

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

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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.

## Contents

### Preface

<i>A Tertiary Level Medical Professional Reflects on the Quality of Hospital Based Healthcare</i>	<b>Page 1</b>
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### Chapter One

<i>Medical Professional Structure and the Patient: Hypothesis and Research Questions Research Methodology</i>	<b>Page 21</b>
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### Chapter Two

<i>Error in High Technology Health Care The Profession of Medicine Case-Study of King Edward Memorial Hospital Impaired Care in Other Health Care Institutions</i>	<b>Page 29</b>
2.1 Introduction	page 29
2.2 Medical Professionalism	page 37
2.3 Report of the Inquiry into King Edward Memorial Hospital	page 42
2.4 Other 'Scandals' of Hospital Care	page 75
2.5 Summary and Conclusions	page 85

## **Chapter Three**

### ***Present Responses to Errors in Health Care Services:***

#### ***Clinical Governance: The Concept of Community Level Involvement in High***

<b><i>Technology Health Care</i></b>	<b>Page 89</b>
3.1 Introduction	page 89
3.2 Recommendations from the Inquiry into King Edward Memorial Hospital	page 96
3.3 Medical Professionalism Charter	page 100
3.4 Continuing Professional Development	page 103
3.5 Audit	page 104
3.6 Managerialism	page 109
3.7 Complex Adaptive Systems	page 113
3.8 Difficulties with an Intrusive General Practice	page 117
3.9 Summary and Conclusions	page 122

## **Chapter Four**

### ***Hospitals, the Sustainability of Healthcare***

#### ***and the Social Capital of a Doctor-patient Relationship***

4.1 Introduction	page 125
4.2 Sustainability and Social Capital	page 129
4.3 The Non-Sustainability of Healthcare Services	page 134
4.4 Healthcare Technology: Restraining the Unsustainable	page 150
4.5 V O M I T and 'Excessive' Healthcare Technology	page 154
4.6 Healthcare Technology and a Doctor-Patient Relationship	page 159
4.7 Summary and Conclusions	page 165



## **Chapter Five**

### ***Research into the Relationship of Western Australian Health Care Consumers with their Medical Practitioners:***

#### ***The Possibilities of a Contribution to Safer and Sustainable Medical Technology***

**Page 167**

5.1 Introduction	page 167
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 Methods (Forum Discussion)	page 171
5.2.2 Results	page 177
5.4 Discussion and Conclusions	page 187

## **Chapter Six**

### ***Experiments in the Empowerment of General Medical Practice***

**Page 193**

6.1 Introduction	page 193
6.2 The British National Health Service 1990-1999	page 197
6.2.1 Introduction	
6.2.2 The Impact of General Practice Fund Holding on Hospitals	page 200
6.2.3 Conversations with Fund Holding General Practitioners and Their Financial Advisers	page 202
6.3 The Empowerment of General Medical Practitioners in Other Nations	page 205
6.3.1 Sweden	page 210
6.3.2 United States	page 212
6.3.3 Australia and New Zealand	page 215
6.3.4 Cuba	page 217
5.4 Conclusions	page 220

## **Chapter Seven**

### *The Value of Continuity in Care*

<i>Conversations with Western Australian General Practitioners</i>	<b>Page 225</b>
7.1 Introduction	page 225
7.2 Methodology for Semi-structured Interviews with General Medical Practitioners	page 228
7.3 Results	page 232
7.4 Discussion	page 260
7.4.1 General Practitioners, Patients and Hospitals	page 260
7.4.2 The Lack of Clarity and Consistency in Continuity of Care	page 263
7.4.3 The 'Fragmentation' of Healthcare	page 270
7.4.4 Trust in Doctors and Hospitals	page 272
7.4.5 Workforce Issues in General medical Practice	page 276
7.5 Conclusion	page 280

## **Chapter Eight**

<i>Resolution and Conclusions</i>	<b>Page 283</b>
8.1 Introduction	page 283
8.2 'Personalised' Patient Care	page 285
8.3 Error in Hospitals	page 292
8.4 A Future General Medical Practice	page 302
8.5 Healthcare and Sustainability	page 305
8.6 Unanswered Questions	page 308
8.7 Conclusion	page 312

*Appendix*

**Page 319**

*References*

**Page 323**

### **Acronyms**

**A I M S** Accident and Incident Monitoring System

**A M A** Australian Medical Association

**A M W A C** Australian Medical Workforce Advisory Committee

**B M A** British Medical Association

**B M J** British Medical Journal

**C A M** Complementary and Alternative Medicine

**C M A J** Canadian Medical Association Journal

**C S A** Clinical Staff Association (at KEMH)

**G C C T** General Coordinated Care Trials (of chronic disease care in Australia)

**G D P** Gross Domestic Product

**G P** General Practitioner

**G P F H** General Practitioner Fund Holding (in the United Kingdom)

**H M O** Health Maintenance Organisation

**I V F** In-Vitro Fertilisation

**J A M A** Journal of the American Medical Association

**K E M H** King Edward Memorial Hospital

**L O S** 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.

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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 consumers<sup>1</sup>, 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

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<sup>1</sup> '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<sup>2</sup> 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

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<sup>2</sup>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<sup>3</sup>.

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.

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<sup>3</sup> 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<sup>4</sup>, level hospitals.

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<sup>4</sup> 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.

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 hesitatingly 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.