities, insights and understandings of general practitioners.

However it is with those GPs content with a very busy but professionally undemanding future that concern must be felt. They are those that Marshall Marinker sees as becoming outmoded with first contact healthcare developing as a non-medical clinical profession (Marinker, 1995, Marinker and Peckham, 1998). Marinker is also not alone in anticipating a new type of general medical practitioner (Kamien, 2002, Tudor Hart, 1988), one evolving, not in conflict with, but in cooperation with, nurse practitioners (Philips et al., 2002). In such a conjectural future the need for increased numbers of general medical practitioners would decrease; and medical practitioners become part of a second tier of primary cum secondary level care. Moreover the inheritance of the primary level doctor-patient relationship might be shared between
nurse practitioners embedded within the community with small numbers of patients, as for general medical practitioners in present day Cuba (Speigel and Yassi, 2004), and medically qualified general practitioners located in major centres.

This future has, however, no support from the research carried out in this thesis. All patients/consumers saw themselves as short-changed by first-contact nurse practitioners, and most general medical practitioners interviewed considered a nursing education as inadequate for front line clinical roles. Nevertheless with ‘role substitution’ becoming a present topic in Australia at professional and at government level (Van Der Weyden, 2006, Brooks and Ellis, 2006, Australian Government Productivity Commission, 2005a) there may be a degree of inevitability involved. Patients and their doctors may gradually accept and then find change welcome but, as Van Der Weyden (2006) makes plain, change there will be.

Currently practice nurses are funded by practices, with subsidies paid for immunisation and wound care from the Government funded Health Insurance Commission (Health Insurance Commission, 2007). Practice nurses feature, however, in only 3.9% of general practice encounters (Australian GP Statistics and Classification Centre, 2006). To anticipate additional activity and the employment of nurse practitioners would entail a profound change in the way general medical practice is funded in a subsidised fee-for-service system. The Australian Healthcare Agreements have however included multiple funding initiatives for the supervision and organisation of coordinated chronic healthcare (Commonwealth Government of Australia, 2003) that are now included in the Medical Benefits Schedule. There exists
therefore precedence for remuneration that does not involve one-on-one fee-for-service.

The meta-analysis quoted in the last chapter, favorably comparing nurse practitioners and GPs (Horrocks et al., 2002), noted that the settings for both could be different with nurses working as members of teams including GPs, and generally dealing with minor medical problems. Moreover the important problem of the non-recognition of serious disease masquerading in ‘simple’ complaints was recognised by that review as requiring large numbers within studies to be revealed. At this stage it would be difficult to anticipate independent nurse practitioners in primary care except in remote and distant areas. Nevertheless semi-independent nurse practitioners working within general medical practice, but not necessarily on-site, would be possible. The other prospect is of community based nurse practitioners working under district hospital supervision for the on-going care of chronic illness, post operative and post maternity delivery care. This is a situation for many patients leaving Australian hospitals; a situation presently constrained by public hospital finance budgeted at a State level but linked with general medical practitioner services and aged care services financed from a Federal budget.

This peculiarity of federal/state funding in Australia is amenable to change illustrated by the joint funding of home and community services for the provision of home care for the aged and disabled (Department of Health, 2006). However the inclusion of medical services would involve more profound political change.
Nevertheless a primary and secondary healthcare system based on a community level economic model as in Sweden (Swedish Institute, 2003), and purchasing tertiary level high technology healthcare from federally funded institutions, might enable a future including a clinician-patient social contract as envisaged in this thesis. In such a future a responsible general practitioner would be able to communicate his or her obligations and credibility via telecommunication networks to wherever, and to whomsoever, his or her patients have been sent.

8.5 Healthcare and Sustainability

It becomes possible to anticipate a more mature relationship between patients and their doctors: patients accepting that their doctors cannot be all things at all times, and personally committed doctors accepting that they have a duty of care that does not stop at the hospital entrance. However the degree to which personally committed general practitioners and their patients can influence the sustainability of healthcare and also have an effect on general sustainability, is open to debate.

The public holds in high esteem those who sacrifice themselves for high ideals, or for the wellbeing of their family and friends; the memorials of history are replete with the forfeiture of youth for misbegotten patriotism. However people are not going to relinquish health and longevity to benefit the economy, social wellbeing or the environment. People will donate funds to those less fortunate, some will donate time and effort, some will devote their life’s work, but very few if any will donate years of their lives to concepts of sustainability. However when the benefits of healthcare
technology become questionable, when cheaper alternatives become available, they might trust a relationship based on proven trust to make decisions that advance sustainability.

This was the theme of chapter four in which it is argued that some investigative medical technology need not be performed, that some medical procedures may not be beneficial, and that some lives are needlessly and heedlessly prolonged. However restraints placed on the use of technology by for example waiting lists, access criteria (Peckham, 1998), and funding limitations (Callahan, 1990, Fuchs, 1999) will always face problems of inequitable access as those with finance purchase healthcare. Moreover blanket schemes need appeal mechanisms to deal with individual need. Hence the need for equipped and trusted primary care doctors to advocate in concert with their patients to promote their patient’s interests.

It is pertinent that the ‘Requirements’ of the Fellowship of the Australian College of General Practitioners notes in its program for a doctor-patient relationship the need to advocate for the patient “where appropriate” (Royal Australian College of General Practitioners, 2005). Further, in the same publication, addressing ‘minimal skills for a Professional Role’, the College notes “advocacy as appropriate”. The reluctance to specify that which is appropriate might be interpreted as being unwilling to risk exposure to professional and political censure. Hence this thesis is more than a critique of professional mores but notes the need for public support for professional change in deciding the degree of appropriateness in advocacy that is adequate and proper. Implicit in much of this discussion is a need for public trust in doctors and the
medical profession. However it is also pertinent to question what it is that the profession can expect from society.

The evolution of the medical profession from paternalism (Van Der Weyden, 2006) and quasi-ecclesiastical reverence (Clark, 2002) is acknowledged. The profession maintains public regard (MORI, 2002) but only in regard to its area of excellence. The question in chapter five concerning an Iranian/Australian female teenager accused of assault generated much irritation when it was suggested that doctors possessed social responsibilities; that they might have a position of influence within society. This was strongly denied as hearkening back to, or referring to, more primitive societies. If those consumers are to be believed the influence of the medical profession on non-medical matters can only be exerted through a clinical relationship. Organised medicine might well support the principles of sustainability (Kluger, 2004), and point to the population health consequences of non-sustainable industrial practice (McMichael (Editorial), 2001, McMichael, 2002), but the healthcare consequences of sustainable practice that affect economic well being may have to be argued at an individual clinical level. We cannot all have the entire healthcare we think we might need now or into the future. Sustainability means addressing the inequity demonstrated in figure 3.1 on the healthcare of indigenous Australians before investing in an unlikely scenario of a cheap cure for all ills (Schwartz, 1999). It means embracing the ‘secular wager’ of a productive life before longevity (McQueen, 2003).

A mature relationship between a reciprocally supportive primary healthcare profession and society may well enable a healthcare system honouring social sensitivity,
prudence and equitability more than the relentless unsustainable pursuit of a life burdened with the inevitability of mortality (Allert et al., 1996). This thesis has shown that at this stage such an ideal will not be realised. It must be concluded that other measures must be taken to enable such changes in the profession and in society.

8.6 Unanswered Questions

This thesis has posed some basic questions:

1) Is the medical profession to remain the sole arbiter of professional structure and standards, or accept the necessity to be sensitive to the needs of a changing society?

2) Is the profession to be concerned with the increasing cost of healthcare and its affect on economic wellbeing?

3) In its turn, is the public to demand access to increasingly expensive high technology healthcare while accepting that its cost may be felt in other areas of human need; and in a contribution to unsustainable economic activity?

4) Other than the ballot box, is the public to be able to influence decisions on healthcare made by institutions, governments and professional organisations?

The answers to these questions involve matters of public policy but in this thesis I have concentrated analysis onto the doctor-patient relationship at a primary healthcare level. I have claimed that decisions made at that level could influence profound questions concerning both professional values and accountability, and also economic sustainability. At that level however this research has raised questions about the soundness of the doctor-patient relationship. I have claimed that were primary level
medical practitioners to insist on a greater involvement in the care of their institutionalised patients this would act to promote a reciprocally supportive relationship and eventually encourage better and more sustainable healthcare. The question is how this can be proven.

It must be accepted that to promote an intrusive general medical practitioner, at an individual and personal level, into high technology healthcare will be impossible without structural changes to general medical practice that will take many years to be created. However an insistent practitioner, insistent on behalf of patients to whom he, or she, feels responsible, could be managed within the present professional structures and with present communications technology. It remains to convince patients to use the influences of their general medical practitioner to a proper participation in their overall care so that, if and when necessary, those general medical practitioners can mediate that care.

The ’10 tips for safer healthcare’, already referred to above (Office of Safety and Quality in Health Care, 2003), acknowledge the risk of error, and promote patient involvement to reduce risk. It might be considered that those ‘tips’ could be augmented by suggestions that patients might contact their own doctor,

if - hospital staff do not supply the investigations and treatment that their GP might have told them to expect,

or - if they are concerned with how their care is being provided,

or - if they wish for help in making decisions,

or - if they wish for reassurance from a doctor that they know.
Both local general practitioners and hospitals would be informed of the program. Moreover ‘participating’ general practitioners would inform patients of their willingness to be involved. It is anticipated that hospital management and professional staffs would see an advantage to involvement of primary care medical professionals as mediators of healthcare. However if a ‘trial’ in one geographical area were considered it might be necessary to supply support staff over a prolonged time to change behaviour patterns with a risk of confounding variables developing over the same time period.

Much of this program is already anticipated by the Health Insurance Commission’s use of incentive payments for GPs to become involved in ongoing care of patients discharged from hospitals (Health Insurance Commission, 2007 MBS number 749, 757-773). These items refer to claims for government funding for attending community case conferences on the discharge and ongoing care of patients. Technology involved in bridging the gap between levels of healthcare is anticipated by the Australian Medical Association’s List of suggested fees concerning ‘Telehealth’ (Australian Medical Association, 2005 p. 29-31).

The remaining problems would be those of outcome measures. If an outcome was to be the frequency with which GPs were contacted it would be necessary to ask GPs and patients to divulge those details, i.e. that GPs were being contacted, a possibly invasive request. There might also be a response to those contacts; i.e. an enquiry
made to hospital clinicians by the general practitioner. There would have to be a measure of that activity.

However measures of contacts made would be complicated by the obvious hoped-for change in hospital staff behaviour. Any reduced contacts could be because of diminished expectations that general practitioners can make a difference, or because hospital care standards have improved making contact less necessary. Moreover there would be a distinct risk of over-expectation of the influence of general medical practitioners, and of the type of exploitation of the GP-patient relationship noted as possible in chapter seven.

Measures of contacts made would have to be supplemented by some qualitative assessment of the nature of those contacts. Finally some measure of the impact of this augmented general practice activity on patients, general practitioners, and hospital staff, both in terms of the time taken and also of degrees of resolution obtained, would have to be determined.

However it would remain difficult to demonstrate an effect of a different doctor-patient relationship at a primary healthcare level on the rates of error or their consequences within hospitals. Determining a measurable effect on restraining the costs of healthcare would be impossible.

Hence the expectations of general practitioners as advocates for their patients cannot be determined as a scientific variable, to be raised or lowered by policy decisions, but
become a rights issue. People have a right to expect that their personal doctor is willing and able to mediate their access to high technology healthcare in their interests, while equipped with access to information as to what those interests would be. ‘Fred’ Lord Dainton certainly expected no less (Dainton, 1990). Moreover general practitioner/physicians might consider that they have a right to be involved in their patients’ care.

8.7 Conclusion

In the second chapter I detailed mistakes made in hospital care with the assertion that a distorted medical professional culture was in part responsible both for the frequency of error and for the reaction to revelations of error. That chapter laid the groundwork for the hypothesis raised in chapter one, that change in the structure of medical professionalism and the primary level doctor-patient relationship should be explored as a means to remedy endemic error rates in healthcare institutions. In the third chapter I criticised the reliance placed on clinical governance and managerial methods to challenge professional culture and, using the concept of complex adaptive systems, suggested that a mutually supportive relationship between patients and their primary level healthcare practitioners could contribute to better healthcare. I used the Report of the Inquiry into King Edward Memorial Hospital in Perth, Western Australia, and other revelations of impaired healthcare standards, to illustrate these arguments.

In chapter four I explored the concept that a close trusting relationship between patients and their primary level general medical practitioner could influence the use of
medical technology; a use that is contributing to an unsustainable increase in healthcare costs. I argued that an unrestrained and inappropriate use of progressively more expensive medical technology will limit expenditure on other areas of human need; and act to encourage wealth creation that is increasingly dependent on unsustainable human activity. The claims of present and future health effects from the consequences of climate change and industrial and agricultural activity are widespread; but that the industrial complex of healthcare could itself contribute to those changes is a novel and provocative concept. Moreover governments, forced to face evidence of emission induced climate change, will adopt policies promoting sustainable development involving risks of economic downturn and a need for budgetary restraint (Stern, 2006). The capacity to support ever increasing healthcare costs will be affected.

I have noted the need to determine priorities of healthcare expenditure that will be dependent on local level support and the integrity of that community connectedness termed social capital. A close relationship between people and their personal primary level medical practitioner was argued as consistent with themes of social capital claimed as threatened by social changes in the latter decade of the twentieth century. A restoration of social capital is part of the promotion of community level activity aimed at encouraging general sustainability.

The research involved in this thesis was directed to enquiry into the present and future prospects of the doctor-patient relationship at a primary healthcare level. It was argued that without some reassurance that this relationship was well founded much of
the aspirations for better and more sustainable healthcare will be unrealised. This research was directed to determining attitudes of participants to relationships and situations and, as such, better managed by qualitative research methods. One of the benefits of these research methods is the ability to raise issues and concepts that can direct later enquiry by both quantitative and qualitative methods.

In chapter five focus groups of people on the registry of the Health Consumers Council in Western Australia were presented with hypothetical situations illustrating aspects of a continuing doctor-patient relationship. I found surprisingly reluctant support by these groups for continuity of care by general practitioners, and especially if visits to GPs entail a co-payment in excess of that returned to patients from government subsidy; ‘surprisingly’ because, just as the general practitioners questioned in chapter seven, I had assumed that close long-term relationships were the defining characteristic of community level medical care. This finding raises doubts about the doctor-patient relationship considered vital to medical professionalism and challenges the basic assumption of this thesis that patients supported by their doctors would contribute to the safety and sustainability of healthcare.

Focus group research revealed that there was little understanding and no support for the concept that GPs had a continuing duty-of-care when patients became referred to specialist medical practitioners and to hospitals. There was little understanding that primary level care clinicians can, or should, develop a relationship with their patients that extend beyond past and present medical matters. The relationship between general practitioners and the public has become an intermittent technological contract.
In the United Kingdom general medical practitioners have a registered relationship with their patients, and in 1991 were empowered to purchase services from hospitals on behalf of those patients. In chapter six I explored the idea that this could have augmented an advocacy role by general practitioners. However a search of current literature failed to produce evidence of such a role and I undertook to inquire from medical colleagues and their financial advisers if any activity of this kind had occurred at local levels. There was some suggestion that one general practitioner had been able to influence standards of care in his local hospital but this did not extend to individual patient care. It was evident that United Kingdom GPs had acquired increased status as a result of this purchasing role but little or no evidence that this had increased institutional standards of care; or was expected to do so.

This large-scale fund-holding experiment has been replicated in some degree in other countries including, with the funding of trials of chronic disease management, in Australia. Those trials, while hoping to provide evidence of benefit from pooled financial resources, were bedeviled by methodological issues and at this stage results are inconclusive.

In continuing the research into the primary level doctor-patient relationship, and its ability to influence healthcare at other levels, semi-structured interviews were carried out with selected general practitioners in Metropolitan Perth in Western Australia. Again and for similar reasons resort was made to qualitative research methods.
The conversations with Australian general medical practitioners were contained in chapter seven. I concluded from these conversations that the gap between healthcare provision at primary level and that at hospital level was being bridged by greater emphasis on information transfer. However general practitioners were not expected to contribute to the care of their patients once they were the responsibility of the hospital and the hospital clinical staff. Some general practitioners had found that patients had occasionally expressed anxiety and disapproval with hospital care but had found no avenue to express their concern, a concern that may or may not have been well founded but needed resolution. There was little or no expectation that their personal primary level clinician could or should influence hospital care.

The aspiration of some general practitioners for recognition of knowledge and experience developed over many years to a position of equality with hospital based specialists will be increasingly acknowledged. This thesis develops the hypothesis that if these doctors were able to demonstrate a supportive role for their patients in dealing with hospital based healthcare this could act as a catalyst for a re-invigorated doctor-patient relationship. The trust so developed could affect the rate of error in hospitals and the inappropriate, expensive and non-sustainable use of healthcare technology.

This research performed to support the thesis has found that the primary level doctor-patient relationship in Perth, Western Australia is not at present sufficiently robust to support an intrusive role for community level doctors. If the argument holds that such a relationship will be important for the safety and sustainability of healthcare services
then action will be necessary to sustain and invigorate the relationship and enable a
renaissance of community level general medical practice. At present the numbers of
general medical practitioners are to increase as the numbers of medical student places
in Australian universities grows. The further policy options raised by this thesis are:

1) To create a professional structure at general practice level by the recognition of a
   senior general practitioner/physician
2) To create a professional structure option by recognition of a general
   practitioner/general practice clinical coordinator.

It would be up to the Royal Australian College of General Practitioners how their
Fellowship Requirements would be extended to incorporate these special categories.

Simultaneous with the creation of a re-invigorated general medical practitioner
research into the passage of patients through the Western Australian healthcare system
modeled on the Swedish ‘Esther Project’ should be replicated (Institute for Health
Care Improvement, 2006a). This research will necessarily reveal complications of
modeling based on basic differences in healthcare systems. Nevertheless the essential
concept of a system related to the needs of different patients, and not that of service
providers with outmoded professional values, must be established.
Appendix

1) Information supplied to general medical practitioners before consent to interview (Chapter seven)

Nature of Questions for Discussion on a Closer Relationship between General Medical Practitioners and Tertiary Level Hospitals

The importance of any divide between primary and secondary/tertiary level health care.
Any problems that such a division can cause
How might the ‘divide’ be ‘bridged’ e.g. electronically or personally?
To what degree can patients use general practitioners to cope with problems occurring in a hospital setting?
Given the other demands on general practice what priority would a closer relationship between hospitals and general practitioners have?
The importance of ‘continuity of care’ to a) your patients and b) yourself
The optimal patient – general practitioner ratio for a) patient care and b) professional well being.
How well are GPs equipped to handle planning for end-of-life issues?

2) Questions introducing topics for semi-structured interviews with General Medical Practitioners (Chapter Seven)

Questions to General Practitioners

It is generally believed that the separation of community level general medical practice and hospital care is an area of disadvantage to patient care. My particular concern is how this affects patient care within hospitals. This series of questions serve to enable discussion on if, and how, general practitioners feel this gap should be bridged. It must be emphasised that this is NOT a survey.
Importance (of the ‘divide’ between primary and secondary/tertiary level healthcare)

Is this ‘divide’ of minimal, some, or great importance?

What problems, if any, do you believe any ‘divide’ causes?

Could you discuss the importance you would place on the following matters:

Patient carried ‘smart’ cards containing their medical history.

Day-of-discharge electronic communication

Availability and readiness of general practitioners to answer queries from hospital medical staff

Availability and readiness of general practitioners to answer queries from patients under the care of hospital medical staff

Availability and readiness of general practitioners to attend patients in hospital concerned with their hospital care

Availability and readiness of general practice staff to attend patients concerned by their hospital care

Availability and readiness of hospital medical staff to answer queries from general practitioners

Availability and readiness of hospital specialists to answer queries from general practitioners

Somethings got to give

General practitioners are being asked to do more in many aspects of health care. It is generally agreed that there are insufficient numbers of general practitioners to service present needs. What areas of general medical practice do you believe could be managed by supervised clinically qualified non-medical staff?
What aspects of primary preventive health care do you consider require medical training and education?

How would you wish to see the future direction of general medical practitioners?

**Continuity of Care**

Defined by a relationship over time in which a GP has knowledge of more than a patient’s medical history, i.e. social and psychological well being.

Do you believe patients are aware of ‘continuity of care’?

Do you think patients place minimal, some, or great importance in continuity of care?

How would you think patients would prioritise continuity of care, i.e. versus costs, convenience, availability, waiting times?

Do you place minimal, some, or great importance in continuity of care?

What aspects of ‘continuity’ could not be replaced by ‘smart’ cards with access to full medical history?

Would there be any benefit to incentives promoting the registration of patients with chosen general practitioners?

A patient admitted to a public hospital has minimal opportunity to acquire continuity of care. Does this matter?

**Trust in Doctors**

Generally GPs Specialists

Has this declined? Does it matter? i.e. patients may be better not to trust too much.

Or patients need to trust someone to enable proper care

**Patient – general practitioner numbers**

In terms of patient care what would be an optimal GP – patient ratio

In terms of lifestyle, present remuneration, work satisfaction and patient care what would be an optimal GP – patient ratio

**End-of-Life Care**

How well are GPs equipped to handle planning for end-of-life issues?
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