Reconstructing Medical Practice
This book is dedicated to my father, Peter Jorm, who has inspired me to seek challenges throughout my life and supported me when this sometimes proved tough.
Reconstructing Medical Practice

Engagement, Professionalism and Critical Relationships in Health Care

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# List of Abbreviations

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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACTH</td>
<td>adrenocorticotropic hormone</td>
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<td>AHS</td>
<td>Area Health Service</td>
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<td>EBM</td>
<td>evidence-based medicine</td>
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<td>GDP</td>
<td>gross domestic product</td>
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<td>GP</td>
<td>general practitioner</td>
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<td>HSC</td>
<td>Higher School Certificate</td>
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<td>IOM</td>
<td>Institute of Medicine</td>
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<td>M&amp;M</td>
<td>morbidity and mortality</td>
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<td>MD</td>
<td>Doctor of Medicine</td>
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<td>MDO</td>
<td>medical defence organization</td>
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<td>MJA</td>
<td><em>Medical Journal of Australia</em></td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NSW</td>
<td>New South Wales</td>
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<td>OCB</td>
<td>organizational citizenship behaviour</td>
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<td>PhD</td>
<td>Doctor of Philosophy</td>
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<td>RCA</td>
<td>root cause analysis</td>
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<td>RCT</td>
<td>randomized controlled trial</td>
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<td>RMO</td>
<td>Resident Medical Officer</td>
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<td>TQM</td>
<td>total quality management</td>
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<td>US</td>
<td>United States</td>
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<td>VMO</td>
<td>Visiting Medical Officer</td>
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Reflecting on the Possibility of Change

And one has to reflect that there is nothing more difficult to handle nor more doubtful of success nor more dangerous to conduct than to make oneself the leader in introducing a new order of things. For the man who introduces it has for enemies all those who do well out of the old order and has lukewarm supporters in all those who do well out of the new order. This lukewarmness arises partly from fear of their adversaries who have the laws on their side and partly from the incredulity of mankind who do not put their trust in changes if they do not see them in actual practice. Thus it arises that whenever those who are enemies have the opportunity to go on the attack they do so forcefully and the others put up a lukewarm defence, so putting themselves and their cause at risk at the same time. (Machiavelli [1469–1527])

I don’t think we’re going to address the problems in our health system because it requires an entire change of philosophy and that’s pretty difficult to do when you have senior consultants doing it this way for twenty or thirty or forty years. To say anything you’ve done is wrong or you’re not going to do it that way anymore isn’t going to be tolerated. (Anaesthetist, Sydney, 2005)

Introduction

This book is about anomie in the hospital system – how medical specialist doctors feel alienated from the system in which they play a central, even the central, role. It seeks to investigate this anomie by examining how they see the health system and their place in it, why they remain in medicine and why they are limited in their ability to lead change in the current system. It also suggests remedies.

This book provides an insight into collegiality; into the collusion that has its origin in professional survival. The organizational change that has resulted in loneliness and isolation is described. Loss of shared identity and the values and behaviours associated with professional identity add dangers to patient care that cannot be replaced by surveillance and rules. Regulation and professionalism make a poor fit, especially when the management of such regulation is primitive and poorly resourced. Finally, the crucial social aspect of organizational life is highlighted.
Public Perception of Doctors

Health, illness and health care are relevant to all. We each carry with us a myriad of preconceptions about medical practice and the role of doctors. Some come from our own experiences and some from those of others. We also have medical soap operas competing with hospital documentaries – at least one for every night of the week. Television offers us tours inside our very blood vessels. Our screens are filled with images of rare diseases, difficult decisions, blood and tears. Salvation is offered in the guise of in-vitro fertilization, cancer cures or, most bizarrely, ‘extreme makeovers’, where creepy plastic surgeons correct nature’s blemishes or the effects of normal ageing. Doctors should be heroes, should be saviours. We ‘know’ this and our popular culture reflects this belief.

At the same time, politicians and the media provide a veritable cacophony of commentary on the healthcare deal being offered to citizens by governments. Our hospitals are always ‘in crisis’. Waiting lists and times are bread and butter for election campaigns. The hospital front door (the emergency department) is especially scrutinized, providing a statistician’s dream with a plethora of elaborately coded triage categories and waiting times.

We measure how long the patients waited, but our measures rarely touch the substance of the care actually given. Were the patients seen by someone with the right set of skills and knowledge? Did they deliver the care the patients needed? How was the experience for the patients? Politicians and policy makers are left struggling to meet ever-rising public expectations.

While the Australian healthcare model provides substantial but inconsistent government subsidization, it also provides far less government control than most taxpayers think. Australian geography itself poses formidable challenges for health care. Patient expectations derived from television viewing simply cannot be met in a small town.

Doctors are often portrayed by the media as recalcitrant and greedy and sometimes careless. Doctors hold the major professional responsibility for keeping patients safe, yet patients frequently suffer preventable harm during health care. The voices of the betrayed, wronged and disappointed illustrate every story of safety failure.

Background

I am a specialist who moved from clinical practice into organizational roles established to improve the safety and quality of health care. The safety and quality movement has drawn attention to the enormous amount of preventable harm that occurs during health care. Most doctors with whom I worked were dedicated to the welfare of their patients, yet were resistant to changes designed to improve clinical outcomes. I needed to understand why they acted as they did. Some of the material in this book came from a study I conducted in 2005 of specialist medical practitioners at two public teaching hospitals in Sydney, New South Wales (NSW) (Jorm 2006). The organizational and healthcare literature referenced is from the US, Scandinavia and especially the UK.

Study results confirmed the existence of a distinct gap between doctors’ care for their patients and their lack of involvement in broader patient safety and quality issues. For their own patients, the doctors were prepared to make every possible effort and
they accepted the detrimental effect this had on their lives and those of their families. Although doctors cared deeply about their patients, they were reluctant to act to increase safety in the health system overall.

For any doctor, speaking or acting to control the behaviour of a colleague is extremely difficult. Maintaining friendly professional bonds with other doctors was considered crucial for patient care. Colleagues are seen as needed for both emotional support and practical assistance.

Disturbing features of change in the medical profession are shown to be present – established practitioners are no longer sure what to recommend to their trainees about how to think and act.

How Did I Come to Write this Book?

My position as a senior specialist medical practitioner and my shared experiences with colleagues gave me insights not normally shared with ‘outsiders’. I was a trusted ‘insider’, therefore some biographical background may assist the reader.

LIFE AS A YOUNG DOCTOR

I became a doctor for conventional reasons. My father made much of the importance for a woman to belong to a profession that provided economic independence. I was an altruistic teenager and the academic challenge of medicine was also appealing as, like most of my interview subjects, I am a competitor.

My second term as an intern was in orthopaedics. As well as being a memorable introduction to the operating theatre, it was my introduction to the loneliness of old age. Hardly anybody came to visit ‘my’ patients and I would find myself sitting by an old lady’s bedside at 10pm because she would not let go of my hand. Some of the older patients would try to lure staff like me into the closer contact they craved by offering gifts of sweets (at the ready in their bedside lockers). The hordes of visitors admiring babies in the maternity ward I compared unfavourably with the paucity of visitors to my elderly patients.

At the same time I was barely coping with the new requirements of my job, learning the vast numbers of unwritten routines, and trying to avoid major trouble and major errors.

I could not continue to work this way: survival required greater detachment, and a finer focus on what I had to do and what I could do for patients. I also needed to choose a specialty where disengagement from the patients’ lives and problems was easier. It has been suggested that:

*The socialisation process that occurs during medical training conflicts with and tends to diminish many of the attributes and values usually associated with good doctoring – for example compassion, reflectivity, curiosity, altruism, self-effacement, and social responsibility.*

(Coulehan et al. 2003)

My realization that I needed to circumscribe my involvement was not due to the development of cynicism, nor of diminished compassion. I had simply come to
understand that the provision of clean pyjamas and good company is a job for friends and family and not for medical staff.

Of course, it was not all doom and gloom. I remember caring for one elderly man for several days, putting an intravenous line in, giving the first dose of antibiotics and so on. He was charming and I was professional. I also fancied myself as rather spruce in my white coat, identity badge and with an expensive stethoscope around the neck at all times. When I visited him with the consultant surgeon on a ward round, the patient’s wife was seated beside his bed. ‘Marjorie,’ he said, indicating the surgeon, ‘this is Doctor X’. He then paused and gestured at me, ‘And his lovely wife’.

**LEARNING TO BE AN ANAESTHETIST**

Doing an anaesthetic term I experienced both mentorship from some extraordinary women consultants and the thrill of actions that were directly reflected in patient outcomes. We were responsible for their physiology and it was exciting! I decided on anaesthesia as a specialization. Becoming an anaesthetist involved learning a physical and emotional stoicism analogous to the process described as ‘forging the iron surgeon’ (Cassell 1998: 100–128). The job requires endurance.

There is also a highly social side to anaesthesia. The operating theatre nurse has been described as performing emotional labour and a ‘party hostess’ role ‘looking after’ the surgeon (Timmons and Tanner 2005). Generally I thought that as the anaesthetist, I was the hostess! The role included making jokes, providing music when appropriate, managing the timing to avoid delay and cancellations, giving advice to junior registrars and nurses about technical details of how the senior surgeon liked things to be, and taking phone calls and negotiating issues with other parts of the hospital for the surgeon. All this work creates a happy smooth-running operating theatre with no impediments to technical excellence nor encouragement to errors.

At a later point in my career as an anaesthetist I worked in the UK in a job that was the ultimate training in what I might even call the cocktail party skills of anaesthesia. There was a fabulously important and busy Harley Street breast surgeon who wore wonderful striped shirts. His initials were both embroidered on these shirts and woven into the carpets of his rooms. He ran two operating theatres at once in a private hospital and ran from theatre to theatre accompanied by pathologists doing frozen sections. An anaesthetic assistant was required, so I was employed by the consultant anaesthetist for £100 cash. (This enormous sum was reputed to be 10 per cent of what the anaesthetist actually earned for the list.) This represented my major weekly income when I was working towards an MD in neuropharmacology.

The anaesthesia was straightforward. The problem was that the consultant anaesthetist could not stand the surgeon, so I had to be in whichever theatre the surgeon was operating in. As a character he was a little like movie portrayals of Henry VIII – large, loud, powerful, charming, prone to rages, thus needing to be entertained, diverted and calmed. On my way in on the Underground I would buy and read the paper and devise a series of topical and entertaining conversational gambits. With practice, all went swimmingly and I enjoyed this weekly challenge. He sent an enormous bouquet of lilies when I had my second child. Clearly, this was a measure of success!
MOTHER AND ANAESTHETIST

I married a doctor whom I met in the operating theatre. I was the orthopaedic intern for a term and he was the resident doing anaesthetics. The consultant surgeon and registrar gave me a very hard time on that term, with crude jokes and double entendres. My blushing was reliable. I was certainly not worldly as I had had a sheltered upbringing and had gone straight from school to university where I studied conscientiously and socialized primarily with vegetarian bushwalkers.

I remember assisting in the insertion of a ‘pin and plate’ for the fractured neck of a femur. The ‘plate’ looks a little like a short ruler with a number of holes in which screws are inserted to hold it to the bone. One jovially said to the other ‘Let the girl do some’. The other demanded of me, ‘First tell us how good you are at screwing’. As a forty-something-year-old, the rich range of possible retorts is now evident, but of course forty-something-year-olds are not the usual target of sexual harassment. My future husband, the masked figure manning the anaesthetic machine, consistently distracted my tormentors.

When I was a trainee cautionary stories were told of those that became pregnant and ‘let the whole department down’ and ‘never did pass their final exam’. While I managed to pass the exams and then have the babies, there were issues around being an anaesthetist and a mother. In the competition for work in the private sector one of the ways used to denigrate a woman was to say things like ‘You don’t want her to do your operating list as she’ll always have to rush off to a meeting at the school’. The identity of a mother had to be publicly relegated to a priority well below that of a doctor, as the professional image required unencumbered availability. This was a wearing masquerade over a long period. The pressure of combined family and work commitments for women doctors results in high rates of burnout, depression, alcoholism and suicide. Despite the pressures on me as a woman and an anaesthetist, I always enjoyed anaesthesia but gradually became interested in issues outside the operating theatre.

MOVING AWAY FROM ANAESTHESIA

My activities running quality assurance activities for the anaesthetic department led to my application to undertake a NSW Department of Health ‘Clinical Practice Improvement Course’. The quality and safety movement has an evangelistic flavour and I became a convert, starting with a multi-disciplinary project to attempt to improve pain management in the post-anaesthesia care unit (Jorm 2003).

I would probably have remained an anaesthetist and small-time healthcare quality enthusiast except that my acquisition of this knowledge was timely for the hospital and it resulted in my being offered a part-time position to set up a quality assurance unit for surgery and anaesthesia. Just as a young doctor I had experimented with the physiology of the anaesthetized patient, I now found myself experimenting with organizational culture.

My efforts in this role led to an invitation to work on quality and safety issues across the whole hospital in the specially created post of ‘Lead Medical Clinician’. I left clinical anaesthesia and took up this role but it was a difficult one. I found I had to walk a fine line. It was important not to be seen as ‘management’ and thereby lose the support of the medical staff, yet I was now required to view hospital functions from a quite different perspective from that of my medical colleagues. Sometimes it seemed as if everything
that went wrong in this large institution was now considered to be my personal problem. In addition, the new role disturbed the power balance in the institution and my own skills in dealing with management processes and managers were primitive.

The sociologist Katherine Montgomery says:

*A physician becomes a physician only by taking care of patients. Medical education confers a social identity and a way of looking at the world that lasts beyond a clinical career, but a physician without a patient is not a clinician any more than a sick person without medical attention is a patient.* (Montgomery 2006: 161)

I am not sure I entirely agree with Montgomery, but ceasing to provide direct patient care does put a doctor in an ambiguous and lonely space.

The patient safety movement arose from recognition of the extent of preventable harm hospitalized patients suffer. However, I struggled in my work with the medical staff to improve the application of evidence and to make practice more consistent (such as improving the rate of use of prophylaxis for deep venous thrombosis) and sometimes received angry calls from the leaders of specialty groups about my interference in their domains.

Yet most doctors I worked with were absolutely dedicated to the welfare of their patients. The discrepancy between the motivation and dedication of staff and the actual product (processes and outcomes) of their work was disturbing, especially when improvement was so firmly resisted. At the same time I became very aware of the managerial dominance in hospitals of nursing staff and the disadvantages of this situation. Uncooperative behaviour by doctors was used to justify their exclusion from management which means exclusion from the organization of healthcare work. This became a vicious circle.

I needed to understand why the doctors acted as they did: I started study as a PhD candidate in the area of medical sociology.

**FACING MEDICAL HEGEMONY?**

I rapidly came to realize that social scientists were fascinated by technical details of health and illness but it was a fascination often tinged with resentment at their exclusion from (or non-inclusion in) the health professions. The perceived problem of medical (doctor) power and dominance was an obsessive focus for some researchers. Medical hegemony was used to legitimize the study of doctors in a way that denied the subject any voice. Yet power and social control do not always amount to abusive domination, but can also be ‘understood as resources for effective, consistent and rational practice’ (Maseide 1991).

Most research was about doctors but did not include doctors. Raymond Tallis, a senior British geriatrician, said this about ‘threats’ to medicine:

*The most serious dangers emanate from those for whom the moral high ground is a platform for self-advancement, many of who have never borne, or have been willing to bear, the responsibilities that weigh on the daily life of practitioners.* (Tallis 2004: 2)

Tallis may be positioning doctors as beyond understanding, critique or indeed reproach from non-doctors. I would not be prepared to go this far, but the failure by doctors to
be involved in much social science study of their world results in limited insights and sometimes incorrect conclusions being drawn. Consequently, and even more importantly, social science is unable to communicate its findings back to doctors.

It has been suggested that while researchers may seek understanding, ‘most study participants are preoccupied with action – how to work and live better’ (Miles and Huberman 1994: 292). This leads to the primary intent of this book – to speak to the participants, those engaged in delivering health care. It is not intended to be confined to an academic readership. However, there are also important direct messages for healthcare managers and policy makers and relevance for anyone interested in issues of identity in organizational or professional cohorts.

Conventions Used

Much of the discussion in this book is related to the research study I conducted in 2005. In general I have used ‘he’, ‘she’, ‘her’ and ‘his’ rather than the more cumbersome ‘he or she’ and ‘his or her’. I have made use of quotes from interviews and, wherever it has been possible without enabling the interviewee to be identified, indicated the interviewee’s clinical specialization. Where I have included excerpts from group discussions specialty designations have also been omitted.

Research

Those interested only in the findings and discussion could move straight to Chapter 2.

The original data in this book comes from the study of specialist medical practitioners at two public hospitals in the State of New South Wales (NSW). The bulk of the data was collected in 2005. This hospital system was (and continues to be) under stress arising from changing societal expectations, publicity given to a number of scandals, and restructuring of health services by the State Health Department (Liang et al. 2005). Reforms in the period 1986–99 had been followed by further change in 2003 and 2004: hospital boards had been replaced by a number of iterations of management at a Health Area level.

Site of Study – Two NSW Public Hospitals

Hospital A is an accredited principal university teaching hospital with 500 beds and more than 2,200 staff. The hospital’s services included a designated trauma service, critical care, surgery, cancer care (surgical, medical and radiation oncology), medicine, women’s and children’s health, mental health, community health and medical imaging. In the 2002–03 financial year there were more than 45,000 admissions and more than 723,000 outpatient treatments were administered. Hospital A had been my workplace for two years as a junior doctor and for six months as an anaesthetic trainee. Then, after seven years away, I worked there for a further eleven years as a senior doctor.

Hospital B is located nearby. In the same period it accepted 20,000 admissions and employed about 1,000 staff. Its service profile is more of a community hospital providing lower levels of specialized services.
While the study focussed on doctors’ interactions with these public hospitals, Australian government policy over the last ten years has resulted in an enormous development of the private hospital sector. This has had consequences for organizational engagement in public hospitals as shown in the following dialogue between study subjects:

**Doctor 1:** My feeling is that – and I’ve been there for about seven years, but I have less ownership [of the hospital] now than I did when I started by far. When you go up to the wards you don’t know the nursing staff, they don’t want to do a ward round with you necessarily. We really have very little input actually about what goes on up there. I feel I have less and less input.

**Doctor 2:** Because of the fact that we’ve all got viable private practices now, we’ve got somewhere else to go. It means that we hang around fighting for the system a lot less.

**Doctor 3:** There are lots of specialties that can literally walk out of public Hospital A tomorrow and …

**Doctor 2:** We’ll take their operating time.

**Doctor 3:** Well you’re welcome to it. We’ll double our income and you’ll halve yours.

**Doctor 2:** You wouldn’t have said that five years ago.

**Doctor 3:** Absolutely not. There was no possibility of doing that five or six years ago.

The employment of doctors as part-time contractors in large public hospitals limits their relationships with these institutions. The private practices of most subjects provided a significant alternative focus for their energies. In some responses, the subjects contrast their interactions with the private and public hospitals.

**Study Methodology**

Studying organizational or professional culture is difficult. In the chapters that follow there is examination of the deeper levels of medical culture, both espoused beliefs and attitudes, and shared values (Mannion et al. 2005: 19). This is the realm of identity.

There were three major data sources used in the study:

1. Forty-one medical specialists (‘interviewees’) with a public hospital appointment participated in in-depth face-to-face interviews.
2. Work scenarios where actions might be unclear (relevant to the safety and quality of patient care) were also developed. These were then presented to two focus groups of medical specialists (‘focus group members’). Their discussion and responses were analysed and also used to refine the scenarios and to develop multiple-choice answers.
3. The multiple-choice instrument was then used to survey larger groups of senior and junior doctors (85 in total) at the two hospitals (‘survey results’).
THE INTERVIEWS

Sixty-nine subjects were randomly selected from the list of 243 senior medical staff attached to Hospital A. Ten were excluded because of factors such as retirement or participation in the focus groups. There were 11 refusals (19 per cent). Saturation of themes occurred at about interview 35, hence the sample was concluded at interview 41.

It is hard to describe the complexity of the social networks based on shared experiences that exist among doctors. I had known most for many years. I had assisted and mentored some of the younger consultant surgeons and anaesthetists during their training. Others were my seniors.

I coded the subjects using the following scheme:

- Have entertained at my home by choice – that is, a friend – 5 subjects.
- Would choose to sit beside at a hospital dinner – known congenial company – 10 subjects.
- Would choose to sit beside in a hospital committee meeting – respected and likely to provide support on a professional issue – 15 subjects.
- Unknown (not met prior to interview) or neutral feelings – 9 subjects.
- Disliked – 2 subjects.

Coding of a different random sample confirmed that there was no significant difference between my relationships with the interviewees and with the rest of the medical staff of the hospital.

Of the 41 subjects, there were 15 physicians, 13 surgeons and obstetricians, and 11 doctors working in emergency medicine, anaesthesia and intensive care. Of the sample, five were women. This was roughly representative of the hospital. For instance, my sample contained three plastic surgeons and no urologists, but there was an appropriate number of surgeons compared with physicians.

Questions were designed to probe behaviours, attitudes and values regarding medical practice with particular emphasis on patient safety and quality issues. The interview subjects were told that the aim was ‘to help understand better how doctors feel about their work and their professional identity’.

The lengths of the recorded interviews varied from 19 to 91 minutes (mean 39 minutes). Invariably I spent a further 20–60 minutes afterwards with interviewees talking about how certain of their answers were interesting or different from others, and about hospital politics and medical life in general. Most researchers or interviewers have to build trust and relationships before gathering data but here it was already established with interviewees because I was ‘one of them’. Only one of 41 interviewed was cautious, the rest frank (resulting in a number of anecdotes too personal to include) and often passionate. The analysis is post-modern, with the centrality of the author to the study accepted: the interviews produced socially constructed data.

I enjoyed the interview process, both at the time and during later analyses. In the chapters that follow, extensive quotations are used. Most are brief and exclude interviewer’s comments. However, the following interview excerpt expresses nicely the gossipy fellowship between doctors, where they are bonded by exposure to peculiar extremes of human experience.
Plastic surgeon: We see GPs all trying to get into cosmetic procedures and some call themselves surgeons and operate and whatever. And you know, you see some funny things … This girl came in and she wanted to have liposuction to her labia basically and she said to me, ‘Oh the GP wanted to do it but I thought I’d rather come to a surgeon for it’. She said ‘Have you had a lot of experience lipo-sucking labia?’ And I said, ‘Well we get quite a few girls for liposuction … but I can’t ever say I’ve done a labia’. And she said, ‘Well I don’t really think you should say that because I asked the GP how many she has done and she said she had done dozens and dozens of them’. Well I thought that was really strange.

Interviewer: (Laughing) What is going on out there?

Plastic surgeon: This is obviously a GP who in her room just does liposuction type of thing.

Interviewer: The mind boggles. It really does.

Here the subject, while emphasizing his status as a ‘real’ plastic surgeon, is also humorous and likeable. What the doctors said was sometimes confused, sometimes eloquent and often colourful. To paraphrase it was often a disservice and hence extensive quotations are included.

DEVELOPMENT OF THE SCENARIOS AND THE SURVEY

In order to test the general observations that had been made in the quality and safety literature about doctors, scenarios were developed that incorporated ethical and professional situations where the correct actions might be unclear. Scenarios enable conflicts and complex issues to be teased out while distancing threatening details from respondents. I gave emphasis to investigating particular aspects of doctors’ attitudes:

1. dedication to their ‘own’ patients and strength of their advocacy for patients in general
2. loyalty to their colleagues
3. approach to their family commitments
4. cooperative organizational behaviour within the hospital setting.

Conflicts were included in some scenarios. For instance, the strength of dedication to patients was sometimes placed against issues of loyalty to colleagues or family commitments.

It was initially planned that the scenarios would be presented during the individual interviews. However, when they were piloted, two medical specialists stated ‘these are moral issues’ and they would not be willing to disclose to a researcher what they would really do in the circumstances posed. The scenarios appeared to target some very sensitive dimensions of practice. The solution to this problem was to devise answers, and thus allow the anonymous completion of a questionnaire. Two focus groups were used to investigate responses to the scenarios.

Five surgeons, two anaesthetists, a pathologist and an obstetrician participated in the focus groups. Four were women. After oral presentation of each scenario, the group was
asked what range of actions their colleagues would do and then what they should do. The aim of would and should was to generate a range of responses, and allow the expectation that these would be different. Participants were inclined to jump to should, but they then discussed why the ideal did not always happen. The groups each took more than two hours to consider the scenarios. The dialogue stimulated by the scenarios was lively, highlighting the uncomfortable nature of the scenarios posed and providing insight into the reasons for the discomfort.

Multiple-choice answer options to the scenarios were derived from analysis of the focus group transcripts. Where possible, quotes from the focus groups were used in the multiple-choice answers to add authenticity. The ‘other’ option also provided formed 20 per cent of the responses to one scenario, but for the remainder of the scenarios it was chosen by fewer than 9 per cent (and was zero for four of the scenarios). This provides strong support for the methodology and for the conclusions drawn about doctors’ views.

The scenarios were provided as a Power Point presentation to three major formal teaching seminars (Grand Rounds) at the two hospitals. Eighty-five medical staff completed answer sheets. Their ages ranged from 23 to 79 years (mean age 39) and 70 per cent were male. They had been in practice for a range of 1 to 54 years (mean 14 years). Just over half were consultants, more than a quarter were registrars (specialist trainees) and the remainder were interns and resident medical officers.

Reading this Book

The book is set out as follows:

Chapter 2 outlines the issues of safety and quality in health care.

Chapter 3 looks at why the doctors interviewed chose to study medicine and their later views on that choice.

Chapter 4 examines what being a ‘good’ doctor might mean.

Chapter 5 confirms the hypothesis that doctors’ behaviour can be quite contrary to that expected for good safe care.

Chapters 6, 7, 8 and 9 each discuss one of four reasons for the limitations and contradictions in doctors’ behaviour:

1. medical work is uncertain
2. doctors need collegiality
3. doctors have an emotional bond to patients
4. the healthcare system alienates them.

Chapter 10 describes how medical practice and health care might be re-constructed to re-engage doctors, strengthen their esprit de corps and shared identity, and to improve patient care.
Why Start this Chapter with Machiavelli?

This book is for those who seek new insights into medical work and hospital practice. The insights will be found through what is, for doctors, merely a guided reflection on the words of their medical colleagues. Change of many kinds – in society, in health care and in medical practice – is underway and the call from this book is for doctors to become more active agents in change.

For healthcare managers the messages are more confronting. For those who work in industries other than health care, this book illustrates the importance of detailed study of the culture of the ‘workers’ (especially when they are professionals). Without an understanding of their world views, self-perception, motivations, satisfactions and frustrations, attempts at improvement will fail and culture change remain elusive.

Nobody will agree with everything in this book. A book that contained ideas that were accepted and agreed by all would neither be worth reading nor writing. It can be easier to cavil at details than to commence the uncomfortable process of reflection and change.

When I have acted in bureaucratic roles, I have had to watch too often while worthwhile ideas lost all integrity and became moth-eaten assemblages of jargon. They became not merely garbled words, but also a massive waste of public money. Naysayers are usually not the brightest and best of their professions. Further, they battle primarily to maintain or advance their own advantages – in money and or power or merely convenience. Achieving good, safe, high-quality health care for patients comes well down their list of motivations. Away from the bedside, it is easy to forget about care and to devalue patient experiences and suffering. However, the doctors interviewed for this study were those who work with patients. Leading change is for the brave and the stubborn – most doctors I know are both. Their greater engagement would offer enormous potential for improved patient care.

*Why do we need to change the way doctors deliver health care?*
Harry was a distinguished pilot and aviation engineer. Because he was a pilot, he was subject to annual and even more frequent medical examinations.

Over a decade or more, when Harry was in his forties and fifties, these examinations had showed he had elevated blood pressure. None of the doctors who carried out these examinations and who were responsible for his medical care recommended any treatment for his elevated blood pressure. Certainly eight, but as many as thirteen, doctors identified this elevated blood pressure.

By the time Harry was in his early seventies his elevated blood pressure had led to reduced kidney function. His age ruled him out for a kidney transplant. He was too active, proud and independent to accept dialysis.

When he developed hip problems in his late seventies he had a hip replacement. He picked up a hospital-acquired infection in his hip. The hip prosthesis could not be replaced because of his overall health – it was thought he might not recover from another operation.

It was difficult to treat the infection with oral antibiotics because of his limited kidney function. Every movement became painful.

He died in 2009 in his early eighties from renal failure.

But for his doctors’ failure to treat his elevated blood pressure at an early stage – but for the hospital-acquired infection in his hip – he’d still be in his shed tinkering with motorbikes, still be ornamenting graduands’ degree certificates with his calligraphy, and his small grandchildren could get to know him.

The story that lies behind this death is not atypical. A series of events occur over time. There is no one individual responsible for Harry’s death. Doctors individually commit to achieving the highest possible standards of care for their patients: ‘Near enough is not good enough and a compromise is not good enough’ (Plastic surgeon1). Yet doctors have

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1 Quotes by doctors used in this chapter have been taken from interviews conducted as part of the research that is covered in greater depth in subsequent chapters.
not been prepared to participate at group level to devise systems that prevent patients such as Harry ‘slipping through the cracks’. They do not participate wholeheartedly in improvement projects to ensure evidence-based care is delivered (such as for hypertension) or to reduce the rate of healthcare-associated infection. They also fail to take action to prevent poor colleagues from harming patients. Reasons for this failure to participate will be discussed in the chapters that follow.

A safety and quality movement emerged in health care which sought to draw the attention of clinicians, the public, politicians and policy makers to the rate of preventable harm that was occurring. It also sought to promote solutions to reduce this – to ensure all care is good care. A description of this movement forms a necessary context for the following chapters. While throughout the book some of the newer approaches to safety, change and learning are described, this is not a textbook on patient safety. For this, readers may enjoy Patient Safety (Vincent 2010) or Safety and Ethics in Healthcare: A Guide to Getting it Right (Runciman et al. 2007). For advice on improving quality in health care there are a multiplicity of competing, but invariably optimistic, approaches and accompanying guides.

The need to improve the safety and quality of health care is indisputable. Approximately one in nine hospital patients suffers an adverse event that may require extra care or cause permanent harm or death. The result is pain, suffering, loss of quality of life and costs to both patients and the medical system. Nearly half of these adverse events are considered ‘preventable’ (de Vries et al. 2009). Poor quality care is even more common than adverse events (McGlynn et al. 2003). In this case, money is wasted and patient outcomes are poor because of both underuse and overuse of investigations and therapies.

Where did the Safety and Quality Movement Originate?

The patient safety and quality movement is a relatively recent phenomenon. The open reporting of mistakes (admission of error to colleagues) was common at the turn of the century (Pinkus 2001). The neurosurgeon Harvey Cushing published such a frank account in 1903: ‘At an ill-advised moment late in the afternoon of this date the dressing was removed ... This misjudged procedure evidently turned the balance against the patient’ (Pinkus 2001). Cushing was a pioneer of ‘scientific surgery’. He introduced the Riva-Rocci apparatus (mercury sphygmomanometer) to measure blood pressure during surgery, silver metallic clips for ligating bleeding blood vessels, the transphenoidal approach for pituitary surgery, and the description of the syndrome caused by excessive production of ACTH by the pituitary gland (Cushing’s syndrome).

Pioneer doctors documented their incidents and accidents so their peers could learn. This led to the development of protocols and standards. This means that, for the modern doctor, many parameters of acceptable practice are defined. Violation of these constitutes a mistake or may even be seen as an inherently immoral act (Runciman et al. 2003). Hence, as standards developed, doctors developed increasing anxiety about reporting adverse events or errors. Litigation for medical malpractice has become a conspicuous feature of the medical landscape, particularly in the US. A term like ‘misjudged’ became unacceptable in the medical world. The medical literature turned to trumpeting medical advances while ‘complications’ were treated merely as random patient-related events.
These practices were challenged by the safety and quality movement. Two reports from the US Institute of Medicine (IOM) – *To Err is Human* (Institute of Medicine 2001b) and *Crossing the Quality Chasm* (Institute of Medicine 2001a) – were highly influential in bringing safety research evidence to the attention of both the public and policy makers (Stelfox et al. 2006). The first report used data from the Harvard Medical Practice Study (Brennan et al. 1991, Leape et al. 1991) to estimate that between 44,000 and 98,000 deaths occurred annually in US hospitals due to medical error. This received considerable publicity, although the number of deaths was an estimate that cannot be definitely substantiated. Later, many similar record review studies were performed and are the source of the conclusions that 9 per cent of patients suffer adverse events in hospital and these are lethal in 7 per cent of cases and preventable in 44 per cent (de Vries et al. 2009). The majority of events detected this way are operation- or drug-related and include healthcare-associated infection, falls and pressure ulcers.

There were significant differences in adverse event rates between studies, variations that are believed to derive from differences in both reviewer interpretations of the medical record and in the quality of the medical record (Runciman et al. 2000, Thomas et al. 2000, Thomas et al. 2002, Hofer and Hayward 2002). For instance, in one set of hospital deaths initially 23 per cent appeared possibly preventable, with 6 per cent probably preventable. Later, it was estimated that less than 1 per cent of the patients who died would have lived more than three months in good cognitive health had the errors not occurred (Hayward and Hofer 2001).

The very high death rate found by the seminal Australian chart review study – *The Quality in Australian Health Care Study* (Wilson et al. 1995) – attracted parliamentary attention. Public concern then resulted in the establishment of the Australian Council for Safety and Quality in Health Care (in 2000) and of safety and quality units within State health bureaucracies.

In health promotion, scare tactics have been justified:

> Motivating ‘at risk’ people to give up behaviours that are psychologically useful, socially supported, peer pressured, habitual, or to adopt behaviours that require continuous effort over a lifetime ... compels the messenger to shake loose defences by whatever scare tactics can be devised. The humane goal of reducing future suffering, a professional obligation, authorizes extreme measures. (Crawford 2004)

The IOM used ‘extreme measures’ in the composition and publication of these two reports. These included the use of terms like ‘chasm’ and the promotion of the death rate due to error as equivalent to a death toll from three jumbo jet crashes every two days. It has been argued that during the last few decades health has generally been depicted with a discourse couched in terms of crisis (Lepofsky et al. 2006). The quality and safety literature forms a prominent part of this discourse. Energy was also added when the quanta of medical litigation started to reduce the viability of medical practice (especially in the US) and by a series of major hospital inquiries that disturbed public trust (Quick 2006, Hindle et al. 2006, Braithwaite et al. 2007). Better-known inquiries include the following examples.

**Bristol, UK** (www.bristol.inquiry.org.uk). This was an investigation into high death rates after cardiac paediatric surgery in the Bristol Royal Infirmary. This Inquiry is said to have ‘propelled the quality and safety of NHS [National Health Service] care up the political agenda. Analysis of these manifest service failings sharpened policy focus on
“modernizing” the deep-seated assumptions, values and working practice that have been affirmed over decades and woven into the fabric of health care delivery’ (Mannion et al. 2005: 1).

King Edward Memorial Hospital, Perth, Western Australia. It was found that junior staff were not supported by senior staff, and the hospital lacked an appropriate culture and organizational structure to encourage safe quality care (Australian Council for Safety and Quality in Healthcare 2002). As well as producing poor clinical outcomes, the hospital failed to respond to the emotional needs of patients.

Bundaberg Inquiry, Bundaberg, Queensland, Australia. There were a number of investigations into the conduct of a surgeon, Dr Jayant Patel (Van Der Weyden 2005, Morton 2005). His decision making was found to be frequently flawed and some patients suffered serious harm. Clinical governance within the hospital was not effective. Dr Patel had an extensive US history of clinical deficiencies that had resulted in sanctions against him in the US. The Queensland Registration Board had not discovered this history.

The Shipman Inquiry, UK (www.the-shipman-inquiry.org.uk). This investigated the actions of a single mass murderer but resulted in many UK reforms, including ongoing attempts to measure performance and assess the continuing competence of doctors (Ellis 2004).

The Garling Inquiry, New South Wales, Australia. Triggers included a number of adverse events that had attracted media attention. Unfavourable coronial comment had also been made into the circumstances surrounding the death of a young girl after a head injury. The final report included 128 recommendations to improve the quality and safety of patient care in NSW public hospitals (Garling 2008).

The role of the media in adding to the atmosphere of crisis is discussed in more detail in Chapter 9, ‘Doctors’ Alienation from the Healthcare System’. While one doctor was supportive most doctors interviewed were highly critical of the media’s role in drawing attention to safety and quality problems:

I’m glad that it’s out in the public arena that our hospitals are unsafe. Geriatrician

I’ve had a lot of dealings with the media over the years, television, reporting. They’re all the same. There are very few you that can actually trust and they lie. They’re just the lowest of the low as far as I’m concerned … The health system is such an easy system to attack. It’s there to try and cater for everything. There has been a change in the public over the last ten years … [The public] are now very critical of anything that goes wrong because they’ve almost been worked up into a frenzy to think the number of complications that occur in hospitals are much higher than the reality because anything that goes wrong gets sensationalized … We’re very vulnerable … Plastic surgeon

I think the media has got a lot to answer for in … over time creating … public expectations of perfect outcomes for everybody. Emergency physician

Defining Quality in Health Care

John Øvretveit, who is a safety and quality expert based at the Karolinska Medical Management Centre in Stockholm, defines health service quality as ‘provision of
The Safety and Quality Movement

Care that exceeds patient expectations and achieves the highest possible clinical outcomes within the resources available’ (Øvretveit 2009). However, exceeding patient expectations may sometimes be unachievable and sometimes be far too low a goal.

Øvretveit also suggests that healthcare quality requires meeting objective standards of humanity. This latter concept is important. When I was in the team developing the Draft National Framework for Safety and Quality (Australian Commission on Safety and Quality in Health Care 2009) we suggested that Strategy 1.9: Promote Healthcare Rights, should include ‘ensuring care meets standards of cleanliness, nutrition and environmental comfort (e.g. air conditioning)’(Australian Commission on Safety and Quality in Health Care 2009: 15). In a similar vein, the recent NSW Garling Enquiry (Garling 2008) recommended that ‘The policy which authorises, and the practice which gives effect to, using inpatient wards to house both men and women in the same room … ought to cease forthwith’. This practice has been a source of distress to patients and clinicians for many years and it is intriguing to see this new emphasis on the preservation of dignity. There is as yet little written on such topics – ‘patient centredness’ is frequently merely an aspirational concept (Jorm et al. 2009).

A substantial quality ‘gap’ exists between what good care looks like and what patients actually receive. Treatment is inappropriate when expected benefits outweigh expected harm. It has been estimated that 25 per cent of hospital days and X-rays are inappropriate, and up to 40 per cent of medications unnecessary (Øvretveit 2009). Conversely, a large US study showed that patients only received just over 50 per cent of recommended care processes (McGlynn et al. 2003). A US study of patient notes found that ‘the overwhelming majority of substantive medical errors identifiable from the medical record were related to people receiving too little medical care, especially for those with chronic medical conditions’ (Hayward et al. 2005). Chronic diseases account for 70–80 per cent of preventable deaths or avoidable hospital stays (Amalberti et al. 2009a).

Defining Error

Error is defined as ‘the unintentional use of a wrong plan to achieve an aim, or failure to carry out a planned action as intended’ (Runciman et al. 2003). In this definition, thoughts and actions are the focus and harm or outcome are excluded, as harm can exist independently of the occurrence of error.

Modern understanding of error draws heavily on the work of the psychologists James Reason (Reason 1997, Reason et al. 1998, Reason 2000) and Jens Rasmussen (Rasmussen 1982). Error itself has been categorized into four types – mistakes due to inadequate or incorrect knowledge or information, lapses (correct information, but wrong use of a rule), slips (the poor performance caused by distraction) and latent errors. Errors can be made by good, careful and highly trained professionals. Errors are not random and usually a single error does not cause a bad outcome.

I think it is appropriate that we’re looking at the patient safety issue … To have a disaster usually takes about six mistakes. I have been associated with a few disasters … You can’t produce a disaster by just making a mistake by yourself. Plastic surgeon
Patients are usually able to get away with going through a hospital admission but most of them will have something that did go wrong, it might be they didn't go down for an x-ray on time or they missed a medication but it seems to me that it's a series of five or six that causes that demise of a patient … We're never going to stop it but we can put in systems to minimize … errors that are occurring for an individual. Renal physician

Latent errors are deficiencies in design, organization, maintenance, training or management that create the conditions in which people are more likely to make mistakes. The work environment can thus increase the risk of individual error: latent errors (or ‘system factors’) may have existed for some time prior to the onset of an accident sequence. System factors can include rostering arrangements that force fatigued staff to continue working and a pace of work that normalizes rule breaking and ‘work-arounds’.

Error is ubiquitous in health care just as it is in everyday life. Whether or not an error results in an adverse event is determined by the cause and effect relationship (tightness of the coupling of processes) and the opportunities to detect and correct the error (system defences and redundancy) that exist. In general, the ‘health care system is so loosely coupled that small adverse incidents resulting from human and equipment errors rarely propagate throughout the system or culminate in major catastrophes’ (Randell 2003). There are many opportunities to detect a drug order written wrongly on a chart, but few to stop an anaesthetist who has picked up the wrong syringe to inject.

How Often does Error Occur in Health Care?

Error occurrence is greatest in complex situations. Doctors recognize this:

The number of people who are admitted because of medication errors or because of polypharmacy at home, the number of people who have AEs [adverse events] in hospital related to their treatment has become a big problem … It harks back to the old slogan ‘The primary thing is not to cause harm’ and the last thing you want to do is admit a patient for a minor problem and have them in hospital for two months with major AEs … There will be times when people have AEs, no matter how well they’re looked after in hospital because of the complicated nature of medicine these days, but I think a lot of it is preventable. Neurologist

Patient safety has declined because what we’re doing is more complex. It takes greater team work to do the complex things we do and the chain can break in any one of a dozen places … Hospitals have become much more fragmented. Gastroenterologist

When human factors researchers observed 165 arterial switch operations there were, on average, seven adverse events per case due to error, of which one was life-threatening (de Leval et al. 2000, Carthey et al. 2001, de Leval 2003). This extremely complex operation corrects a major congenital cardiac abnormality. Major adverse events included forgetting to put the pacing wires in and failing to cool the cardioplegia solution. Minor events included communication problems and distraction at critical times; for instance not looking at the electrocardiogram when inserting a central line. There were 16 patient deaths and for these there were both major and minor events that independently predicted mortality.
As part of the inquiry into care at Perth's King Edward Memorial Hospital, notes from 375 high-risk obstetric cases were examined (these were not chosen for bad outcomes) and 47 per cent had at least one clinical error (Australian Council for Safety and Quality in Healthcare 2002). The staff member involved at crucial times in these cases was ascertained, and it was found that error-free care was delivered by 72 per cent of consultants, 40 per cent of midwives, 36 per cent of junior registrars and only 27 per cent of resident medical officers.

In a busy US emergency department, staff were questioned at the end of every shift and in just seven days, 346 errors (18 per 100 patients) were volunteered by staff (Fordyce et al. 2003). A prospective study revealed one or more errors occurred in two thirds of a group of children admitted to hospital (Proctor et al. 2003). These errors contributed to adverse outcomes in one third of the children.

Many adverse events occur in intensive care units, including mechanical, infectious or thrombotic complications from central venous catheters, healthcare-associated infections and complications due to errors in drug administration (Boyle et al. 2006). Direct observational study in intensive care revealed that residents and interns made significant numbers of serious errors (14–25 per 100 bed days). Some were intercepted, some reached patients and some both reached patients and caused harm (Landrigan et al. 2004). It should be noted that many medical errors do not result in harm or even minor consequences for patients (such as when a patient receives the analgesic or even the antibiotic intended for the patient in the next bed).

Sometimes the definition of error focusses on failure to follow protocol. An example is a study of 90 children admitted to an emergency department and for whom the trauma team was called (Oakley et al. 2006). An alarming average of six errors per resuscitation was identified, yet there were only two errors found per resuscitation of the more seriously injured children who would necessarily have been more complex cases.

The discussion gives a clue: ‘Any deviations from Advanced Trauma and Life Support (ATLS) guidelines were recorded as errors … It is possible that experienced clinicians would not adhere to all of the ATLS guidelines for all patients … especially those with more minor trauma’. Therefore some of the study ‘errors’ represent experienced clinicians determining that the child was not severely injured and delivering appropriate care. That is, experts did not follow the global rules devised by experts and the other expert reviewers thought this was satisfactory in these specific cases. (The importance of expertise in ensuring safety is something we will return to in Chapter 10.)

Post-mortem studies comparing patient notes with autopsy results suggest diagnostic error rates of 17–40 per cent (Tavora et al. 2008, Ferguson et al. 2004, Twigg et al. 2000). The number of unexpected major diagnoses is staggering. For instance, of a series of 36 cases where cause of death was listed as myocardial infarction, the actual causes included pneumonia, sepsis with acute respiratory distress syndrome, cerebral haemorrhage and cardiac tamponade (Ravakhah 2006).

Every testing method used pre-mortem is inexact. Diagnostic errors occur in 1–43 per cent of all anatomic pathology specimens reviewed (median being 1–5 per cent) and there is considerable variability among expert opinions for many specimens (Raab 2004, Frable 2006). An overall error rate for biochemistry and microbiology of 27 per cent has been given, with the suggestion that 8 per cent is irreducible due to biological variation (Stroobants et al. 2003). Both false negative and false positive tests carry risks – there is no perfect diagnostic test (Body and Foex 2009). Major error has been found in 2–20 per
cent of radiological investigations (Goddard et al. 2001). While error can be reduced by double reporting (reporting independently by two practitioners), Goddard et al. note that ‘there is almost no test in which there is perfect separation between normal and abnormal results’.

Studies on appendicitis have led to the introduction of the concept of ‘appropriate’ rates of error. Error can be defined as the number of normal appendixes removed. As there is an inverse relation between perforation rate and the surgeon’s false positive surgery rate, it has been suggested that an error rate of 20–25 per cent is reasonable to keep the risk of perforation acceptably low (Graff et al. 2000).

**Doctors and Healthcare Errors**

For a patient, the three risks combined in health care are those of the disease itself, clinical decision making and the implementation of the selected therapy (Amalberti et al. 2005). All risks are of different magnitude for each patient. The risk of the disease or injury itself is very rarely considered in discussions on safety. For example, the major risks faced by a victim of a high-speed car accident will be from the injuries sustained.

Each person’s physiology and medical problems are unique. The way each individual describes his or her symptoms, experiences pain and heals is unique (Montgomery 2006, Ghosh 2004). Daily, staff tailor individual care solutions, but they sometimes fail to recognize problems in their unique guises. In Sir Donald Irvine’s view:

> Doctors often have to make decisions – even if it is a decision to do nothing – on clinical data that are normally incomplete. Like most doctors, I have worried whether the child who has a headache is in fact suffering from the onset of a minor infection or meningitis. Is the vague pain in that man’s chest a symptom of heart disease or indigestion? This kind of problem solving involves considerable judgement and pragmatism as the process of unravelling the problem follows its course often over some time. It is therefore prone to error. (Irvine 2003: 23)

Diagnostic error has been assessed as forming 10–30 per cent of all errors but may be much higher (Schiff et al. 2005, Forster et al. 2007). Diagnostic process errors (for instance, failure to follow up abnormal test results) are common (such as in Harry’s case) and clinicians do not always recognize the limitations of the diagnostic tests they are using. Missed or delayed diagnosis is not always reported and is often not even recognized (illness may simply resolve with time), but forms a significant percentage of medico-legal claims, especially in primary care.

Patients do not arrive at the doctor with ‘cerebral aneurysm’ or ‘sub-arachnoid haemorrhage’ written on their forehead, and to describe having another initial diagnosis for the aetiology of the headache as misdiagnosis may be also problematic (Schiff et al. 2005). The language used by clinicians is temporal – conditions evolve, diagnoses emerge and sometimes cure requires the ‘tincture of time’. The initial diagnosis is often described as a provisional diagnosis.

When the frequency of adverse events, mistakes, test inaccuracies and difficulties in diagnosis is considered it is not perhaps surprising then that many doctors are uncertain what exactly constitutes an error – 41 per cent in one study (Taylor et al. 2004). Healthcare researchers in Victoria collected an astonishing 39 definitions of what constitutes an
adverse event and 46 definitions for a ‘near miss’ (Auditor General Victoria 2005: 42). Limited shared understanding of error may be one cause for apparent medical indifference to the exhortations of the patient safety movement (Wachter 2004). Doctors are not enthusiastic about the reporting of errors, with nurses significantly more likely to report errors (Taylor et al. 2004, Neale 2005, Lawton and Parker 2002, Van Geest and Cummins 2003). That some doctors consider errors ‘too trivial’ to report (Evans et al. 2006) may be an inevitable consequence of the ubiquity of medical error. The ‘near miss’ may be a particularly alien concept for doctors as it can be difficult to determine whether a detected near miss represents a system (or personal) failure or a success (Taylor et al. 2004, Hamilton et al. 2003, Tamuz et al. 2004).

Patient safety has this connotation that there is some ideal safe process that could occur and therefore something is unsafe and I don’t actually think there is such a thing ... Everyone is going to die and someone’s going to make a decision [that] ... could directly contribute to ... death, even if its ‘we’ve decided you [should] not undergo any further active treatment’.  

Anaesthetist

The Drive to Improve Quality and Reduce Errors

Many quality improvement techniques have been imported from industry. These techniques developed from the Japanese industrial renaissance after World War II. Local philosophies were combined with notions developed by W. Edwards Deming. The success of Japanese industry then forced a re-examination and re-development of such work in the US. These techniques included clinical practice improvement (Langley et al. 1996), lean thinking (Brennan 2002), total quality management (TQM) and flow (or business process) re-engineering (Brennan et al. 2005). Quality management theory suggests that the establishment of standards can reduce the number of variations, thus represents a ‘world view ... based on an assumption of identically repeated processes aiming at non-controversial measurable targets’ (Lillrank and Liukko 2004). Many doctors dispute this world view: ‘We’re not dealing with a Ford Falcon with the mechanic’s manual next to us. We’re dealing with very individual people, very individual circumstances ...’ (Surgeon).

The study of safety improvement in ‘high-reliability industries’, especially aviation and the nuclear power industry, resulted in enthusiasm for attempting to reduce adverse events in health care by incident reporting, analysis of error causation followed by system changes (Thomas and Helmreich 2002, Schulman 2002). The IOM advocates ‘Six Sigma’ reliability for health care (Institute of Medicine 2001b). This is a rate of fewer than 3.4 errors per 1 million events – beyond 6 standard deviations from the mean of a normal distribution. Yet the aviation and nuclear environments are capable of much greater standardization than health, and errors in those industries will place the workers themselves at physical risk (Lillrank and Liukko 2004, Andrus et al. 2003, Randell 2003, Cook et al. 1998: 58). It may be an incorrect assumption that health care could ever become a high-reliability system.

Strong systems solutions are more elusive in health care than industry. In addition, ultra-safe systems are described as having a ‘tendency toward constraint’ (Amalberti et al. 2005), such as a maximum number of flying hours permitted by a flight crew. Yet currently it is unacceptable to close an emergency department in a country area because
the doctors are fatigued. It is politically unacceptable, but also unacceptable to doctors, who have skills that can save lives even when they are not functioning at optimum levels.

Even in some high-reliability industries there is concern about the lack of specific correlation between what is becoming an increasing burden of rules and policies and the safety levels achieved (Amalberti et al. 2005). Additionally, automated aircraft systems designed to protect against pilot error are being associated with new error, either through crew failure to understand their logic or crew delay in detecting errors and taking over.

There has been a large investment in incident reporting systems and analysis methods, such as root cause analysis (RCA),\(^2\) despite the lack of evidence of benefit (Wu et al. 2008, Iedema et al. 2007). Advocates ignored or were ignorant of the ubiquity of error in health care. Further, the events collected by voluntary incident reporting systems are not representative of the bulk of preventable harm and poor care events. Such voluntary reporting systems record only a small set of the adverse events detected by medical record review. Voluntary incident reporting systems mainly collect errors of commission reported by nurses, such as medication incidents. They rarely contain errors of omission (or delayed diagnoses or misdiagnoses) or adverse events that are recognized after discharge. In chart review studies, errors of omission outnumber errors of commission by two to one (Wilson et al. 1995).

Problems with the Evidence that Supports the Safety and Quality Movement

Patient safety has been defined as: ‘A discipline in the health care sector that applies safety science methods toward the goal of achieving a trustworthy health system of health care delivery. Patient safety is also an attribute of health care systems; it minimizes the incidence and impact of adverse events’ (Emanuel et al. 2008). However, the focus on errors that has occurred has been regrettable: ‘It hasn’t been patient safety that has been the concept: it has been patient harm that’s the concept’ (Haematologist).

Focussing on single errors is a very expensive way to try to improve safety. Health care already consumes nearly 10 per cent of Australia’s gross domestic product (GDP). There is a point where the cost of small gains in accuracy or safety or reduced risk of error will be excessive when compared with benefits that could result from, say, a greater investment in preventative medicine.

The knowledge translation from sociology and cognitive psychology performed in the IOM report To Err is Human was flawed. Danish academic Casper Bruns Jensen notes that To Err is Human asserts that much error could be prevented; that human error was the cause of 60–80 per cent of accidents; and that fixing ‘the system’ could eliminate error. However, the original error theorists argued for the inevitability of errors or accidents in complex systems and considered that while human error may be listed as a cause of accidents the major problem was latent errors (Jensen 2007). In addition, error theory suggests that errors will always occur. Therefore, rather than use the term ‘preventable’, it is more helpful to discuss opportunity to reduce the incidence of harm.

\(^2\) RCA is a formal group process of error analysis that includes interviews with staff involved but which has a focus on identifying system problems rather than holding individuals responsible.
The evangelical stance of the safety and quality movement and promotion of the importance of industrial solutions is responsible for a paucity of high-quality research in this field (although see Davidoff and Batalden 2005, Øvretveit and Gustafson 2002, Smith 2003, Shojania and Grimshaw 2004, Shojania and Grimshaw 2005, Lohr 2004). The number of safety interventions supported by evidence is very small (de Vries et al. 2009) and there is even less known about implementation of these interventions, including spread and sustainability (Øvretveit 2009). Cost effectiveness has rarely been considered (Øvretveit 2009, Jackson 2009, Warburton 2005). Many improvement projects do not undertake rigorous analysis (Zuiderent-Jerak et al. 2009) but nevertheless report ‘success’ (Øvretveit 2009). The need for improvement persists but commentators are increasingly wary of ‘just getting on with it’ (Jorm and White 2009). The attempt to track down and eliminate individual errors has provided a narrow improvement focus that has ignored preventable harm at the macro level. The introduction of industrial solutions into health care was logical: our failure to treat them as an experiment was not.


Have Doctors Engaged with the Safety and Quality Movement?

Australian doctors have a significantly lower regard for quality improvement than evidence-based medicine (EBM) (Toulkidis et al. 2005, Øvretveit and Gustafson 2002). Of 73 Melbourne specialists, only half had knowledge about the existence of seminal quality and safety publications, and most had not read them (Brand et al. 2007). When the views of US doctors and the public regarding medical error were compared, it was found that the doctors were less likely to consider preventable medical errors to be a big problem, less sure than the public about the possible causes of errors, and more negative about the likelihood of success of a range of patient safety initiatives (Blendon et al. 2002).

Early visions of widespread uptake of safety and quality thinking and practice have not been realized (Francois et al. 2005, Leape et al. 2009). Many articles suggested that with a smattering of psychology and quality improvement techniques, the influential doctors should and would simply pull together and change would be achieved (Becher and Chassin 2002). This has not happened. Harry’s story is not novel and many so-called ‘complications’ can be eliminated or their rates severely reduced by simple measures (Pronovost et al. 2006). Change is always hard and early safety and quality enthusiasts ignored the wider socio-political context of healthcare delivery and were not cognizant of the motivations and the reasons behind the current practices of doctors. The next chapters begin to explore this. We start by asking:

*Why do doctors choose to become doctors?*
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Motivations for Studying Medicine

Getting into Medicine – A Day at Olympic Park

I have three in the car and I listen to the nervous chatter. ‘Do you guys have any tips for me from the MedEntry course?’ Sharon asks. Discussion of pattern problem-solving techniques with particular reference to triangles ensues. (I reflect on the absence of triangles from any patient problem I have ever encountered).

‘Did you know that Louise stayed on-site last night?’ Imogen announces. The others chorus: ‘She is sooo neurotic.’

I have to query: ‘She stayed in a hotel at Olympic Park?!’ ‘Yes, getting into medicine is her whole life.’

At Olympic Park we follow illuminated overhead traffic signs to the UMAT [Undergraduate Medicine and Health Sciences Admission Test], the traffic slows. They fuss: ‘Should I leave my bag in the car?’

‘Yes, they get cross if you have stuff in the hall.’

‘Do I need both my jackets, I can’t decide.’

Suddenly they’re hurrying away and I’m shouting my last-minute advice: ‘Just remember to slow down, don’t rush the questions’. (The right advice for my child, but possibly wrong for the others; I feel uneasy and then remember they won’t listen to someone else’s mother anyway.) Around me students are being farewelled with a fuss of pens, forms, jumpers, kisses and wishes.

I park and walk back across the monumental boulevards, thinking of wishing them good luck again, passing on that text from Dad. No chance. Outside the hall there are thousands of students. I abandon the attempt to seek ‘mine’ and wander off to find coffee and the swimming pool.

After my swim, I pass rows of cars with waiting parents. They are parked much closer to the venue than the recommended car park. I wonder if I should move the car or purchase snacks. Surely a devoted parent would. I then remember that they are perfectly healthy teenagers who
have been sitting on their backsides for three hours. The site for the 2000 Olympics suddenly seems the perfect place to set exams for these striving teenagers and their anxious home teams.

Was There Always such a Fever to Get into Medicine?

Currently in Australia there are approximately 20 applicants for every place in medical school. Teaching postgraduate medical school entrants now, I find the scientists leavened by those with arts, commerce and engineering degrees, by veterinarians, pharmacists and dieticians. Some are continuing straight on from their first degree but some have left their workplaces to pursue their dream. Sick children sometimes accounted for tutorial absences. Sacrifices are being made. In my research I asked current medical specialists why they had chosen medicine and how this choice had worked out for them. They almost all had entered medical school straight from high school.

INTERVIEW QUESTION
Why did you choose medicine as a career?

The interview subjects described a range of motivations. Most answers were brief and some recalled their adolescent confusion:

Yes, good question. Probably affected by the death of a friend in high school after our final exams. I wasn’t doing medicine up until then … I didn’t have a lifelong ambition to do it. I’ve never really had an interest in looking after people’s health. I’m more interested in technology … and I suppose I never really thought I would be able to do it until I … got the right marks. So two reasons: one, perhaps from personal experiences and two, achieving marks to do it and thinking that it was possible. Renal physician

Three of the ten surgeons interviewed described a desire for an artistic or craft occupation:

The craft that I was attracted to, surgery, was fairly similar to my father’s family building background where you work with your hands and think in three dimensions. Paediatric surgeon

I was really quite a nervous sort of person in terms of blood and gore … My mother was amazed that I even did medicine … I was always interested in drawing and design. Plastic surgeon

The status of being a doctor was sought by some and role models were an influence:

There was also a selfish component to it – a profession which is highly esteemed in a society. Emergency physician
I came from the country ... I was interested in science as a profession. I thought medicine was good, as based on the role model in a country town. Anaesthetist

This appeal was clearly about respect:

Yes ... it's rewarding financially, it's rewarding professionally ... Increasingly medicine's under threat, but I think when it's all said and done, the patients do respect their doctor. Anaesthetist

Parental aspirations played an important part in decision making. Sometimes the adolescent was a willing participant:

Why? To please my mother. I had a brother who was a very successful businessman ... but I couldn't seem to get anybody's attention. My mother, when she was young, had a fairly rugged time. We didn't come from a very wealthy family and she was a charity case in a public hospital ... and she was operated on by a guy ... who saved her life (but looking back they probably did it all wrong). She admired her obstetrician and I thought I'd be an obstetrician initially. Oncologist

Another accepted his immigrant parents’ need for their son to obtain financial security and status, recalling it with wry understanding:

Why did I become a doctor? Because I was the son of a refugee ... I had to have a profession to survive in this new country when my parents could not speak English. It was law or medicine and unfortunately I could stand the sight of blood so it was medicine ... The doctor had a social status in Eastern Europe. Rheumatologist

Sometimes the memories of parental pressure were bitter, with some fathers sounding like grim figures:

Aah, my father was a doctor and it was expected of me. Emergency physician

My father told me to [the subject would not elaborate when asked]. Surgeon

The challenge of the marks required for entry into medicine was the only motivation for two and both were regretful. Both had become specialists in areas that were highly prestigious, with competitive entry and long training periods:

I'll be frank. I actually was a year younger than everyone at school and was probably fairly immature. I was a high achiever and highly intelligent and I did medicine because it was the hardest thing to get into. If it would have been agriculture I would have done it. I found I was completely disappointed with university and I was fairly gifted at mathematics and that's where I should have gone if I had followed my heart. Cardiologist

Another specialist had deliberately not followed his intellectual interests and was not regretful:
I spent a lot of time as a child with computers. I started programming computers from the age of nine. Clearly there is a very strong link between me and computers … But when it was coming time to decide what to do with my life I thought it would be dangerous for me to choose a career that focussed on computers because I would do nothing else at all. So I decided to try and pick something that had to do with people rather than computers because I knew I was going to dabble in computers whatever happened. … When I was an intern I hated it and I thought I had made a terrible mistake and I consider myself extremely lucky that I fell into [a specialty that suits me]. Sydney specialist

Most of those interviewed had had little idea of what choosing to do medicine meant. Eight had parents who were doctors and thus had a practical understanding of medical work involved. Only one other described work experience that had enabled a mature and informed choice:

Because I didn’t actually get into medicine originally, I actually tried a few other career paths … [specifically] computer science and economics and found maybe I was suited to medicine so I actually started working as a student in a few clinics and really enjoyed the patient interaction … and I worked my guts out for the next year to get into medicine. Emergency physician

Some were altruistic, wanting work that would allow them to help others and where they would be needed:

The thing that made me change my mind as a fifteen-year-old from wanting a career in business to a career in medicine was a quote from Mark Twain which I probably haven’t got quite the right wording but ‘the test of the worth of the job is whether you would be doing it if you weren’t being paid or not’. Paediatrician

One had the desire to enact faith through work:

It’s a great way of having an opportunity to express your Christianity … in a very quiet way of doing just good. Sydney specialist

Two of the women had initially wanted to be nurses:

I was very altruistic … My father was a scientist … I initially started out wanting to be a nurse, then my father said, ‘Don’t be stupid, be a doctor’ [laughing]. That was when I was seven and that was the end of the discussion. Sydney specialist

When I was eight I decided that I liked helping people and caring for people and I thought about being a nurse and then I thought, ‘No, I’d rather be in charge of the situation rather than taking orders’ [laughter]. Sydney specialist

The doctors were also asked about their philosophy of work. While some struggled with this question, their answers combine their early motivations with the reality of practice.
We all need to earn income but is there anything else that guides or sustains or motivates you in your work as a doctor?

Two thirds included helping or caring for patients; for example:

At the end of the day, I have a satisfied patient, a happy patient and I think that overall that means I am out there to be able to help people. Obstetrician and gynaecologist

Just under half stated that they wished to make contributions beyond helping individual patients. These varied from a general commitment to social justice to involvement in health planning to a being a good team player to a commitment to teaching future doctors. The following quotes are illustrative:

Our plans specifically address capacity at a State and local level ... so in my personal working day I am striving not just to care for the individual patient, but in fact the whole cohort of ... ill patients where I have limited resources and that's a big challenge. Intensivist

I want to feel that I've trained some people to be good ... I want to feel that I've made a difference that goes beyond looking after patients ... because if you help a generation of doctors then that will help more people. Dermatologist

Patients who see a psychiatrist are often very vulnerable and allow us to ... see part of that world of theirs so that's an obligation to try to change things for them if that's possible. Psychiatrist

The psychiatrist above was describing the patient's world as being one of poverty and disadvantage. Later in the interview the same psychiatrist said:

I think we have unrealistic expectations about what can be provided in health care ... People with mental illness have needs that go from education to housing to general health to family intervention. Psychiatrist

Personal satisfaction formed part of many answers. This was derived from a range of things, including solving problems, the exercise of personal mastery, participating in academic advances and helping patients:

To make advances in my field: make new discoveries. Dermatologist

You honestly feel ... when you come to work and go home you're doing something useful in a way and productive. Plastic surgeon

The simple thing of being able to help somebody and make a difference to somebody who cannot breathe or who is bleeding to death [sustains and motivates me]. To be able to save their life makes a huge, huge difference. To see a child who is having problems with their tonsils
or their throat or their ears and not sleeping in case they choke in the middle of the night and all of a sudden you’ve done an operation for them and they come back two weeks later and mum and dad are happy, the child is happy … and it’s just, it’s just, I don’t know why it’s just unexplainable. That’s the reason. **Ear, nose and throat surgeon**

What motivates me as a doctor? Achieving things, I was really interested in maths at school and nothing, nothing pleased me more than having a problem at the top and working out a solution. Going into medicine there was lots of altruism. That aside, what keeps me going is the challenges, both small and large, in a patient achieving a good outcome, in a system achieving a good outcome, working out a complex diagnosis, doing a bit of research and showing that something works. So it is essentially achieving a goal with a good outcome. **Geriatrician**

Later in this book the fact that many doctors are reluctant to participate at the macro or system level will be discussed. However, two did mention the pursuit of systemic excellence as being motivating for them:

*I swore that anybody who I treated would get access to the best care in the world … I even said to them, ‘I’m going to set up a … clinic here and it’s going to be as good as anywhere in the world.’ … My aim is to do the best.* **Sydney specialist**

*My goal is to ensure that the patients that come through the emergency department are actually provided with the best care that we can afford to provide and the staff that are working there are working in an environment which is supportive, which is safe, where they can do what they’re trained for and they can actually get satisfaction out of the job. So, I see myself as the coordinator, someone who will try to provide an environment that will benefit the patient as well as ensuring that the staff are particularly careful.* **Emergency physician**

Several subjects mentioned specific issues as being not part of their mission, with the implication being that they believed that such issues might be included by other doctors: these included research and management. Although two mentioned a secure income to support self and family as part of their life aims, significant pursuit of income was suggested to be a risk to the doctor–patient relationship:

*No matter how people start off on their road, all of these other influences come in on their lives. It’s the private schools, and it’s the cars, all of these kind of things … If you see your patient as your next holiday on the Gold Coast it contaminates [the relationship].** **Rheumatologist**

**INTERVIEW QUESTION**

Has medicine met your expectations?

The question of how medical practice has matched with expectations has rarely been asked. Certainly very few doctors leave the profession. Of the 39 doctors interviewed, for more than half medical practice had met or exceeded their expectations and many of these were highly enthusiastic:
Oh, far and beyond. ... It's, far, far more than met my expectations. **Ear, nose and throat surgeon**

I never thought I would be as fascinated by the group of patients I've got in my practice. **General surgeon**

Can't imagine myself doing anything else ... I love what I do. **Obstetrician and gynaecologist**

Some of the remaining group found medicine frustrating. Boredom was an issue described by one in five subjects, and one that previously has rarely been described in the literature:

Sometimes I am bored. It is sometimes repetitive. Commonly repetitive ... As time goes on, work becomes less and less a part of my life and ... I am grateful in many ways, that I chose anaesthesia. I do enjoy it still, but I try to restrict work to a lesser part of my life and to enjoy other things. **Anaesthetist**

Some aspects, the science of it, the working out of things, are fine but it's often the mundaneness that gets you down ... The same thing all the time occasionally is boring and that's when your mind wants to go off and do other things. Occasionally the relentlessness of the job means you have to have a break from it. **Oncologist**

I find the science of medicine most interesting and there is always one patient in a hundred who is nice ... but a lot of it is, routine which is fine ... I haven't lost interest in medicine but I can go on autopilot very easily. I hope this isn't going to a court of law or something ... **Rheumatologist**

Two of these subjects displayed anxiety about confessing to boredom in their work. One subject had explicitly sought a counter for the boredom:

A lot of it is very routine and mundane ... You know we do a lot of clerical work and teaching is a way in which I gain some kind of stimulation. I actually did an MD [Doctorate of Medicine] and it's probably one of the better decisions I have made because otherwise my perception is that we just sit there in an office and the drug representative comes and tells you about the latest drug ... It is something I didn't think about as a medical student or before I entered medicine but it has suddenly become very important as a doctor, being able to think broadly. I enjoy reading, I enjoy doing a literature search on Medline [a computer-based search facility] and writing the occasional paper. **Psychiatrist**

Other reasons for the career of medicine failing to meet expectations were the difficulty of coping with poor standards of clinical care and indifference in the hospital system:

I have seen the decline in the whole public hospital system ... [and] I do care about it. **Paediatrician**

Financial struggle was also an issue:

I think it has been in some ways more difficult than I thought it would be and I don’t think I've met any of my financial goals whatsoever [laughing]. **General surgeon**
I didn’t think it would be as hard to actually make a living as it is. It is very hard work and it never stops. You’re always sort of on edge and worried about stuff. **Rheumatologist**

Some of those whose career decision had been motivated by altruism were disappointed:

[Some people] you might think you could help, are never going to be helped because they don’t want to or they won’t allow it or their circumstances make life difficult. **Anaesthetist**

I can’t say that everything I do now fits into that kind of aspiration that I [had of] providing health care to those who are in need. A lot of care is trying to meet expectations, or because of medico-legal reasons or part of the practice of [major teaching] hospitals. It’s really not necessary in a lot of ways. I have also worked in more underprivileged areas. In those environments, you actually have a more significant impact compared to here. **Emergency physician**

These were sad, but sadder still was the tale of a brilliant and wealthy subspecialist. When asked if medicine had met up to his expectations as a career, he said:

I think it did earlier on. It’s funny I think I revelled in the challenge in a way. I came from a little country school … I was sort of challenged to achieve from that point of view. I revelled at university and I worked very hard. … It’s like you’re running a marriage or running a marathon in a way … [Discusses difficult and time-consuming process of obtaining qualifications] … Then you realize the reality of the world and it is set for the next twenty years. You know what I mean. You run out of goals and things to achieve and you wonder whether it’s the process of getting there in a way which is the challenge and enjoyment. So, going into practice, it’s almost like postnatal depression … **Sydney specialist**

I guess I did know what he meant, as after all I’d gone searching for new challenges myself.

One presented a crumbling and fragile self-image:

**Interviewer:** Has it met the sort of expectations that you might have had when you were a medical student?

**Anaesthetist:** Yes, godlike expectations as seen on TV. For instance, I grew up in the time of a television series called ‘The Young Doctors’, which projected an image of male doctors as being … seductive, attractive, [and] intelligent which is how I saw my future in the field.

**Interviewer:** It’s a good answer, I like that. So has it met your expectations? So have you become seductive, attractive, and intelligent during your time [laughing]?

**Anaesthetist:** I’d have to say quite the reverse. There is no relationship to the fantasy.

**Interviewer:** So, it hasn’t met your expectations?

**Anaesthetist:** Nothing about it, no, zero. Nil out of ten. Do you know what I have found? Highly stressful, at times very demoralizing … Anaesthesia is not a respected specialty, which I find challenging to deal with at times. I feel that the demands … for the position test my very
being and often feel I am inadequate to the job. So far from making me feel better about myself, in many ways, this job makes me feel worse.

Burnout

It is evident that while most specialists started medicine enthusiastic and altruistic, only some maintained these attitudes. While some were extremely positive about their jobs others were distressed by their current work. Using the Maslach burnout inventory, 20–40 per cent of Australian (and British) doctors can be classified as psychologically distressed (McManus et al. 2004, Willcock et al. 2004, Bruce et al. 2003, Kluger et al. 2003). In an 18-month Australian study of new graduates, 75 per cent reached the criteria for burnout by the end of the study period and 70 per cent had signs of psychiatric morbidity at least once (Willcock et al. 2004). The authors suggest that a major cause may be the failure of these high achievers to meet their own altruistic goals and to obtain approval of their efforts from others.

Burnout is a state of psychological strain produced by prolonged response to job stressors and, in health care, it has the following features:

- emotional exhaustion
- depersonalization and cynicism – including treating patients like objects
- feelings of low personal accomplishment – meaning the individual cannot understand or identify with the problems of both self and others and feels powerless to have any actual impact on problems.

Burnt-out doctors are diminished in their abilities to care for patients. This interview subject who, as a little girl, wanted to be a nurse so she could help people now shows a lack of empathy for her patients:

*There is not enough appreciation ... that doctors don’t have the patience of a saint ... People shouldn’t not listen when they are being told about a [procedure] and then come in and ask the same thing twice again later.* Sydney specialist

A large group of US teaching hospital specialists were asked which aspect of work they found most personally meaningful (Shanafelt et al. 2009). For 69 per cent, this was patient care, research for 19 per cent, education for 9 per cent, and administration for only 3 per cent. Those who spent more than 20 per cent of their time in the area of work that was most meaningful for them halved their rate of burnout. The authors of this study suggest that those who derive the greatest amount of meaning from medical education or research may have greater difficulty obtaining the necessary protected time for a satisfying career. The pull of these different work aspects can also be a problem and a cause of stress:

*To try and do three different jobs means that you don’t do any one of them well ... In the last few years it has been clinician/teacher/administrator. Prior to that it was clinician/teacher/researcher and I don’t think anybody can do all those jobs simultaneously.* Sydney specialist
It is often presumed that doctors are unhappy in their work (Edwards et al. 2002), yet examination of the literature reveals more opinion than evidence. International evidence suggests most doctors gain high satisfaction from their work (Nylenna et al. 2005). Despite their varied motivations for choosing medicine and selection based (for most) on high academic achievement as an 18-year-old, many of those interviewed were extremely satisfied. However, the boredom described by some subjects has not been previously elicited. The impact of boredom is unknown, but the subjects clearly thought it placed them at risk of making errors.

Selection for Medical School

It has been stated that the testing procedure for medical school entry has the following aim:

*To reduce the large number of otherwise qualified and capable applicants to match the number of places available, and to enrol students thought most likely to succeed in what is an arduous program of study and to subsequently become effective members of the profession.* (Wilkinson et al. 2008)

Current testing procedures for entry to Australian medical schools involve consideration of academic achievement, an interview and one of two measures of intellectual ability – the Undergraduate Medicine and Health Sciences Admission Test (UMAT) or the Graduate Australian Medical School Admissions Test (GAMSAT). The UMAT consists of three sections – logical reasoning and problem solving, understanding people and non-verbal reasoning. Prior academic achievement such as performance in final school examinations or results from another university course has been found to be correlated with future general academic achievement. However, these alternative tests of intellectual ability (UMAT and GAMSAT) and the associated interview process may or may not be predictive of performance in medical school (Groves et al. 2007, Wilkinson et al. 2008).

There are numerous papers on the topic of medical school entry in *Medical Education* and similar journals. It is clearly appropriate that medical educators struggle over a topic so central to their work. The fierce debate appears rooted in a strong attachment to retaining and/or improving tests and interview processes that attempt to select students who have good clinical reasoning abilities and adhere to professional values. Yet it is not clear which attributes an applicant needs before medical school and which ones may be appropriately learned during medical school. Some skills and sensitivities may require clinical experience (Bardes et al. 2009). ‘Medical students become professionals as they learn their skills, responsibilities and privileges. They are not professionals on admission’ (Johnston and Peacock 2009: 155).

Section two of the UMAT is designed to assess ability to understand and think about people, but it does not correlate with conventional measures of emotional intelligence (Carr 2009). Although empathy is accepted as a desirable medical trait, a recent review concluded that no existing empathy measures are reliable and valid for use in the selection of medical students (Hemmerdinger et al. 2007). There is insubstantial evidence overall that performance on non-cognitive assessments is associated with better residency performance (Baldwin and Self 2006, Peskun et al. 2007). There is no agreement on testing
Motivations for Studying Medicine

Instruments for professionalism. This is not surprising, as the next chapter reveals it to be a confused concept. Reviewers have noted the lack of adequate evidence for the links between measured attitudes and future behaviour in such instruments (Jha et al. 2007).

The behaviour in medical school of US doctors who were later disciplined by a medical board has been examined (Papadakis et al. 2005). They were more likely than a control group to display unprofessional behaviour while in medical school as evidenced by irresponsibility, diminished capacity for self-improvement, poor initiative and impaired relationships with other students and nurses. The authors suggest that this points to the importance of teaching and testing for professionalism. However, only a very few doctors are disciplined by medical boards and only a fraction of these were troubled students. Of greater interest perhaps is what sort of practitioners the other ‘unprofessional students’ who never receive medical board censure make? How satisfactory is the care they deliver, as assessed by peers, co-workers and patients? Patient satisfaction is an important goal. Patients satisfied with their care are more likely to exhibit self-confidence, be motivated, practise healthy behaviours and follow medical advice (Conboy et al. 2009). Good patient practitioner communication improves physiological health status in such areas as blood pressure and diabetic control (Conboy et al. 2009).

Psychologists based in Townsville (Queensland, Australia) have screened medical students for ‘dysfunctional tendencies’ (Knights and Kennedy 2006). They found 0.8 per cent to be uncooperative, over-sensitive to criticism and with a preference for working alone, while 11 per cent had an extreme tendency toward aggressive self-promoting behaviour. Two other more common syndromes are of great relevance to teamwork. A third of students had extreme scores on a syndrome they titled ‘diligent’ – characterized by being picky, critical, stubborn and unwilling to delegate because of perfectionist tendencies. (Perfectionism is evident in many of the quotes in this book, and indeed appears to be a trait associated positively with some safety behaviours and negatively with others.) The syndrome of ‘dutifulness’ was extreme in 26 per cent: these individuals tend to be indecisive and conforming and reluctant to express disagreement. They may be good team members but not leaders and perhaps not easily able to ‘speak up for safety’; that is, to be appropriately assertive. As yet these authors have studied only the relationship of these characteristics with medical school performance (Knights and Kennedy 2007). The implications of such characteristics for workplace performance and patient safety are fascinating but have not been researched as yet.

To date, no testing has considered selection that maximizes the chance that practitioners will be satisfied with their professional life and able to resist burnout. Many medical school selection interviews look for altruism as well as empathy. However, dedication to patient care (‘caring’) is stressful as things do not always go well and cannot always be controlled. Many of those interviewed who had made a highly altruistic career choice were unhappy. In summary, there is a lack of evidence for the fitness of any medical school selection criteria to ensure career satisfaction or technical proficiency or patient satisfaction.

What happened to my aspiring medical student passengers? My own child – an artist, writer, debater, seamstress, gourmet cook and outstanding HSC student – did sufficiently poorly on the ‘triangle section’, and just that section, to be ineligible for interview for medical school. None of her companions made it through the selection process either.

What characteristics does the ideal doctor have?
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Story 1: Morning in a Sydney Teaching Hospital

Well-shined leather shoes pace a confident stride over the linoleum of the ward floor. His team are waiting at the desk: registrar, resident and intern.

‘Morning all. Let’s start with the new admission then check on the outliers after our tutorial.’

‘How was the conference?’ asks the registrar as they walk. ‘How’d your presentation go?’

‘Excellently received by the internationals, especially the French. They’re really impressed with our results.’

In the second room there is a very old lady sitting beside the bed of an even older man. His eyes are closed and his breathing is laboured. The nurse is nearby.

‘Good morning, Mrs Smith. Good morning, Sister.’

‘Oh, I see you’ve just done the observations. Excellent.’ He quickly studies the chart.

‘Mrs Smith, the team tells me there has been some improvement in John’s neurological function. He is improving, just not quite as fast as we had hoped and of course we still can’t be sure what the eventual result will be. But the fever he’s running is a new worry.’

She nods, and sighs: ‘Doctor, you did warn us of the risks … We knew all the possibilities’.

He pats her arm. ‘The waiting is hard, isn’t it?’

He turns to the team: ‘We need a repeat cerebral CT scan and a septic work-up. We might need a consult, some advice from our microbiology colleagues, but I’ll be back at five sharp to review.’

He nods at Mrs Smith and the nurse.
They turn to go, the intern scuttling ahead to the ward desk to book the scan. The others are immersed in a technical discussion by the time they reach the corridor.

‘He really is wonderful, isn’t he?’ Mrs Smith smiles up at the nurse.

The Professionalism Debate

Discussions about professionalism are marked by etymological confusion around the words ‘profession’, ‘professional’ and ‘professionalism’. A profession is ‘a vocation requiring knowledge of some department of learning or science’ (Macquarie University 2005). The word ‘professional’ has some contradictory meanings, including ‘expert’ and ‘making a business of something in which amateurs engage for recreation’ (Macquarie University 2005).

Dictionary definitions aside, doctors have long been concerned with the quality of professional practice and have sought to define professionalism. In the 1700s the English physician-ethicists Gregory and Percival promoted the concept that physicians are ‘fiduciaries’ of their patients (McCullough 2004). The three components of their fiduciary duty were:

- Practitioners should exhibit competence.
- Skills and knowledge were to be used primarily for the benefit of patients, with self-interest secondary.
- Medicine should be seen as a public trust existing primarily for the benefit of the patients and science.

Fiduciary obligations refer to the obligation to act on behalf of clients, even when this means foregoing business opportunities (Clark 2002). This is prescribed by law in the case of lawyers, but more loosely regulated for medical practitioners via codes of conduct. These codes are based on virtue ethics (that is, with an emphasis on the moral characteristics of practitioners) and overseen by medical boards who use terms like ‘being of good character’. The fiduciary concept resonated with older ethical traditions in medicine such as those enshrined in the Hippocratic Oath.

The Oath itself is a somewhat misunderstood document. For instance, the mantra ‘First, do no harm’ does not actually appear in it. Hippocrates came closest to this directive in his treatise Epidemics with an axiom, ‘As to diseases, make a habit of two things – to help, or at least, to do no harm’ (Markel 2004). There have been many revisions to the Oath (and the development of alternative oaths) to reflect changing beliefs and medical practices. The most controversial issue has been around the sanctity of life with adaptations that allow for euthanasia and terminations (United Nations 2006). The original Geneva Declaration was developed after the Nuremberg war trials, and was highly influenced by the evidence of doctors’ roles in war atrocities. An emphasis on placing patients’ interests first and on confidentiality remains common to all versions.

The fiduciary promise is said to have enabled medicine to be granted a ‘social contract’ and thus monopoly status, autonomy and self-regulation (Hilton and Slotnick 2005). Thus medicine obtained what the sociologist Eliot Freidson describes as a ‘dominant
position in a division of labour so that it gains control over the determination of the substance of its own work’ (Freidson 1988: xv), including oversight by the profession alone.

Charters of Professionalism

These are simply lists of ways of thinking and acting that enabled doctors to obtain and maintain patient trust and thus to practise in times when the public had very little ability to assess the results or appropriateness of medical care. An element of public relations is part of some descriptions. Daniel Webster Cathell MD wrote a best-selling book *The Physician Himself*, first published in 1882, that went through more than ten editions (and was last in published in 1932). This was a doctor’s guide to success and included guides to appropriate dress for doctors as well as the décor for the consulting rooms. It also warned against being seen ‘loitering around … hotel-lobbies, saloons, club-rooms, cigar-stores, billiard parlours’ (Neuhauser 2005). However, the core of his advice is the adoption of both professional values and practices:

*Bear, therefore, the greatness of your trust, and the responsibility and glory of your almost divine mission, ever in your mind. Remember at all times that every phase of your conduct … will be observed and considered. Therefore strive to make your manner and your methods as faultless as possible … and strive to do the greatest absolute good for each and every one of your patients, that you may merit to be called ‘A MODEL PHYSICIAN’.* (Neuhauser 2005)


When the American Board of Internal Medicine defined professionalism in the 1990s, the definition included ‘qualities and skills that are not knowledge-based or technical in nature’ (Shrank et al. 2004). Subsequent US debate produced *The Physicians’ Charter* endorsed by 90 professional organizations (Blank et al. 2003). The ‘Fundamental Principles’ in the Charter were primacy of patient welfare, patient autonomy and social justice. Both patient autonomy and social justice were new concepts added to those of the fiduciary duty. The ‘Professional Responsibilities’ of *The Physicians’ Charter* were commitments to:

- professional competence
- honesty with patients
- patient confidentiality
- maintaining appropriate relations with patients
- improving quality of care
- improving access to care
- a just distribution of finite resources
- scientific knowledge
- maintaining trust by managing conflicts of interest
- self-regulation (including recognizing human limitations and needs).

The preferred UK definition (developed by the Royal College of Physicians) is both more elegant and clearly goes to matters of affect: ‘a set of values, behaviours and relationships that underpins the trust the public has in doctors’ (Levenson et al. 2008: 1). This definition implies that patient or public trust would then form the measure of professionalism. In the recent annual Australian market research survey that rates the honesty and integrity of various professions, doctors ranked third, behind nurses and pharmacists, with 75 per cent believing doctors to be honest and trustworthy (Morgan 2010). (The sad lows were car salespersons, advertisers and journalists, who were trusted by merely 3, 6 and 9 per cent of the population respectively). Commonwealth fund studies also show high levels of population trust in medical practitioners (Hardie and Critchley 2008, Calnan and Rowe 2004, Calnan and Sanford 2004). Yet it is not clear what underlies this trust. It can be misplaced:

_Some of the worst doctors I know of, are loved most by their patients. They’re fantastic communicators. They can convince their patients that they’re terrific and the patients don’t know how to assess them and so they get operated on, and they have twenty to thirty complications. They think it’s great because the guy is nice to them but they wouldn’t have the complications if the right guy would have done the operation._ **Oncologist**

While patients can recognize good communication and caring behaviours, they are limited in their ability to assess other parts of medical performance and competence. However, if patients had the opportunity to select doctors based on clinical performance and patient satisfaction ratings, a shared community awareness of what a good doctor is could develop in society. This awareness would include those aspiring to be medical students and doctors themselves.

The Decline in Public Trust

What has inspired the re-definition and elaboration of professionalism in the last two decades? The major factor seems to be a perceived reduction in public trust. Many authors hope that renewal of professional virtues will enable doctors to deserve greater public trust and autonomy and thus spur a return of these aspects of medical life (Wear and Kuczewski 2004, Surydk et al. 2003, Rhodes et al. 2004, Wynia et al. 1999). This has been described as ‘nostalgic professionalism’ (Hafferty 2009) and is characterized by discussion that indiscriminately mixes values, attitudes, traits, attributes, principles and behaviours. Public trust has been disturbed by increased awareness of medical errors, whether due to well-publicized system failures, errant practitioners or medical error studies.
Professionalism – Being a Good Doctor

Doctors have always had to learn and retain large amounts of scientific knowledge – anatomy, pathology, physiology, microbiology, biochemistry and pharmacology. In the past, medical practitioners were patients’ only source of this information. Trust was therefore sustained by ‘the stranglehold that doctors traditionally enjoyed over medical knowledge and information about the quality of healthcare’ (Quick 2006).

The Internet has dramatically widened access to medical information. As large amounts of technical medical information are available to patients and others, power struggles are inevitable. Various concerned parties (other kinds of clinicians, managers, funders, commercial interests and patients) now assume the right to interpret the available evidence on which decisions can be based and so contest both the processes and outcomes of clinical decisions.

Lay knowledge creates an increased awareness of the multiplicity and uncertainty of medical opinion (Brown 2008, Levenson et al. 2008: vii). The work required to give an uninformed patient the subset of knowledge the doctor deems necessary is substantial. A consequence of the new access to information may be frustration for both patient and practitioner, as the communication now required to reach a shared understanding becomes even greater. When this is not possible, consumer distrust is to be expected. It is suggested that where medical knowledge is viewed as medical opinion, to win trust the professionals have to engage in a new art of impression management (Brown 2008). Considering Cathell’s advice in The Physician Himself, this art may not be as new as some in the medical profession believe.

The Virtuous Professional

Many lists of the fundamentals of professionalism are not lists of acceptable behaviours or competencies but rather relate to commitment and values. There is a requirement not only for the enactment of virtues, most particularly altruism, but also for empathy and for a commitment to social justice. Virtue is desired, but may not be easily taught:

Committed observance of professional norms cannot be coerced but may emerge among trainees through their responsiveness to the lived moral life of virtuous faculty, encouraged by the tacit and explicit invitation of such faculty to imitation over time. (Huddle 2005)

The image of a monastic order is inescapable. The issue of what to do with non-virtuous faculty is not discussed. Altruism has been described as a ‘core characteristic of competent health professionals’ (McGaghie et al. 2002) and self-sacrifice as the premier medical virtue (Chervenak and McCullough 2001).

The metaphor that informs the medical conscience is that of selfless attending on a single patient, no matter what the hour or other calls on the physician’s time (Brennan 2002). Note that this self-sacrifice has at its centre the single patient. Yet this book had its genesis in the abdication of doctors from the organization of the hospital and thus from the care of broader groups of patients.

Contemporary medical students may reject obligations to such moral codes and describe ‘needing balance in their lives’ and ‘to look after themselves’ (Hafferty 2002). The SARS epidemic (Severe Acute Respiratory Syndrome caused by the SARS coronavirus) prompted a new attention to the conflict between personal safety and duty of care (Davis
Doctors of old, of course, did more regularly catch their patient’s diseases. In a severe pandemic triage, principles such as ‘the greatest good for the greatest number’ (Iserson and Moskop 2007) may even require conservation of medical manpower by limiting doctors’ risk exposure.

The risk of physical illness aside, there is modern confusion about how to prioritize the needs of self, patients, family and community (Wear and Kuczewski 2004, Dudzinski 2004). The suggestion has been made that placing the patients’ needs before that of the doctor is ‘valid in a very limited context, and that carrying this principle to the extreme (i.e. to the point where the doctor becomes personally depleted) actually undermines professionalism’ (West and Shanafelt 2007). Might the modern practitioner worry: ‘If I don’t look after myself I’m not looking after my patients’?

In the 1960s the relationship between the patient and doctor was analysed through the doctor–patient consultation (Armstrong 2002: 164–173). This created new demands to be able to see through the patient’s eyes and to understand and express the doctor’s subjectivity. It became expected that doctors be empathic care givers. To do this, they have to engage in ‘emotional labour’ through acting (Larson and Yao 2005). It has been suggested that deep acting (analogous to theatrical method acting) results in more effective patient healing (Hojat et al. 2002a, Larson and Yao 2005) and greater professional satisfaction.

It is not clear if deep acting is required of doctors or if such behaviour is optional. It is also unclear how much such behaviour is natural or whether it must be learned. Richard Horton, editor of The Lancet, believed in the ‘doctor’s natural desire to promote positive patient outcomes compassionately, altruistically and scientifically’ (Horton 2005). Medical schools are now expected to produce empathetic graduates (Hojat et al. 2002b) but, as discussed in Chapter 3, as yet cannot reliably measure aptitude and do not measure the results of their efforts (patient perspective on the practices of the subsequently qualified professional).

There has been an increasing awareness of the wider health and social system surrounding the doctor–patient interaction. Professionalism charters include ‘social justice’, being sensitive to limited resources, improving access to care and fair distribution of finite resources (Barry et al. 2004). The conflict between these elements of social justice and the primacy of individual patient welfare is widely discussed but is one not given to easy resolution. Surveys show that more than a third of US doctors would accommodate a patient who badly wanted a test, even when they knew the test was unnecessary and a waste of medical resources (Campbell et al. 2007).

There is increasing pressure on doctors to consider the quality of care in the health system overall and not just for the individual patient. Therefore, tensions result (Brennan 2002). Detailed examination of health inequalities results in policy propositions focussed on such things as childhood education, preventative health programmes and policies to ensure full employment and fair wages (Marmot 2010) – however, these are not areas within the remit of the individual medical practitioner.

**Australian Perspectives**

It should be noted that there are marked differences in the US-based professionalism literature (which is individualistically framed and altruism-centred) and the more
social policy-oriented European literature (Hafferty and Castellani 2009). An Australian national guide has recently been developed based primarily on UK work: *Good Medical Practice: A Code of Conduct for Doctors in Australia* (Working Party of the Australian Medical Council 2009). I do not believe we have yet had sufficient national debate or study of the particularities of medical professionalism in Australia. Professional values relate to political and social environments and ethical and religious beliefs and must necessarily vary between nations.

Limited information exists. Australian doctors have been asked to detail the qualities of a ‘good’ and a ‘bad’ doctor (Lupton 1997). The most important quality of the good doctor was found to be that of being a good communicator – including empathy and being a good listener. ‘Good’ doctors also needed to treat patients as individuals, avoid patronizing them, be up to date, be good judges of risk, and be obsessional about follow-up. The ‘bad’ doctors ‘didn’t listen’ and were avaricious.

Australian patients, when asked, listed two distinct sets of attributes they considered necessary in a good doctor. The first set covered skill, experience, clinical knowledge, decisiveness and calmness in a crisis. The second set covered being able to exchange information and being able to communicate effectively and sensitively. What is particularly interesting is the almost-contradiction in the requirements – between the decisive and calm doctor and the chatty, sensitive doctor. It would seem an ideal doctor needs to be able to operate in both modes.

How do contemporary Australian specialists feel about professionalism? Are any of the lists of principles important to them? Specialists were asked the following question:

**INTERVIEW QUESTION**

If I were to describe a doctor as ‘highly professional’, what would that imply to you about their behaviour?

While one subject considered professionalism a ‘very old and cumbersome term’, most rapidly listed up to six behaviours. Competency, skill or knowledge were included by only 60 per cent. An extremely diverse set of attributes was volunteered including many listed earlier but there were also surprises. The following is a list of the themes:

- Has high level and up-to-date knowledge or follows professional norms or is competent or is highly trained and skilled: ‘has a strong body of knowledge which is updated continuously’, ‘who has a good working knowledge of his or her job’.
- Makes quick decisions or is efficient and reliable: ‘gets it done efficiently, quickly, quietly and moves on’.
- Respects patients, in general and in terms of consent and confidentiality: ‘consent ... there is over-emphasis on the medico-legal aspects ... it’s actually much more about people going into things with their eyes open ... that’s what they deserve as a basic part of the whole process’.
- Is honest about limitations and with patients: ‘being aware of your own limitations and being honest with yourself and being honest with the people you deal with’.
• Is compassionate, kind, caring: ‘genuinely concerned about the patient’s well-being’.
• Has a respectful attitude to peers: ‘they have a way of treating their fellow professionals which is with integrity and honesty and justice’.
• Does the job to high standard, no matter what.
• Is virtuous: ‘morally good standings’, ‘no other scandal brewing of a personal nature’, ‘behaviour was commensurate with what would be expected from the patient’s community’.
• Places patients above all other agendas: ‘doing all you can for your patients’, ‘not self-interested’.
• Is committed to social justice: ‘an advocate for health provision’.
• Is accountable, responsible.
• Is committed to teaching.
• Has a smart appearance: ‘you don’t look unshaved as a doctor’, ‘well-dressed, well-groomed’.
• Avoids chat, reserved with patients and colleagues.
• Is courteous, with good communication skills: ‘affable, polite, respectful, kindly and unruffled’.

The word ‘job’ was used often, even monotonously, by some subjects. It was used to describe a self-imposed burden or discipline with the subjugation of life to ‘the job’. ‘Doing the job properly’ is also well suited to perfectionist natures.

My father was an architect. He had a profession. … But I think you could be a garbage collector and be very professional at it and be very good at it if you wanted … So professionalism is not a job: it’s doing a job. **Endocrinologist**

I use the word ‘professional’, teaching the house staff in terms of the difference between an amateur and a professional. The amateur does it because they want to do it and if they don’t want to do it they leave. The professional has to get the job done no matter what. **Paediatrician**

Firstly, to define the word ‘professional’ … I see that as an individual who sacrifices significant quantities of his or her time and lifestyle for career … I see myself as a healthcare delivery professional … Members of the nursing staff might like to see themselves as professionals [but they] clock on and clock off and that would not fulfil my requirements … Therefore I would be upset if somebody else in another branch of healthcare delivery likened themselves professional. **Anaesthetist**

A supportive attitude to colleagues was considered to be an extremely important attribute of professionalism:

That they had the best interests of everybody at heart – their colleagues in the operating theatre, if they’re an anaesthetist, as well as their patients. **Anaesthetist**

Making a minor error of clinical judgement would be much less important to me in terms of professionalism than behaving inappropriately to a patient or colleague. **Gastroenterologist**
However, a paediatrician specifically pointed out that ‘get the job done includes overruling colleagues’. This potential conflict between responsibilities to patients and relationships with colleagues was mentioned by another, together with a hopeful compromise:

_It means that they will flog a derelict system to get the last breath of workability out of it for their patients … hopefully not stepping on their colleagues’ toes to do it._ **General surgeon**

In Chapter 9 the issue of the positioning of doctors in relation to the health system is discussed in more detail. However, professional values were cited as a reason for some doctors to limit their engagement with hospitals as institutions:

_Near enough is not good enough and a compromise is not good enough … In the public hospital system it’s almost getting to the point where you don’t feel you can carry on a first-class professional practice … It’s becoming so compromised … I feel uneasy working in a system that is not producing ideal results. That … compromises my idea of professionalism. You know, I like to do things properly. I like to get A1 results for everyone whether they are public or private patients and you really feel that people going into the public system now are really being compromised. My dilemma is ‘Am I happy to go along providing B-grade results and feel comfortable about that?’ … So if the system is going to let me down and not work with me to provide professional care …, then I’d rather not be involved in it. Perhaps that’s a defeatist attitude._ **Plastic surgeon**

_It’s also putting the patient first, putting the client or patient first and acting as their advocate … I think that is probably where doctors do remain difficult to incorporate into the health management system [because of their] patient advocacy role._ **Physician**

_If you act in the patient’s best interests at all times then that’s really a much safer sort of thing, and I think it’s more rewarding as well. Then that brings the question of how does one wear multiple hats if one is an administrator, and a director and a clinician as well. And that is a very difficult question that I have no answers for._ **Cardiologist**

Several specifically mentioned ensuring that personal financial considerations did not affect clinical work:

_Having absolute integrity so you always make the right decisions based on the right reasons rather than any financial remuneration or any personal gain._ **Plastic surgeon**

_[A professional’s] primary motivation would be the clinical outcome for the patient and [practice] would be driven purely to make the patient happier rather than to fulfil personal need, be it financial or anything else._ **Gastrointestinal surgeon**

_In my specialty we don’t get paid a lot for what we do, so we have to work really hard to try to maintain a reasonably good lifestyle. You might say ‘Well, you don’t need a nice house and a nice car’. Well, we probably don’t but I want one like everybody else does. I did make a vow that I would not do things to patients just to make money out of them. I did make that vow and I thought if I ever find myself just doing things to make money it’s time to quit._ **Oncologist**
A certain approach to competition and ‘trade’ was advocated:

*You get customers ..., if you want to call people customers, in this business by being good. You don’t try and steal a lot of people’s patients. That’s highly unprofessional. You do attract lots of patients if you’re very good. That’s what you should be pursuing. That’s what I think of as professionalism.* **Rheumatologist**

How are patients ‘stolen’? This description would be most likely when referring relationships are disrupted by new specialists marketing to general practitioners. They may offer a more responsive service, lower prices or clinical approaches that are more appealing to patients, such as less-invasive surgical techniques.

One of the most surprising desirable professional attributes proffered was that of cool reserve:

*Not really very involved in the gossip or the undercurrent bitchiness ... Staying very aloof.* **Anaesthetist**

Some considered limitation or control of emotional expression desirable:

*[Dr X] is compassionate, diligent, attentive to detail ... Information comes across, consent is good ... but still has humanity and whatever. He can get flustered and all that. Does that make him less professional? Probably not. But that is an added bonus in professionalism – the ability to control those sorts of things.* **Intensivist**

Some doctors struggled, identifying themselves as professional (or ‘good’ doctors) while rejecting traits, in particular formality and efficiency, that they considered attributes of the ‘highly professional’ doctor:

*Often people say to me that ‘You don’t seem to be a specialist because you’re too kind of laid-back and you call a spade a shovel’ but I still feel I am professional. There are some of the niceties that I don’t have, I’m just someone who knows their job well and treats their patients with respect. That’s ... a professional I think, that’s my feelings.* **Rheumatologist**

*[Professionals] are something that I am not quite: they are more business-minded ... Doesn’t stop for the chat ... more efficiency ... [fewer] human qualities, I suppose. Not exposing your normal traits to clients.* **Physician**

It’s interesting you ask that question because I often get people writing thank-you notes, and thanking me for my professionalism [laughing]. You get patients saying ‘Thanks for the expertise, for being caring and understanding, but also for your professionalism’ and I don’t see myself as ... being professional when it comes to ... providing the medical service. That is why the patients have come to you. But ... I like to take a sort of laid-back approach, especially with the obstetric patients, because you get to know them. You like to have a bit of a chat with them, which I don’t see as being very professional. I am not saying that I’m not professional. ... When you do need to get in and do something, that’s when you do show your professionalism. **Obstetrician and gynaecologist**
The concept of professionalism was passionately rejected by one doctor, who associated it with right-wing political attitudes and financial success:

Does that mean that they are a member of the AMA [Australian Medical Association, a politically conservative medical lobby group], therefore charge AMA rates and don’t see any elderly old ladies and they do their work very well? Does that mean that they’re respectful of all their colleagues? It means nothing. Does that mean he puts in extra hours? That doesn’t mean that they’re professional because they’re hard-working. Do they go to every single conference? Well, they’re up to date. Geriatrician

The issue of the relationship between professional and financial success is interesting. Social commentator Hugh Mackay suggests if ‘children raised in a highly competitive atmosphere, where parents and teachers equate high marks with high worth … choose the right professions, all they’ll have to do is substitute money for marks and nothing much will change’ (Mackay 2005).

It seems that some, at least, saw themselves as a different sort of professional from the cool and somewhat cardboard figure who opened the chapter, and perhaps closer to the character that is the star of this television series.


(For those not familiar with the characters, M*A*S*H is a vintage and well-loved US TV show that applied humour to the grim realities of a Mobile Army Surgical Hospital in the US–Korean war of the 1950s.)

In the Operating Room (OR), Hawkeye is operating, assisted by Major Margaret Houlihan.

**Hawkeye:** Oh boy … Give me some suction here … anterior vertebral body is fractured, I’m going to go after that big fragment. Forceps …

The scene changes to the recovery unit where Hawkeye’s patient looks in bad shape. Hawkeye is talking to a nurse. They go over to the patient, Hawkeye examines the wound.

**Hawkeye:** How’s it going?

**Thompson:** Lousy.

**Hawkeye:** Well, that figures, you were on the table a long time. I was beginning to think we were going steady.

He walks away to talk to the nurse and Trapper enters.

**Trapper:** Hey, how about a round of golf this afternoon? After the mortar barrage last night we’ve got a 19th and 20th hole.
**Hawkeye:** No, I can’t. [To Nurse] Start him on IV penicillin. He may be developing a wound infection and I want to get a blood count so bring me the tubes right away.

**Trapper:** Penicillin might bring him around.

**Hawkeye:** Yeah, but ‘might’ isn’t good enough. I want to be sure of it.

The scene changes to the mess tent, Hawkeye enters looking lost.

**Trapper:** Hey, how’s Thompson?

**Hawkeye:** Still down hill … He’s falling apart on me.

**Burns:** Was it something you did, or something you didn’t do or something you forgot to do?

The baiting ends in a fight. The scene then changes to the ward. Hawkeye picks up Thompson’s chart, lies down on to the empty bed next to him and falls asleep still staring at the chart. The next morning Hawkeye is fast asleep next to the patient. A number of scenes follow, showing Hawkeye suffering severe angst over his patient and withdrawing from his normal social life. The scene changes, Hawkeye is asleep, but wakes up.

**Hawkeye:** Hey, hey, hey, HEY!

He runs out of the tent to Margaret’s tent, knocks on her door. Major Houlihan opens the door in her nightdress.

**Houlihan:** What’s the matter?

**Hawkeye:** I’m opening him up. You’re going to assist me.

**Houlihan:** Let me get some clothes on.

**Hawkeye:** Later. Go wake up Ugly John and get someone to prep Thompson. I said now. Move.

The scene changes to the OR where Hawkeye has re-opened Thompson.

**Hawkeye:** Lap sponge. Bingo, the bullet hit the back of the sigmoid colon.

**Houlihan:** That has to be it.

**Burns:** Anybody could have missed that.

**Hawkeye:** Thanks, Frank. OK, let’s close him up.

There are some fascinating lines in this script excerpt. Black humour is a hallmark of this show, and Hawkeye is a ‘bad boy’ who tells jokes in dubious taste, is sexist and engages
in promiscuous behaviour, heavy drinking and gambling. He is, however, humane, and his other behaviours are portrayed as coping mechanisms for the carnage of war. This whole episode deals with his distress over ‘his’ patient. He spends the night by the young soldier’s bedside, demonstrating dedication. Later he wakes the team to operate urgently. He displays perfectionism: ‘Might isn’t good enough, I want to be sure of it’. His language demonstrates the deeply felt nature of medical failures: ‘He’s falling apart on me’. At the end, his usually hostile colleague Burns offers the necessary forgiveness: ‘Anybody could have missed that’. This forgiveness corresponds to sociologist Charles Bosk’s conclusion:

There is a general reluctance to let a technical failure be a conspicuous occasion for social control since its sources are so variegated, since the decisions demanded are so subtle and complex, since it happens to everyone, and since it is believed that the responsible physician will draw the proper lessons from the evidence. (Bosk 2003: 174)

Some of the interview subjects perhaps liked to imagine themselves as dedicated renegades like Hawkeye. How do Australian doctors respond to real-life scenarios that probe professionalism in matters far removed from the fictionalized drama of a field hospital during the Korean War?

The following scenarios explore responses to the major fiduciary issue – the primacy of patient welfare. The first two deal with unpaid labour that is in the patient’s interest. The following three deal with the tension between professional obligations and the doctor’s family responsibilities or personal life.

FOCUS GROUP SCENARIO

A new drug may improve your patient’s condition. You can obtain the drug if you produce a three-page case summary with justification and make many phone calls to Canberra (to the Therapeutic Goods Administration which regulates the use of new drugs). The time involved in this application will not be funded. What would you do?

This scenario and the one following were attempts to assess how much irritating and unpaid work doctors were willing to do for their own patients. It appeared common practice to comply with time-consuming processes of this nature to assist patients.

Focus group members felt very angry about the regular use of their time for such things:

I was going to spend this weekend working out the procedure for using it because it’s not Therapeutic Goods Administration-approved, so got to have a process for the special access scheme and the forms have to be filled in and they’re not easy.

When you work for NSW Health you’re working for a government that taxes me, it doesn’t give me any lower taxes and so on, and I charge them for everything that I can because no one else works in that system for free. If I wanted to be a missionary then I would do it for World Vision … I will do things for free for patients but I’m increasingly hacked off being asked to do things free for the system.
When the interns and residents never used to charge for un-rostered overtime it was quite clear that the hospital would work people 90/100/150 hours a week … When I was at Campbelltown hospital … the ECG [electrocardiogram] technician went on holidays so the solution was that the interns did their own ECGs, which meant you had to stay back for another couple of hours because otherwise they would have had to pay for someone to do it. We were free labour.

Many of us as juniors have done a lot of gratis work because of the combination of career blackmail versus – and you know – you’ve just got to get the job done. You just do it. By the time you get to VMO [Visiting Medical Officer] you’re starting to get bitter about what you have and haven’t done … Two of us worked out as registrars that at one hospital we were both not claiming between fifty and one hundred thousand dollars’ worth of overtime a year – each.

But no one has ever thanked you for that. And you don’t get a letter from [the State Premier], saying, ‘We know you’re doing all this work for gratis so let’s knock off your property tax for the year’.

The workplace may be somewhat different now, but a legacy of anger from the training years clearly remains. While group members would generally pursue such administrative processes, there was a certain degree of pragmatism and it was suggested that the patient’s enthusiasm might be discouraged:

If there is a slender chance it will help, I’d mention the adverse effects as well.

The hassle to benefit ratio has to be worthwhile.

‘To damn with faint praise’. You can give a tacit support but not enough to push it over the line. You make sure you don’t.

The possibility of considerable work for a single patient’s benefit being discouraged was therefore included in one of the answers for the next scenario (which was subsequently taken to the larger survey group).

**FOCUS GROUP SCENARIO**

A treatment your patient needs has been blocked by the director of the hospital. The only chance of obtaining it will involve a very detailed application to the Area New Procedures Committee and then the Area Board. What would you do?

It seemed likely that responses here would be different from the previous scenario as Area processes were viewed as less fair. In addition, I was aware attempts were regularly made to commence new procedures without approval to produce a ‘fait accompli’ situation.

Focus group members thought the application should be made. ‘Just do it’ was a popular response:
You have to do it … Yeah, you’d have to do it. And get as much evidence as you can. Present the facts. Not get too emotional about it.

Again, the issue of the number of patients who might benefit was raised. A colleague in the middle of such a process was discussed:

He’s going through a lot of hassle because it’s for a number of patients, and I guess, by default I assume, his practice and his income.

It was suggested that the process of seeking approval was sometimes ignored:

In practical terms these fancy things are often done without getting any sort of approval, because it’s so much trouble.

Such voluntary rule breaking was found to be common among Swedish health professionals due to both lack of time and when ‘there was conflict between the regulation and what the personnel saw as best for the patient’ (Kalvemark et al. 2004). Other methods of pressure, including approaching the media, were suggested, and there was an understanding of the complex politics that may be involved:

I’ve got myself on that new procedures committee.

If the patient needs that treatment and a bureaucrat is blocking it, it’s obviously not sufficient reason to say ‘I can’t do anything about it’. And you might fax everyone from the Minister of Health right down.

You’d be surprised how many times the Director of the hospital will say to you: ‘I should advise you not to go to the media but I can’t stop you’, which is him saying, ‘If you go to the media it might release the pressure that’s on me but I can’t tell you to do it’. They talk in code.

SURVEY RESULTS – ‘TREATMENT BLOCKED’ SCENARIO

A treatment your patient needs has been blocked by the director of the hospital. The only chance of obtaining it will involve a very detailed application to the Area New Procedures Committee and then the Area Board. It is most likely that you will:

a) make the application for this patient – 66 per cent
b) make the application only if it is likely to benefit your other future patients – 13 per cent
c) give treatment without approval if it is at all possible – 4 per cent
d) encourage the patient to see the local member instead – 4 per cent
e) encourage the patient to see the local member as well as pursuing the matter yourself with the Department of Health (DOH) – 11 per cent
f) other – 1 per cent
g) no response – 1 per cent.
It is of interest that 13 per cent chose ‘b’. It is possible that such conservation of time and energy could well be a sensible course of action. However most doctors, at least 77 per cent (‘a’ plus ‘e’), would do substantial unpaid work for the benefit of a single patient.

FOCUS GROUP SCENARIO

It’s 6pm, you’ve had a long day and you are expected at home. An in-patient begs you to wait until 6.30pm for her family to arrive so you can repeat the clear and involved explanation of her condition that you have just given her.

How strong is the bond or obligation felt to the patient when placed against a doctor’s family life? I am a doctor’s wife as well as a doctor. Any medical practitioner’s family is familiar with disappointed children who were hoping their father/mother might make the piano concert, or a birthday party, or help with maths homework, or be home for dinner or bath-time, or in time for fish and chips at the beach on Friday night.

An operation taking longer than expected or a delivery occurring are just part of life for a doctor’s family and are to be endured. For me, what was most frustrating when our children were small was when delays or non-appearance were due to time talking to, or emotionally supporting, patients. The patient’s needs were consistently placed ahead of the family and ‘The serious work of a doctor is difficult for a spouse to repudiate’ (Riley 2004). A psychology of ‘postponement in the medical marriage’ has been described (Gabbard and Menninger 1989).

Using the Maslach burnout inventory, 20–40 per cent of doctors can be classified as psychologically distressed (see Chapter 3, under the heading ‘Burnout’). When these doctors were studied, they were found to have higher levels of work and professional stress, but interference with family life was also found to be a significant factor (Clarke and Singh 2004). Long working hours are an accepted feature of medical life. As one focus group member, a surgeon, put it, ‘Forty hours is a picnic. It’s part time’.

Long work hours per se do not determine the marital satisfaction or dissatisfaction of doctors. Role conflict, with frustration from the competing demands of career, marriage and family, is suggested to be the important intervening variable between work hours and marital satisfaction (Kao et al. 2005). Doctors with dependent personalities have been shown to be too prone to appease patients, unable to prioritize demands, especially those of their family and unable to meet their own need for recreation. (This type of doctor may use patients as the primary source of self-affirmation and so avoid confronting deteriorating relationships at home – see Riley 2004.)

Focus group members favoured waiting back:

I’d stay. You’ve either got to stay or you’ve got to make an appointment to see the family at another time, in a very short time, because my understanding of this is a diagnosis that’s just been made and obviously it’s very important. You need to be on side with the patient and their family and you need to have good lines of communication. If you can’t do it then you need to at least have a guarantee to the patient that you can do it tomorrow.
Arrange another time if big family factors [are involved]. If it was my son’s mid-year concert and I’d promised him that I’d go to it, and if I stayed I wouldn’t make it, but they have to be big family factors.

They’re asking you personally to hang on so I’d [wait].

The last two speakers used informal language, developed their responses as they spoke and clearly had empathy for the hypothetical patient (based presumably on their own past experiences). Alternatives included talking on the phone and organizing another time:

What I would often say in that situation is … ‘This information is very important and we have to sit down and spend unhurried time. If you want me to stay till 6.30 I will, but I am going to be talking way too fast and I don’t think I’m going to cover your issues’.

Getting a junior doctor to stay was mentioned as a possible action by ‘others’ – those less dedicated than focus group members:

Some people would say, ‘My registrar will speak to you’, ‘I’ll speak to them [only] if they’re here when I do my ward rounds’. I think there are some people – in public hospitals especially – who don’t have the same commitment.

SURVEY RESULTS – ‘LONG DAY’ SCENARIO

It’s 6pm, you’ve had a long day and you are expected at home. An in-patient begs you to wait until 6.30pm for her family so you can repeat the clear and involved explanation of her condition you have just given her. It is most likely that you will:

a) wait – 47 per cent
b) try to talk to the family by phone later that evening – 16 per cent
c) make a definite time to see the family tomorrow – 34 per cent
d) ask your registrar to stay – 0 per cent
e) other – 1 per cent
f) no response – 1 per cent.

While the focus group suggested that ‘other’ less committed doctors might get the registrar to wait, this option was not actually selected by any doctors surveyed.

FOCUS GROUP SCENARIO

It is your tenth wedding anniversary. You planned a weekend away, but haven’t yet told your partner. The booking is transferable. One of your patients has developed a complication. A close professional colleague is covering your practice and plans to take the patient back to theatre on Saturday.
How strong is the bond or obligation felt to the patient when placed against significant family events? The scenario was written to imply the colleague is competent and the respondent has a good relationship with this colleague. The value of a traditional personal relationship milestone is placed against the bond or obligation felt to the patient.

I remember a strained family holiday in Tasmania with three children (one, three and five years of age) because my husband had a patient with a complication back in Sydney. Multiple phone calls were made and much guilt and anxiety pervaded the holiday. Bosk suggests that fiduciary duty simply obligates a certain course of action:

> In most client–professional relationships the client has a great deal at stake ... Suspicions of the professional's motives and the appropriateness of this conduct is always a possibility. To defend against this, the professional proves how secondary his personal considerations are by placing himself in his client's service. He is available when the occasion demands. (Bosk 2003: 169)

What did the focus group members think? For the above scenario most respondents advocated cancelling the trip. Only for an extreme personal emergency was the cover arrangement considered appropriate:

> It would have to be an extraordinary situation before you didn't operate on your own complication and certainly risk management would suggest that that's undesirable.

> If it was the baby being born you can't delay that sort of thing. Or if it was a parent dying or child who was ill, that sort of thing you can't delay.

> We've got this unwritten understanding between all of us that if that happens [we cover out of] kinship.

There is support in the conflict between patient need and the doctor's own life, when some felt their colleagues would support them as 'kin', a very powerful word. More formal arrangements and group practices were discussed as solutions to avoid this dilemma occurring:

> Sydney's organized very badly so that everyone is on call all the time. They don't work that way in Melbourne ... It's always been that way. You're seen to be a wimp if you claim more time off.

> When people come and see you they should know that ... you're in a unit and I think it's the only way that we're going to survive because I don't think we, and particularly our spouses, are prepared for the sort of sacrifice that your generation or the generation before you gave to medicine because the rewards are not there for us. We are looking for different rewards. We want to know our children: we want to have a life outside of surgery. If you're bringing home big saddle bags of money these days, that doesn't equal being a successful father. It equals 'loser' if you're not at the kid's ballet. So in that context, to still provide quality, care has to be transferred at some stage, doesn't it? And patients have to get used to it.

This last was an emotional plea for a better and different way of practising medicine. It sat at variance with what focus group members (including the doctor who made this
comment) would actually do in response to these scenarios dealing with personal versus professional obligations.

Members agreed that patients should be pre-involved in cover arrangements:

*If I'm going to have any sort of life I have to be able to cover those Friday afternoon patients ... I say to the patient, ‘Look I'm actually not going to be here but if anything goes wrong Dr so-and-so knows what to do’.*

*I've had people where I know I'm going overseas the next day and I say, ‘I don't want to operate on you: I'll send you to a colleague’. They say, ‘No, I would rather you operate and I'll take the risk’. And you say [to yourself], ‘Oh God, I was going to use that day to prepare to go away’. But that's a situation where you’ve told them and they’ve said, ‘No, I still want you’.*

The notion of cancelling the trip because the doctor wouldn't enjoy it was raised:

*You might raise the topic with your spouse and say, ‘I'm going to feel really badly about this. What would you prefer I did?’*

*If ... you left a swab in, and they had a high swinging fever, they’ve done the X-ray, the swab’s there, they’ve just eaten and they can’t get into theatre until the next morning and you're flying out to Hamilton Island [a tropical resort]. You feel badly about it ... The patient might get pretty annoyed. They couldn’t give a stuff about your anniversary. You could probably lie and say my wife is seriously ill ... The patient doesn’t need to know you’re off having fun.*

*If it was just one of those known complications, that's another thing. But it would affect me. I would spend the time worrying about it. Wish I hadn’t come.*

**SURVEY RESULTS – ‘ANNIVERSARY’ SCENARIO**

Your tenth wedding anniversary is coming up. You planned a weekend away, but have not yet told your partner. The booking is transferable. One of your patients has developed a complication. The patient has to go back to theatre, and Saturday is the only possible time. A close professional colleague is covering your practice and is willing to do this for you. It is most likely that you will:

a) cancel the trip without telling your partner of the planned weekend because this is the right thing to do – 18 per cent
b) cancel the trip without telling your partner of the planned weekend because you would not enjoy it anyway – 7 per cent
c) raise the topic with your spouse and say ‘I’m going to feel really badly about this. What would you prefer I did?’ – 35 per cent
d) go on the trip, but lie to the patient about why you were unavailable – 5 per cent
e) go on the trip and be honest about why you were unavailable – 32 per cent
f) other – 1 per cent
g) no response – 2 per cent.
The discussions around this scenario and the one that follows confirm research showing relational dilemmas, especially if similar occurrences have been experienced, evoke anger and upset (Skoe et al. 2002). Nevertheless, only a third of the survey group took the trip and were honest with the patient. The ‘avoidance’ option of making the partner decide was surprisingly popular. Pity the doctors’ partners!

It has been suggested that the common belief that doctors are altruistic in their daily work is false (Glannon and Ross 2002). Acts of altruism are acts that are supererogatory (beyond what one is obliged to do). While altruistic impulses may form part of the decision to become a doctor, the special relationship with patients then obligates beneficent actions. A sense of obligatory beneficence is apparent in the answers to these two scenarios, although the respondents recognized the personal and family sacrifices that ensue.

FOCUS GROUP SCENARIO

You are holding a party at home for your six-year-old. The jumping castle is in full swing. A colleague phones and says he is having a bit of trouble and would appreciate your coming in to the hospital to provide some help. He then detects the birthday party sounds, says he’ll be fine, apologizes for troubling you and hangs up.

How strong is the bond or obligation felt to the colleague (and someone else’s patient) when placed against significant family events? Once again family life is placed against patient need. Here it is not the doctor’s own patient, but a colleague asking for help. Ironically, one doctor who had planned to be a focus group participant was unable to do so because he had gone earlier to answer such a call!

Focus group members were found to be keen to go to the hospital to help:

*I’d probably go in because I can see myself in [similar] trouble and I wanted help and it’s a terrible position to be in.*

*Probably very hard [for the colleague] to make that phone call.*

*You may understand that the situation is one of a post-partum haemorrhage where someone needs a hysterectomy. If they were to ring the person … who would have the skills to do that. [Then] … there’s not many of him around. And his spouse starts to be cross, but she’d probably understand.*

*I’m coming. You try and make sure you’ve got enough adult supervision for all the children and work something out and ring back to say, ‘I’ve organized something. I’ll be in as soon as I can.’*

*If someone’s prepared to call you, especially if it’s a senior colleague, and even more so, because they rarely would ask for help, them being polite because it’s your party, you almost have to take more notice of it.*
If they’ve got someone bleeding to death on the operating table and they need an extra pair of hands, you just go.

One novel suggestion was to send another party guest:

Chances are there might be others at the party who may offer to go.

It was also suggested that advice could be given by phone or someone else found:

I would probably spend ten minutes making phone calls quickly to see who else could do it.

This scenario triggered some bitter reflection among the focus group members:

A guilt trip is only maintained for about 24 hours anyway. ‘Oh yes, you always put the hospital first’, ‘You never put the family first’, ‘You missed the last 23 of your daughter’s birthday parties and you’re coming to this one’.

Our whole life has been a compromise since we were interns.

SURVEY RESULTS – ‘PARTY’ SCENARIO

You are holding a party at home for your six-year-old. The jumping castle is in full swing. A colleague phones and says he is having a bit of trouble and would appreciate you coming in to the hospital to provide some help. He then detects the birthday party sounds, says he’ll be fine, apologizes for troubling you and hangs up. It is most likely that you will:

a) go in immediately ‘because I can see myself in trouble and I wanted help and it’s a terrible position to be in’ – 28 per cent
b) spend 10 minutes quickly making phone calls to find someone else, go in if that fails – 27 per cent
c) call back to see if you can give advice over the phone – 44 per cent
d) take no further action – 0 per cent
e) other – 0 per cent
f) no response – 1 per cent.

The survey group members were less likely to pick ‘a’ than would have been expected from the focus group discussion, but not one would allow the hung-up phone to constitute the end of the matter.

Finding the Balance

Debate about medical professionalism provides a window into how doctors grapple with maintenance and renewal of a coherent medical identity. An excess of worthy but conflicting attributes are advocated. It has been suggested that charters of new
professionalism set unrealistic expectations and make unrealistic demands on the medical profession (Kellet 2004) and so constitute a possible cause of doctors feeling helpless and demoralized (Fochtmann 2004).

The Australian Medical Council has recently developed *Good Medical Practice: A Code of Conduct for Doctors in Australia* (Working Party of the Australian Medical Council 2009). The process of national registration of medical practitioners creates a need to publicize, teach and implement this code, as the new *Health Practitioner Regulation National Law Act* (2009) requires mandatory notification by other registered practitioners of a range of conduct including:

> Where a practitioner has placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards of conduct.

The grounds for voluntary notification include the following:

- **a)** that the practitioner's professional conduct is, or may be, of a lesser standard than that which might reasonably be expected of the practitioner by the public or the practitioner's professional peers;

- **b)** that the knowledge, skill or judgment possessed, or care exercised by, the practitioner in the practice of the practitioner's health profession is, or may be, below the standard reasonably expected;

- **c)** that the practitioner is not, or may not be, a suitable person to hold registration in the health profession, including, for example, that the practitioner is not a fit and proper person to be registered in the profession.

Unfortunately the statement on ‘Professional values and qualities of doctors’ (1.4) in the new code of practice contains an assortment of briefly described professional aspirations and provides little guidance on defining unprofessional conduct. However, this code was developed by a self-selected group – medical leaders who were both senior and altruistic. They are presuming, perhaps, on shared cultural and ethical understandings among doctors.

Commitment and altruism (specifically the primacy of patient welfare) are central to the social contract and patient trust, yet they cannot be precisely mandated (Cruess and Cruess 2009). Professionalism is hard to assess, but the absence of measurement means we do little to ensure its presence (Stern 2006). The lists of medical virtues that were given by the doctors were both curious and contradictory, and interviewees personally rejected some of the attributes they associated with professionalism (such as reserve). Yet in general, the qualities the subjects listed for the highly professional doctor accorded with patients’ ideas of a good doctor (Irvine 2009). From many answers there was a sense of a personal philosophy and of the practice of virtues. The practice of these was also associated with emotional satisfaction. There was a real sense of vocation as these doctors were dedicated, were prepared to assume responsibility and were concerned with the primacy of patient welfare.
Really it comes down to if you don’t quite know what to recommend you always know how to act. If you act in the patient’s best interests at all times then that’s really a much safer sort of thing, and I think it’s more rewarding as well. **Cardiologist**

The professional has to get the job done no matter what. No matter what the circumstances are, no matter how tired you are, how distracted you are by family, no matter how uncooperative the patient is or whatever you get the job done, no matter what. **Paediatrician**

To define the word professional … I see that as an individual who sacrifices significant quantities of his or her time and lifestyle for career. **Anaesthetist**

The last two quotes above introduce the notion of sacrifice. This is not a concept one would expect an engineer or economist to apply to professionalism. It is also perhaps not a requirement necessarily acceptable to younger doctors.

**Young Doctors are Different**

There are generational cohorts in medicine who share similar aspirations and experiences. The global traits of a generational cohort can be attributed to their shared exposure to major social events and trends (Johnston and Peacock 2009). For instance, the generation receiving high school education in the age of the Internet has a different view of knowledge and learns in fundamentally different ways from earlier cohorts. In the workplace, each cohort has different relationships with authority, different career expectations, different learning styles and different approaches to the work–life balance. The majority of the interview subjects would have been Baby Boomers with some Generation X, while the young doctors they were discussing would have been Generation Y. It has been suggested that, as generalizations, Baby Boomers are driven, have a strong career identity and expect to be respected, while Generation Y is notable for being ‘high maintenance’ or having a sense of entitlement (Johnston and Peacock 2009).

Younger respondents were in general more supportive of the need for work–life balance and they saw a satisfactory quality of life as a legitimate goal for a doctor. Young GPs in the UK had similar views and explicitly contrasted these with the traditional view of a vocation, which required high levels of commitment and was consequently deserving of high community status (Jones and Green 2006). However, young GPs justified this by citing the ‘obligation’ not to burn out and to maintain energy for good doctor–patient relations.

While socialization occurs in all workplaces and training situations, medical training may be a special type of socialization because of its hierarchical and extended structure and with its intensive, stressful cognitive and emotional demands (Hafferty 2009). Young doctors may have a important role in shaping professional values, as early in their careers they will ‘understand dominant social norms more acutely than professional ones’ as ‘their common experience is mostly outside medicine’ (Johnston and Peacock 2009: 154). So a proportion of any perceived difference between younger and older doctors may be related simply to career stage: conversely the values of seniors may be influenced by the values the young bring to the workplace.
The great majority of those interviewed agreed that the residents of today are different from those of earlier generations. Even though the competence of the young doctors was generally accepted, this was insufficient and the seniors considered the ‘right’ attitudes also to be critical to being a ‘good doctor’:

_They work in a totally different way but I think their standard of care, by and large, is not worse. I think their attitudes are very different and are not as good._ Colorectal surgeon

Attitude problems included lack of endurance, unwillingness to take responsibility, whining, lack of respect for senior doctors and avarice.

A range of views of the knowledge levels of residents was given, some being positive:

_I actually think they’re much better doctors than when I came out … They’re much better communicators with patients: they’ve got a much better understanding … of general medical things._ Haematologist

Most were pragmatic:

_I think there has always been the really good, the pretty good, the pretty yuck and the bad._ Gastroenterologist

_There are certainly some people that I would be terrified if I saw them standing at the end of the bed. But on the other hand, there are still a few people that I think who would do okay. I’m more concerned there won’t be a bed for me, rather than there won’t be the right person at the end of it._ General surgeon

It was suggested that changes in the way doctors train was a factor that resulted in greater variability. Training times and requirements post-graduation for all doctors are now substantial. Medical faculties and students are aware of this and hence the motivations of both parties – one to acquire, the other to assess – a comprehensive set of skills and knowledge by graduation may not be strong:

_I think the variability in sixth year, from the laziest who doesn’t give a damn to someone who is really smart, is huge. Whereas fifteen or twenty years ago, the sixth-year students after one year of internship could be looking after your family._ Emergency physician

The requirement for young doctors to practise with a rapidly changing knowledge base was noticed:
Probably forty years ago you could do a six-year course and learn 99 per cent of what medicine was about ... And now you can do a six- or seven-year course and probably not know what 40 per cent of medicine is about. **Paediatric surgeon**

Several mentioned the problems created by subspecialization. There was the suggestion that, although the quality of teaching and training was poorer for the younger doctors, they were also subject to a higher work load and to higher public expectations:

*I am not worried about them looking after me. I suspect that most of them will be good doctors. I do worry about the way in which the training has changed because I think that they don’t have the same opportunities ... and they have much greater pressures on them. They’re busier and ... people are very critical of them but they get literally no reflective time. ... [O]ne shouldn't reminisce ... but in my first year, even though I was married, we were obliged to pay rent here in the hospital and you could go home only every second night. But during those times when I was on call we had not a lot to do. So we played billiards, and cards and we talked to the guy who [saw] a difficult patient and we did medicine 24 hours a day. We whinged and complained about it, but we ate with the consultants in the hospital dining room. We talked about patients over lunch and over dinner and we went to the pub on Friday afternoon. Current residents just don’t do that. They are all busy trying to pass exams from the day they arrive in the place. It’s not a very welcoming place, I wouldn’t have thought. But that’s not just this hospital. I mean when I was a resident I played in the hospital rugby, tennis and billiards teams. My life revolved around the hospital even though I was married. Nobody’s life revolves around the hospital anymore. **Gastroenterologist**

I think they’re working under much harder conditions. Community expectations are different, professional expectations are different, so actually I have enormous respect for them. It’s a matter of whether the medical system can actually allow them to get the appropriate experience and training. **Haematologist**

The residents of today are just getting a raw deal. Their education is different ... and they are under enormous pressure. I look back to my days ... If we had a patient with Hodgkin's Disease, they got admitted into hospital, they stayed in hospital for two weeks, we did all the tests, we chased up all the results, we did leisurely ward rounds, we went and saw the pathologists, we went to the x-ray meeting, we discussed the case, we made a decision, we treated the patient. Same patient now, patient with Hodgkin's Disease ... [is a] chemotherapy out-patient. The resident hasn’t got a clue what’s going on. There is no joy in being a resident: it must be soul-destroying for most of them. ... [W]e’re all too busy to interact with each other. **Oncologist**

The doctors of the future were viewed as more money-oriented and that was considered to be a major problem:

*I think the residents today are very different and very much more aware of themselves and where they are going than I ever was ... I think plastic surgery in particular has this issue of attracting people who want to make a lot of money ... It’s not the sort of person that I would like to train particularly. They don’t contribute much to the development of reconstructive surgery ... That disappoints me. **Plastic surgeon**
[Some] are unbelievably income-driven workaholics. It’s not that they’re not caring but it’s just a means to an end ... It’s just a job. **Intensivist**

I think the new generation of trainees by and large are quite different from people that I consider my colleagues ... They are a different generation but I think ... we’re seeing a different sort of person going into surgery now and plastic surgery in particular. I’ve been quite disconcerted actually about the type of person that we are now training in plastic surgery. They seem to be very money-focussed, wealth-, creation-orientated, not committed, not passionate, lazy, just hopeless really. Obviously competitive from the point of view of fulfilling all the criteria to get them into training. And you miss out on a lot of people who really have the potential to become great colleagues and surgeons and anaesthetists but just don’t quite make the grade because they’re not streetwise and whatever. So I think that is a great pity. The new generation want everything now ... And they have to pay for their training now too, so they’ve had to invest a lot into it so their concept is ‘What will I get out of this?’ They are completely different, but occasionally you see somebody who is like you were in terms of they are just good people and they’re doing it for the right reasons. I’ve been very disappointed in the junior staff, by and large. **Plastic surgeon**

This modern wealth-creation orientation described by the respondent in the third extract above seems to be the factor that makes the residents ‘lazy, just hopeless really’. However, it is not suggested that they will lack technical proficiency. ‘Streetwise’ refers to a focus on personal advancement identical to the ‘very much more aware of themselves and where they are going’ described in the first extract. Such people are not like the respondent, and this makes them not one of the ‘good people ... doing it for the right reasons’. Those ‘right reasons’ are altruistic or related to intellectual curiosity. Losing those residents with the potential to be ‘great colleagues’ suggests a barrenness: there are no worthy ‘children’ to inherit or teach.

The younger doctors were considered to have less commitment, to take less personal responsibility, to whinge, to have less endurance and to be less self-sacrificing:

> So many complaints about the shifts and the number of hours that they have to do ... But I think that in terms of competency at the end of their training they are still as good as they used to be, but the endurance of having to put up with the long hours is missing. **Obstetrician and gynaecologist**

We were grateful to be given a job and we were pleased to have any benefits. We were lucky to get lunch! ... At Sydney Hospital where I was an intern I can remember I was at the lunch table in the common room, and I got a page and I answered and I said, ‘I’ll just finish my lunch and come …’ and Dr X said: ‘You don’t have lunch. Go and do it now’. [Laughing] You know, I mean it was amazing ... That whole concept has gone out the window. **Gynaecologist**

As soon as they have rung you they’ve divested themselves of the problem. You now have the responsibility for this patient, even though you are at home and they have got the patient there ... They give you a long case presentation but if you actually ask them to go and do anything to that patient or try something then ring back, that’s nearly impossible. I find that a serious problem and I think that is completely different from how we were when we were medical registrars. **Cardiologist**
Often though, the views of the senior respondents were quite mixed regarding their juniors’ different approach to lifestyle and commitment. The issues of lifestyle, commitment and attitude were also inextricably linked. In the long extract below, the respondent is a strong advocate of a work–life balance but complains bitterly about an inadequate modern work ethic. Finding a reasonable balance is hard, but this respondent is rendered impotent to guide attitudes and behaviour when the junior doctors ‘turn on their heels’:

*I think there are two things. I believe strongly that you have to be more than just a doctor 24/7. That it is a big slice of your life, but not the whole pie, and I think you can be a better doctor because of that. If you achieve that balance, you can come to work and do it with enthusiasm and quality.*

*The problem, I think, is that like everything you do in life, even if it’s not the whole pie, you have to try to do it well, you have to take responsibility. I’ve got to say I feel a bit disappointed sometimes. … When one reflects on what they [doctors of earlier generations] were like and I remember when I was a resident, an intern here in 1987 and I shared a house with four other doctors, which was ideal in a way, that great camaraderie. We were all doing different terms and different specialties … People would trickle in after work anything from 6 ’til 9 o’clock … They all didn’t go home until it was done. There was that sense of commitment to the job and to the patients. … [Now] I hear people on the phone ducking and diving about ‘Well, they’re not admitted under us’ and ‘They’re not our patient’ and ‘We’ve done the consult and that’s not our job to do that, you know’, all junior residents.*

Maybe I shouldn’t be annoyed by this, but I think in a bureaucracy of a large hospital there has to be a bit of hierarchy and a bit of respect for seniority, regardless of what you think of people. Someone very early in my career told me that you have to respect your teachers. … Clearly I’m grey-haired enough and old enough to not be one of the other residents [but I can] approach one of the junior doctors who will barely give me the time of day. ‘Not my problem, not my patient’ or even if it is their patient I’ve had people sort of turn on their heels and basically say ‘What am I expected to do about it?’ I’m totally stunned by that and they’re in the wrong job because there isn’t enough financial reward in medicine to sustain you if you’re not interested in doing it for other reasons.  

**Anaesthetist**

In terms of patient safety, it is not at all clear whether the doctor should go home or remain at work until everything possible has been done. To me, a doctor of a certain generation, there is merit in the suggestion that ‘excellence should trump endurance, but sometimes excellence requires endurance’ (Caldicott and Holsapple 2008: 139). Of even more concern is the unprofessional behaviour described, with the young doctors trying to minimize their own role and responsibility in the joint endeavour that is patient care (Caldicott 2007). The ‘old-fashioned’ values and attitudes may have provided significant quanta of both safety and patient satisfaction.

Yet many older specialists were surprisingly supportive of the different modern approach to lifestyle:

*We had those long hours and there is no doubt that sleep deprivation is a bad thing for medicine and I had personal experiences and bad outcomes with that … So I’m cognizant of the fact that you’ve got to go home, you’ve got a family, you’ve got to sleep, you’ve got to do exercise, you’ve*
got to keep yourself healthy. So I think, trying to make ... young doctors work 12- to 16-hour shifts, that's ridiculous. I think the change is for the good. Having said that, it takes much longer to be trained up to the same level because you're not being exposed to the same volume [of cases]. **Cardiologist**

There is a change in the culture of the younger doctors ... They are not just one-track-minded [saying] 'I'm a doctor full time and that's it. I'm devoting all my life there'. It doesn't mean that ... they are distracted or they are substandard. It's just they are less willing to be sacrificing their family time or their leisure time to their career. **Emergency physician**

I think they [young doctors] are still seriously interested in their patients but they're seriously interested in their own well-being as well. And I just keep saying 'Good on them'. That's what I got wrong, big time, and if I had my time over again there are a few things that I would do differently. These guys have got a much better perspective on life in general than I did .... I tell juniors about a certain other consultant that 'If you are his patient, you know he is technically skilled and he is going to give you attention at, literally, any time of the day or night' but he is not a good role model and [the] 'last one to turn out the lights doctor' is not necessarily the best doctor. And so I see these guys as having a better perspective on life than we do. And if they keep that balance ... with the incredible workloads that go with being a doctor, I believe they would be better doctors than us. **Renal physician**

The thoughtful response of the last doctor in this series is notable. What patient, though, would not choose to be under the care of the kind of dedicated individual who is the 'last one to turn out the lights doctor'? Think of Hawkeye sleeping next to the patient's bed. Dedication was central to the ethos of the more senior respondents. They were passionate about their duty to patients. Self-sacrifice was an intrinsic part of their understanding of professionalism and to their identity as a doctor.

The discussion about the doctors of tomorrow was troubling. The loss of social support among doctors is not just related to external influences and organizational and practice change. Their inability to know how to mentor young doctors was evident. It was not that the interviewees were generally critical. This was to be expected. Typically the conservatism of middle age dislikes difference – dress, music, technology. The discussion turned on attitudes and values and it was agreed that these were very different and not as good as those or previous generations. However, the professional ideals held personally dear by the seniors were considered to now be perhaps outmoded. Senior doctors were unsure whether modern attitudes (less altruistic, more self-serving) were good or bad. They could see a future when being a doctor was stripped of professional values and was 'just a job':

*In the future I suspect people will work less than they do now, and medicine will ... become more like just a job rather than a profession. **Anaesthetist***

They knew that mentoring was critical for socialization – and the literature supports this belief (Park et al. 2010):

*I think training and culture with senior mentors where the patients’ requirements are sort of sacrosanct so you instil in them that it is really the patient that comes first, above all those*
other things like budget. Really it comes down to if you don’t quite know what to recommend you always know how to act. **Cardiologist**

Yet the senior doctors now seem unable to model or teach values or attitudes and they are unsure about what is the right way for the young doctors to conduct their professional lives. The professional ‘children’ are no longer seen as clear heirs. This represents a significant loss of identity for the medical profession:

*Those guys have been a great influence as mentors not only to teach you how to do surgery but to teach you how to behave and practice and whatever … You know, ‘Steady boys, this is the right way to do it’ … Hopefully that will be passed on.* **Plastic surgeon**

Medical education is considered an adult re-socialization where ‘certain aspects of one’s prior self are replaced by new ways of thinking, acting, and valuing’ (Hafferty 2009: 63). The recipients of medical education are high achievers who, when placed in settings of tension and anxiety, are the perfect subjects for socialization (Hafferty 2009). However, their senior teachers are now confused and the trainees are working in an increasingly complex and chaotic health system. A medical educationalist has suggested:

*Residents are currently socialized to cope with broken systems; if they were taught to master systems, the aims of professional formation would be furthered. An unwritten curriculum exists in which residents get high marks for getting things done in a broken system and given little or no guidance about how to fix the broken system.* (Leach 2009: 97)

He goes further, suggesting that, while not universal, ‘large numbers of the residents in the various specialties are abandoned and left like the children in Golding’s novel *The Lord of the Flies* to cope as best they can’. The result is the development of mores that are the antithesis of professionalism. This analogy is perhaps a little extreme but thought-provoking.

There is little consensus on what professionalism should look like in the future. Yet currently there were shared notions of virtue and self-sacrifice, and respect for the fiduciary duty among senior specialists.

*How do current doctors act, though, when actions required to increase safety or improve care necessitate peer sanctions?*
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CHAPTER 5

Colleagues or Conspirators? – Doctors Do Not Act

Extract from the 2005 Queensland Public Hospitals Commission of Inquiry Report

The Hon Geoffrey Davies AO, the Commissioner for the Queensland Public Hospitals Commission of Inquiry, said in reference to Dr Jayant Patel and events at Bundaberg hospital:

‘There are a number of reasons for staff reluctance to report safety issues.

‘6.285 First, some would have felt unwilling to tell of their concerns and effectively challenge Dr Patel, who was known to intimidate staff and effect some retribution upon those who challenged him. Consistent with this impression was the collective understanding propagated among the staff who worked with Dr Patel that because Dr Patel generated a large amount of revenue for the hospital by his capacity to perform elective surgery he had the unwavering support of management. Dr Strahan testified that he and others felt that if they complained against Dr Patel they would not only be challenging him, they would be challenging management.

‘6.286 Secondly, Dr Strahan testified that the reason why he and others were less willing to come forward was that they did not believe that the information they had available to them was sufficient to warrant challenging Dr Patel. He effectively said that whilst, to an individual, information did not seem to justify a complaint, that information comprised a larger picture that was beyond any individual’s knowledge. Had that information been combined so that the gravity of the situation was known to all those who held the separate pieces of it then he said that more people might have been willing to come forward.

‘6.287 Thirdly, people who had concerns could only be confident about those things within their expertise and would be less willing to challenge Dr Patel on matters outside it. This problem is multiplied by the increased level of specialisation which characterises modern medical practice. The effect of this is that a specialist may not be willing or able to suggest incompetence in another practitioner who practises outside the specialist’s scope of expertise. An eminent nephrologist, for example, may be less willing to claim that a
surgeon is incompetent because surgery is not within his expertise nor within the expertise of the hospital’s executive who would have to consider the claim’.1 (Davies 2005)

Davies seems to have accepted excuses in this case for the failure of doctors to report unsafe care by another doctor. Yet medical sociologists such as Fox, Becker, Bosk and Rosenthal (Becker et al. 1963, Fox 1957, Bosk 2003, Rosenthal 1995) have described the extensive loyalty between doctors – a colleagueship that, while supportive, could also mute dissent and hide problem behaviours. A survey of US doctors revealed that 90 per cent thought they should report all instances of significantly impaired or incompetent colleagues. However, of those who admitted to having an impaired or incompetent colleague in their group or practice, 45 per cent had not reported this (Campbell et al. 2007).

Worldwide, the process for handling problem doctors is exemplified by a scrappy patchwork of regulation and process (Lens and Van der Wal 1997). In Australia, the effects (if any) of The Health Practitioner Regulation National Law Act 2009 that supports the new National Registration process for medical practitioners are yet to be seen.

One of the problems with study in this area is that, while professional self-regulation may appear to be no regulation, some powerful social controls may be quite invisible to outsiders. It is known that such control exists among doctors (Bosk 2003: 21). Argument has been made that normative rules enforced by co-workers are extremely powerful, as usually individuals desperately want to remain part of the group (May et al. 2004, Barker 1993).

Of course, such controls only work if the individual is sensitive to the good opinion of colleagues and wishes to have an ongoing relationship with the group (Freidson 1988: 151). Authoritative individuals who do not respond to social pressure often avoid censure (or it is delayed). In New Zealand, Professor Herbert Green was able to continue with an unethical study into cervical cancer at the National Women’s Hospital in Auckland for many years (Paul 1988). The cancers were allowed to develop, resulting in considerable morbidity and mortality in the women enrolled. Two junior colleagues tried to stop the trial – without success (Paul 2000).

There was a ‘skilled but heretical’ US obstetrician, Irving W. Potter, who performed ‘routine’ internal podalic version. Every woman was given general anaesthesia and the babies were turned and extracted in the breech position (Bullough and Groeger 1982). Potter claimed that feet-first delivery was the way nature had intended babies to be born, since it was unnatural that the head or biggest part of the body should present first, a conclusion he reached by watching horses give birth. He also claimed that forceps often marked a baby’s head for life, and his method relieved the mother of a long and painful delivery. (It also enabled him to manage an enormous practice.) He was respected, powerful, charismatic and skilful at what is a dangerous procedure. He delivered 20,000 babies by this method, including his own children and grandchildren. Censure by the obstetric community because of the neonatal morbidity and mortality that ensued never translated into the action required to cause him to cease this practice.

1 As an anaesthetist I am mystified by the absence of action by the anaesthetists, who are placed to assess many aspects of surgical skill and appropriateness and indeed are required for the surgery to continue.
Doctors with low insight into their own limitations may be leaders in the development of new treatments (Hays et al. 2002), but may also conflate self-interest with the patient’s interest (Coulehan and Williams 2001) or engage in risky practice. An entirely egotistic perspective can develop (Bosk 2003: 187) and the sense of entitlement to high income, prestige and social power that can occur after completion of arduous training may be exaggerated in some individuals (Coulehan and Williams 2001).

The sociologist Marilyn Rosenthal interviewed doctors in Scandinavia and the UK and, from these interviews, developed theories why medical incompetence was both poorly and secretly managed (Rosenthal 1995). This work preceded the major inquiries and the subsequent changes in the regulation of UK medical practice (Irvine 2003). To criticize a colleague was considered ‘serious professional misconduct’ by the UK General Medical Council up until 1985, when Council documentation began to stress responsibility to act in the patient’s best interests and the duty to inform regulatory bodies of dangerous practitioners was imposed. Rosenthal found informal mechanisms for control of poorly performing general practitioners included the quiet chat (personal persuasion), protective support (system responses), and work shifting and diverting patients (avoidance responses) (Rosenthal 1995: 54). The quality of interpersonal relations largely determined whether the doctor would receive protective support (Rosenthal 1995: 96). Sometimes it was a matter of helping ‘friends in need’ (Rosenthal 1995: 105).

Rosenthal derived seven themes from her interviews (Rosenthal 1995: 16–28), finding that for doctors:

1. Permanent uncertainty exists in the nature of medical practice and variation makes it hard to identify mistakes with confidence.
2. There is necessary fallibility – even good doctors will make mistakes. (In the M*A*S*H episode Major Burns says in reference to the shrapnel-damaged colon: ‘Anybody could have missed that’. This comment forms an important coda to that story.)
3. There is shared personal vulnerability as every doctor makes mistakes. There is therefore a great deal of empathy.
4. Understanding and forgiveness are easily offered, especially if there is remorse. (Bosk similarly noted: ‘For error to be considered culpable, technical failure must be wedded to a moral breach’ (Bosk 2003: 177).)
5. Egregious errors get action – when they are gross, or frequent, or the perpetrator lacks insight.
6. Non-criticism is the norm.
7. Only the profession can pass judgement on peers.

The Doctors’ Perspectives

The following nine scenarios were devised to investigate how doctors managed their relationships with each other where there was a real or potential patient safety issue. For each, the focus group members were asked to identify what their colleagues would do and what they themselves should do.
The implications for patient safety are quite theoretical, but M&M meetings should allow the professional group to learn from the presentation and analysis of complications. Hospital-based M&M meetings are usually held monthly and the majority are for medical staff only. (An exception is obstetrics, where multidisciplinary analysis is the norm.) M&M meetings may or may not provide good forums for discussing adverse events and supporting colleagues as their quality and nature are variable (Schwappach and Boluarte 2008). Most continuing medical education (CME) programmes run by Australian medical specialty colleges require evidence of ‘Quality Assurance Activities’. Often this is most simply obtained by attendance at M&M meetings. It would appear the colleges are relying on peer scrutiny within the professional workplace unit to ensure safe and quality care.

I ran M&M meetings in a department of anaesthesia for some years and later in surgery and medicine (Eather and Jorm 2003). There were regular attendees and persistent non-attendees. The latter were a source of irritation and frustration to the attendees.

What did the focus group members say about the busy colleague? One of the strong-minded individuals in the first focus group led off with the ‘Ignore it’ response but another member immediately stated ‘You can’t ignore it’ and the group agreed something ‘should’ be done and options were discussed. The second focus group started with an attempt to regulate the behaviour of the non-attendee by limiting his ability to claim an excuse. This group frequently suggested ploys involving humour or acting and ways to maintain ‘face’ and avoid confrontation.

You could ensure that they know that they’re on ... perhaps even phoning the secretarial service the day before just to make sure they haven’t got the excuse – ‘Oh, I forgot, I didn’t know it was on’.

Discuss it ‘as a friend’ was a popular suggestion, with the most telling comment being:

Don’t you think that if you read them the riot act that it’s actually less of a stick than your mates saying, ‘You’d better start coming, you’re a bit slack, mate’.

Possible reasons for non-attendance included inconvenience, ‘because it is at night’, and poor quality meetings:

In the past M&Ms have been, in some departments, fairly aggressive and blameful ... rather than a quality thing.

As a result of these comments, in the final question the meetings were described as being ‘excellent’. However, it was felt that the successful colleague’s arrogance was one possible reason for failure to attend:
Sometimes it is because of arrogance … You think your colleagues can’t teach you anything.

It sounds like he’s very busy, very successful, he can’t be bothered. That’s often the case. They then miss out on the fact that you can’t be autonomous. You have to have your stuff independently looked at and discussed … Maybe you take another approach … say, ‘Look your input is so worthwhile because you have so much experience’ and you pander to their personality defects, but they have to come.

Discussion of sanctions and incentives was wide-ranging. The incentives constructed by the medical colleges (the associations responsible for specialist training and examinations and the maintenance of specialist skills) were considered useful. It was also felt that, if the individual was not present to defend his actions, criticism at meetings would act as a form of peer group sanction.

Business meetings, if a person doesn’t choose to attend that’s good because you make decisions without them and they have no come-back. So that’s the sanction … In one of the hospitals I work somebody doesn’t attend and there are a number of important cases that need to be discussed. So we’ve said ‘The third time we will discuss it, whether you’re there or not’.

The desire for rules to exist and be enforced was strong:

[There] should be … requirements for attendance … and there should be consequences if they don’t attend. So it shouldn’t be left up to some best friend to tell them what to do.

However, it was felt that perhaps the hospital and even a private hospital ought to set rules:

It’s like a pre-nuptual agreement, isn’t it? You want to work in this hospital. These are the rules you work by. If you don’t want to come to this meeting then you don’t want to work in this hospital.

I think that an organization such as [X] private hospital has a responsibility and every right to demand a certain performance.

The limited ability of a private hospital (as distinct from a public hospital) to control doctors’ performance or behaviour and maintain revenue is discussed later. The desire for action by the hospital would appear to represent a way for the doctors to avoid taking responsibility for professional self-regulation. (All the answer sets included only issues the groups suggested as possible individual actions for doctors and did not include solutions for others such as nurses or management.)

**SURVEY RESULTS – ‘TOO BUSY’ SCENARIO**

A successful colleague is always ‘too busy’ to attend the excellent business and M&Ms meetings of your department. What are you most likely to do?
Reconstructing Medical Practice

More than 80 per cent of interviewees felt a responsibility to act. Answers ‘c’ and ‘d’ both represent strategies to minimize conflict and obtain compliance while maintaining a positive relationship with the non-attendee. Relationships and friendships between doctors formed a frequent part of the discussions. Such bonds also form a limit to professional self regulation. In general, the doctors were willing to encourage, but not willing to invigilate, to ensure peer review occurs. One ‘other’ response read: ‘There are too many [non-attenders] to do anything’ – perhaps this was a response to the variable quality of these meetings!

FOCUS GROUP SCENARIO

Some colleagues at your hospital were involved in a case with a disastrous patient outcome. They probably made errors which contributed to the result. Some investigation may be required. How would you prefer the hospital to proceed?

How would the desire to protect colleagues from shame and humiliation fare against the need to learn from an event for the benefit of future patients?

This scenario was not developed with the focus groups, although relevant responses were received incidentally in the discussion of other scenarios. It was developed later when my own work on M&M meetings (Jorm 2003) and my experience with the implementation of root cause analysis (Iedema et al. 2007) had revealed substantial and very strongly held differences in opinion on what sort of public discussion of medical error was acceptable.

Doctors are known to feel considerable guilt and upset about adverse events and some value the cleansing confessional nature of M&M meetings (Gallagher et al. 2003). If avoidance or denial of unsatisfactory outcomes is bad for the psychological health of health workers (Firth-Cozens 2001), closed medical-only environments may provide much-needed opportunities for confession and counselling (Bosk 2003, Rosenthal 1995: 29). Australian physicians surveyed about strategies to improve clinical practice were moderately supportive of peer review meetings (74 per cent finding them useful, and 3 per cent not useful), but they were much less supportive of multidisciplinary ones.

Bosk described the processes of surgical M&M meetings as ‘putting on the hair shirt’ (Bosk 2003). When a senior doctor ‘puts on a hair shirt he admits error, points out the
lessons in it, and urges all to consider these before hasty action in the future’ (Bosk 2003: 142). This intense self-criticism is psychologically manageable because it is among a group of colleagues who take their own turns at the process, while outside scrutiny hinders this process. Bosk suggests ‘This is a hair shirt on the outside only; for the wearer it has the silken lining of unconditional professional support’ (Bosk 2003: 145).

How true are these findings for Australian doctors twenty years after Bosk described US surgical teams? They seem credible, a focus group member saying:

*There are two functions of the M&M meetings. One is for someone like me who has made every mistake in the book, and when somebody makes a mistake, I pipe up and say, ‘Yes I made a similar one. These are the circumstances that led up to it. I learnt from that, you guys should learn from what I’ve done and don’t make that same mistake again.’ The second is a counselling session where somebody really thinks he’s stuffed up and you can say, ‘Yes, but you couldn’t have avoided that. That was inevitable, you might feel bad about it but nobody in this room thinks you did the wrong thing. The patient was just incredibly unlucky.’*

**SURVEY RESULTS – INVESTIGATIVE PROCEDURE SCENARIO**

Some colleagues at your hospital were involved in a case with disastrous patient outcome. They probably made errors which contributed to the result. Some investigation may be required. How would you prefer the hospital proceeded?

- a) no public discussion – 0 per cent
- b) should be discussed in a medical-only subspecialty forum – 44 per cent
- c) should be discussed in a multidisciplinary forum – 41 per cent
- d) should be discussed in as many large forums as possible, to maximize learning from the adverse incident – 11 per cent
- e) other – 2 per cent
- f) no response – 2 per cent.

Forty-four per cent chose the ‘medical-only’ forum. It has been suggested that disclosure to the patient of an adverse event must be accompanied by work with all members of the health delivery team to identify and discuss system weaknesses. However, it would seem doctors are yet to be convinced.

**FOCUS GROUP SCENARIO**

*You are certain a colleague’s practice in a particular area is so substandard that patients are suffering harm. An audit in this area has been proposed. You are aware that if public attention is drawn to his performance his career and income may be affected.*

Like every anaesthetist, I have had to work with surgeons of questionable competence. Like every doctor, I know ‘bad’ doctors. A focus group member said: ‘Everyone in Sydney
knows – we could all name ten people now who are incompetent at practice and nothing’s been done about it.’

Useful risk-adjusted outcome data is lacking for most aspects of clinical care. However, we do know that surgeons and units performing high volumes of major surgical procedures have significantly lower rates of morbidity and mortality (Birkmeyer et al. 2002, Goodney et al. 2003). This is proven for repair of intracranial and abdominal aneurysms, carotid surgery, radical prostatectomy, pancreatic and oesophageal resection, coronary artery bypass graft, aortic and mitral valve replacement, hepatic and lung resection, and resection of colonic and rectal cancers. Despite the ample data available, there are many low-volume surgical units even within major cities in Australia.

Doctors are ambivalent about performance measures (Marshall et al. 2001, Anonymous 2005). In 1985, a controversial anaesthetic study showed that patients anaesthetized by one practitioner had a much higher rate of myocardial infarction after cardiac surgery than those anaesthetized by unit colleagues (Slogoff and Keats 1985). A similar study in New Zealand found the identity of the anaesthetist to be significantly related to patient outcome (Merry et al. 1992), but such work has remained extremely rare. While New York State has been publishing detailed public reviews of performance in cardiac surgery for some years (New York State Department of Health 2004a, New York State Department of Health 2004b), most practitioners are fearful of such activities. Once the data is collected it is hard to justify keeping secret the identity of a ‘below average’ performer. (There is much anxiety about the potential for public reporting to affect the quality of care (Werner and Asch 2005), for instance if surgeons simply avoided high-risk patients (Guerriere 2005, McKibben et al. 2005, Narins et al. 2005). This has not been proven to occur (Bridgewater et al. 2007). The overall value of public reporting is as yet unclear, as although reports may influence poor doctors to leave clinical practice or cease procedures at which they are less skilled, the information has had little influence on patient decision making (Epstein 2006, Fung et al. 2008, McKibben et al. 2006).

What did the focus group members say about the incompetent colleague? One group commenced with a textbook example of how it should be done, involving possible removal from practice while the audit was under way and extensive communication and documentation. The other group started with a measured response, alluding to the need for confidentiality.

*I think the only way to do it is as a department and probably that means let the audit go on. That’s not something that should become necessarily public.*

The language used is revealing. ‘Do it as a department’ suggests the importance of protecting individuals from being seen as instigators of the audit. ‘Let it go on’ also falls some way short of admitting support for the audit. It was suggested that, rather than an audit, gossip and restriction of referral practices could deal with the problem. It was acknowledged that this is the usual way such a situation is handled (or avoided).

*That person will still get patients [being referred]. You can’t do things. There have been two hospitals where I’ve worked at where there has been someone who everyone has said Don’t let them touch you and that was basically the way everybody handled it. They just avoided referring.*
The competent doctor who deteriorates ... is by far the hardest thing to knock over because that person ... has a huge power on a political base. The outsider who is incompetent is pretty easy to knock over and we do that. We marginalize them. They don't get jobs in teaching hospitals. Sooner or later they just, through market forces, go out of business, don't they?

Most people discuss among themselves. The person gets a reputation and they usually don't know about it and everyone else does, and the people avoid referring [patients] to that person, and eventually their practice ... dies out.

It was also suggested that while the audit should occur, barriers to any audit included a lack of data bases and statistical analyses and appropriate training. However, the real issue appeared to be the lack of a very different sort of resource – a true mandate for the professional workplace group to intervene. Clearly peer intervention is difficult:

He's repeatedly doing the same operation three times before he got it right. People tried to suggest things at meetings to him and everything else was really underhand.

It's hard to sort of take responsibility – who takes responsibility for it?

When anyone's work is substandard and it's generally known, there's always incredible resistance to do anything about it, especially if it's a well-liked colleague. Even if it's not a well-liked colleague, it's very difficult to speak with someone personally and say 'Your work is substandard'. It's a moral dilemma that if someone’s work is substandard you can't think what to do about it.

It was suggested that audits can be unfair:

You've also got to protect those surgeons or physicians from a run of bad pathology. You get bad results because of the natural process of the disease ... and you have a statistical system that throws up three in a row ... [Then] you're defending yourself for no reason of your own.

There is an element of being on and off as a surgeon. Every sportsman knows all about that yet we're meant to knock out the same quality game every week. And the wife is blah, blah and the kids – and at the same time you're meant to come to work and produce the same product.

The focus group member quoted above obviously did not agree with the 82 per cent of surgeons who felt ‘that true professionals can leave personal problems behind when working' (Sexton et al. 2000). However, it is of note that only 53–59 per cent of pilots, anaesthesia consultants, residents and nurses denied the effects of personal problems (Sexton et al. 2000).

Surgical frustration has been found to predict recurrence and operative complications after inguinal hernia repair (Kaafarani et al. 2005). (The contribution of the surgeon's mood prior to operating was not studied.) It was an unusual and useful insight by this surgeon in a focus group that he understood negative mood added to clinical risk.
Essentially, despite the reasons given for not acting and anxieties about the consequence of acting, such as defamation or being unfairly judged on a ‘bad run’, both groups recognized a professional responsibility to promote the audit to ensure patient safety:

*At the end of the day patient’s safety is paramount.*

*The truth is that we have set ourselves up as having internal control in the profession. We actually resist external control … If we want to play that game then we have to play that game.*

**SURVEY RESULTS – ‘HARM BY A COLLEAGUE’ SCENARIO**

You are certain a colleague’s practice in a particular area is so substandard that patients are suffering harm. An audit in this area has been proposed. You are aware that if public attention is drawn to his performance his career and income may be affected. Would you support the audit?

a) no, because everybody can have a bad run of pathology or period of ‘bad form’ – 3 per cent
b) no, because the person gets a reputation, then people avoid referring to that person and eventually their practice kind of dies out anyway – 3 per cent
c) no, as doing one creates a moral dilemma if we do discover someone’s work is substandard, as we have few good ways of dealing with this – 1 per cent
d) yes, but only if your support is able to be discreet – 42 per cent
e) yes – 40 per cent
f) other – 1 per cent
g) no response – 9 per cent.

Respondents overall strongly supported an audit where patient harm had occurred. However, disturbingly, approximately half of those in support would do so only if the audit was ‘discreet’.

Sociologist Eliot Freidson described the handling of an aberrant colleague thus:

*Professional handling of such a case is marked by ambivalence and pain … One would not want to do him out of his very work … His colleagues settle for what their very individualism would see as their first duty – keeping their own nests clean. He is encouraged to resign from their company, but he is not expelled from the profession. They protect themselves and their patients. (Freidson 1988: 181)*

In Australia nearly twenty years later, similar attitudes are seen to prevail. The case of the surgeon Jayant Patel at Bundaberg Base Hospital in Queensland is apposite, with the surgeon’s twenty-year trail of complaints and unsatisfactory performance outside Australia (Nason 2005). At Bundaberg some doctors and nurses allegedly managed ‘around’ Patel so that ‘their’ patients were unharmed. Those who were allegedly harmed by Patel have said they found this alleged ‘managing around’ extremely disturbing (Dunbar et al. 2007). This matter is ongoing at the time of writing.
FOCUS GROUP SCENARIO

The nursing staff in the private hospital complain to you that the elective theatre list of one of your colleagues regularly goes from 7am to midnight. Their hospital management has refused to restrict this. The staff think this is dangerous and ask you to bring the matter up at the medical staff council.

The background for the scenario was the extreme and unusual working hours observed in private practice. Elective operating in the private sector after 9pm was frequent. Unplanned complications can always produce a late finish, but often this was routine practice in the private sector by a busy and successful surgeon who was often a skilled and speedy operator. The list may have started in the morning or even at 6pm after a full day of consulting. These lists were lucrative for both the private hospital and the anaesthetist. Any anaesthetist who complained could jeopardize his or her association with the surgeon and future income. There were always younger anaesthetists available and keen to acquire work. The nursing staff were sometimes working under duress, but the senior scrub sister in particular was often treated as ‘special’ by the surgeon. This could involve public approval and sometimes financial rewards.

In a nearby part of the city there was a notorious knee surgery list that regularly went on until after midnight. It was rumoured that once, after a power failure in the operating theatre, a new patient was anaesthetized at 1am using a series of electrical extension cords. Midnight was chosen as a time likely to divide responses: 3am seemed likely to provoke unanimous censure, while 10pm would have been unremarkable.

Fatigue is topical. Six thousand articles on workload, sleep deprivation, safe working hours and work schedule tolerance were added to the major database of medical literature (Medline) between 1996 and 2005. Twenty-four hours of wakefulness or disturbed sleep impairs psychomotor performance and vigilance (Murray and Dodds 2003), and fatigue worsens mood – causing depression, anxiety, confusion and anger (Gaba and Howard 2002). The performance of more skilled and experienced individuals is less likely to be affected. In all individuals, sleep deprivation will negatively affect attention, decision making, and retrieval from the long-term memory (Jakubowicz et al. 2005), although these may only be tested in a crisis.

Decrement in clinical performance has proven harder to measure (Gaba and Howard 2002, Mak and Spurgeon 2004). Study combining ambulatory polysomnographic monitoring (monitoring eye blinks) (Lockley et al. 2004) and the simple but expensive technique of direct observation (Landrigan et al. 2004) has revealed significant numbers of potential and actual errors during clinical work. A high percentage of anaesthetists admit to fatigue-related errors (Howard et al. 2002), and surgeons also consider fatigue a major contributor to errors (Gawande et al. 2003). Tiredness and overwork are frequently cited as causes for poor medical care (Firth-Cozens and Greenhalgh 1997), medico-legal claims (Nash et al. 2009) and accidents when driving home (Howard et al. 2002, Wylie 2005).

Examination of attitudes to fatigue is a standard feature of safety culture surveys (Singer et al. 2003). Operating room teams have been compared to cockpit crews. When the statement ‘Even when fatigued, I perform effectively during critical times’ was put to
doctors, 60 per cent of all doctors agreed, ranging from 70 per cent of consultant surgeons to 47 per cent of consultant anaesthetists (Sexton et al. 2000). Only 26 per cent of pilots agreed. However, answers to such a question are likely to vary depending on whether the doctors or pilots are working on a fee-for-service basis or a salary.

What did the focus groups members say about midnight operating? The opening comments of the two focus groups were strikingly similar:

*Have they seen evidence of ill outcome in patients operated on?*

*They’d need proof that this was impacting on the quality of outcome.*

These statements were not challenged by other interviewees. Surgical outcome is determined by so many factors that incontrovertible evidence would be unlikely to be found (yet the fatigue literature would have been familiar to all). Therefore in the final form of the scenario, the words ‘There is no concrete evidence of patient harm’ were added to prevent further investigation being suggested.

There was clear discomfort about nursing staff making a safety judgement:

*Just because they think it’s dangerous. That implies it’s a quality issue but …*

The ‘but’ was an assertion that some doctors are safe as exemplified by the comment:

*People have a hugely different capacity for work and some people are on fire 24 hours a day.*

A possible motive behind the complaint was considered and the need for doctors to protect themselves was discussed:

*It’s probably worth talking to the [doctor] … because it’s not so much an issue of patient care but if you have started the operation at 11 o’clock and they have complications … [they] could easily argue in court, ‘Don’t you think you were tired, doctor?’ The doctor is putting himself at risk for medico-legal action but he still may be perfectly capable of operating.*

Generally focus group members knew the situation was not safe.

*There’s very good research to say that it’s a disaster to do it.*

*I think it’s dangerous to be operating all day … I don’t think anyone, no matter how perfect they are, can be perky at 12 o’clock at night.*

The groups then admitted such a practice would be unsafe for them personally while denying the practice was unsafe generally. Therefore they could avoid taking responsibility for action that would impinge on the professional autonomy of a colleague:

*I’ve got colleagues who sleep three or four hours a night. That’s all they need. If I did that for a week I’d be off my head.*

*Yes, you could get twitchy if things are falling apart or whatever.*
I can’t do those [operating] lists. I’m physically not capable of doing it.

There remains the focus group comment that ‘Forty hours is a picnic. It’s part time’. The implication is that doctors have some superhuman capacity for long hours. It is certainly traditional – ‘overwork as normative’ (Myers 2004) – and it seems pride is taken in this aspect of medical life. Some fascinating justifications for why this situation might occur were given. One was that it was a lifestyle choice:

It’s not for us to interfere with someone’s family life. If they’re working those hours to avoid seeing their family, well that’s … [their choice].

It might be the other way around. It’s like you want to do it all in one day so you can have a day off.

The surgeons may have structured their day so they can play golf.

These statements were not challenged. The implications are that psychological survival as a busy medical practitioner can be difficult and lifestyle autonomy is thus placed above safety. The issue of lifestyle choice is interesting. Work–life ‘balance’ forms a minor part in medical fatigue literature, although it is recognized that allowing extra time for sleep (as can be achieved by scheduling changes) does not always result in its being used for sleep (Howard et al. 2002). Many junior and senior doctors would prefer to work longer days and have a day off to catch up on family, personal and social needs.

The so-called ‘escape into work’ syndrome (Myers 2004, Riley 2004), when there is tension or unhappiness at home, was both recognized and supported. One of the doctors I interviewed chose to meet me at 6am before seeing his 6.30am patients. (An elderly couple was indeed in the waiting room when I left.) He proudly displayed pictures of his small and difficult offspring before stating that he was making money now so he’d have time to spend with the infant later.

Pressure from a busy practice was suggested as a reason:

Some of the surgeons who do this just have such large referral practices [that] market forces are forcing them to do this and if they don’t … their waiting list goes out and then they’re at risk [of the patient deteriorating while waiting].

This pressure is more relevant to country practice. A city doctor can simply reduce consultation access if his or her waiting list for surgery is too long. There are many other practitioners in Sydney. However, a possible effect of this is to lose referring doctors and later find the practice too quiet. Financial incentives for the doctor were mentioned. Patients with private insurance expect to be operated on immediately and the effect of fee-for-service surgery is simple:

It means a lot of money to them, each extra case, like the hernia or the hip or the knee.

A more unusual suggestion was that the situation can be perpetuated by the nursing staff:
There’s also that somewhat awkward camaraderie that builds up in a team. There are some scrub sisters – it’s a bit like saying ‘You can drink five drinks, I’m going to drink six’. It’s trying to outdo each other.

‘Yes, I can scrub for you, Sir, for 12 hours, that’s not a problem. Want to go 15 hours? Yes, that’s fine.’ There can be that sort of element of being … tough.

Both groups converged on the theme that someone else (not them) should discuss it or do something. One member told an anecdote of being involved as an anaesthetist in inappropriate late operating and then:

*I thought someone should write a letter of complaint to the management of the hospital.*

However, there was an awareness of the powerless plight of nurses and private hospital administration, as surgeons ‘can threaten to take their business elsewhere’. (Note that the scenario referred to a private hospital.)

*I think the nursing staff, as individuals, would complain but they’ve got very little power. But the nursing administration and the hospital administration are not actually sure where they are separate or where they merge.*

So the groups accepted the risk of the situation, explored likely reasons for this practice, delineated the powerlessness of nursing and hospital administration staff and yet felt these politically weak groups should police the situation.

**SURVEY RESULTS – ‘OPERATING AT MIDNIGHT’ SCENARIO**

The nursing staff in the private hospital complain to you that the elective theatre list of one of your colleagues regularly goes from 7am to midnight. Their management has refused to restrict this. The staff think this is dangerous and ask you to bring the matter up at the medical staff council. There is no concrete evidence of patient harm. You feel:

- a) that it may not be a problem at all, many doctors safely work these hours – 15 per cent
- b) you should talk to the person to let them know others are concerned so that the doctor can protect themselves – 51 per cent
- c) that this is a nursing issue – 9 per cent
- d) that this is dangerous and you hope someone else will complain – 12 per cent
- e) other – 6 per cent
- f) no response – 7 per cent.

The responses in general seem to reflect poorly on the safety culture of these medical practitioners, with 35 per cent either unconcerned or leaving action to others. The ‘other’ responses involved speaking to the practitioner because these work practices are dangerous. Gossip in organizations preserves group solidarity, reinforces social bonds and
also discourages individuals from straying too far from collective standards for fear of attracting criticism (Michelson and Mouly 2004). Answer ‘b’ then could be an effective way to regulate another doctor’s behaviour.

FOCUS GROUP SCENARIO

You are a surgeon. Your complex elective operation requires two specialty teams. After you have commenced, the surgeon from the other team arrives. He scrubs for about 20 seconds and then commences to gown and glove.

Surgical site infections are a major source of preventable harm to patients. During surgery gloves are regularly holed, with reported puncture rates as high as 61 per cent (Laine and Aarnio 2001, Australian College of Operative and Recovery Nurses 2004). For surgery ‘the rules’ prescribe a five-minute scrub for the first of the day and three minutes for subsequent scrubs. These rules have been unchanged for at least 30 years. There are a few papers supporting shorter scrubs or scrubs with alcohol alone but the most recent edition of Surgical Scrubbing, Gowning and Gloving approved by the Australian College of Operative and Recovery Nurses continues to recommend the five- and three-minute standards (Australian College of Operative and Recovery Nurses 2004).

In my experience, hand-washing rules and norms were not infrequently ignored by senior surgeons. Often the trainees would start the operation and later ‘Sir’ would make an energetic and loud appearance after a very brief scrub. I have known nursing staff to draw attention to scrub ‘short cuts’, but usually only to junior nursing and medical staff. However, some surgeons are methodical and expect compliance from all members of the operating team.

What did the focus group members think about the surgeon who fails to scrub properly? This is a very concrete issue as there is an accepted standard of behaviour based on evidence and enshrined in both practice and written recommendations. The scenario indicated to doctors that it was their own patient who was affected by the violation. However, the responses of the interview groups showed extensive manoeuvring because of their discomfort at the thought of confrontation. While one participant stated ‘Tell him to scrub’, this was not followed by a chorus of agreement. The discussion journey of one of the groups is illustrated thus: It happens → I might try humour → I respect a colleague who enforces standards → Speaking will potentially cause ill will or embarrassment → I hope the nurses might intervene → Is it everyone’s or my responsibility? → I might try humour → Speaking will potentially cause ill will or embarrassment.

There was agreement that such failures to scrub happen:

*I knew one surgeon who used to scrub wearing a watch and the nursing staff actually pulled him up about it and said, ‘Mr X, you’re still wearing your watch’. He said, ‘Oh that’s OK, it’s waterproof’. He knew what was being said, but he chose to ignore it.*

One suggested that this not was a major infringement:

*I’m not convinced that it’s that important as long he puts his gloves on in a sterile fashion.*
Both groups mentioned that they respected colleagues who enforce standards, but the implication is that these doctors are admirable exceptions:

*I've got one colleague who is just fantastic because for just any tiny deviation in the way it's done, irrespective of who it is he'll say something. It's done nicely. Because he says it every single time … He's a great role model.*

*I know a surgeon who corrects anyone who walks into theatre … He would tell the visiting specialist from the Mayo Clinic to go out and re-scrub.*

A humorous approach was recommended:

*Ideally you might say, ‘It’s OK John, we’re not in that much of a hurry if you want to go and re-scrub’.*

*And it’s often the situation where you think to yourself, ‘I knew I had a good quip for that situation, I would have said X’. You could say ‘Did we run out of water out there?’ That would be sort of a win-win situation. Like you’d say, ‘I know what you did’ and he can say ‘Oh bugger, they saw me. Better go and do a scrub’. ‘Oh, I didn’t know how to operate the switch, it just turned off …’ That way it’s a win-win, but you have to be quick. But if you said that to me, I’d sort of blush and run out and have trouble coming back in.*

There was a hope that the theatre nursing staff might intervene:

*Depending on who is the nursing staff … if they’ve got confidence and the experience they will often say something.*

*What you need is some big bitchy nursing infection control sister to come round and say – that’s what you need.*

Doctors showed conflicting attitudes towards the roles of nurses. It was generally not acceptable for nurses to have authority over doctors but they may be useful to take action in areas where it is awkward for the doctor to do so – here to enable the doctor to avoid confronting a colleague:

*You resent the scrub sister being so arrogant. But ‘This is a really tricky situation; we’d really like you to deal with it.’ We want our theatre sisters to be all sweetness and light to us [though].*

Survey respondents were not given the ‘easy out’ of leaving the initiative to nurses, though it clearly would have been a popular choice!

Focus group participants agreed that speaking about this transgression would run the risk of causing ill will or embarrassing the colleague:

*It is harder with a senior colleague … Certainly it is intimidating to say to someone ‘Please do this …’. I’m always worried that I sound officious and rude.*
Most of us in general like to stay within the rules ... If you were told, you do have that degree of embarrassment that you've done the wrong thing. You don't feel resentful.

Surgeons have been shown to be supportive of steep hierarchies in which junior staff do not question senior staff (Sexton et al. 2000):

It's part of the responsibility of surgeons that once we're senior enough that we actually try to teach people, not just the surgery but all the careful ways that we want to do things.

Anyone who is underneath you, you have no trouble correcting. ... But it's when people are your peers that the trouble arises.

The peer interaction demanded by this scenario proved difficult to envisage. The members of the second focus group were quite unsure of their ability to say anything:

I would love to say I would tell them to go and re-scrub. I don't think I would, but I'd love to say I would.

The other thing is you could have this vague conversation about how important scrubbing is.

But think of the ill will ... [between] the two teams. I don't think you could say anything.

I think if I was brave I might say something afterwards. Or if a patient has an infection you might raise the issue.

When pushed on who was ultimately responsible, one interviewee said:

I think everyone should take responsibility. It's a known fact that you scrub for a certain amount of time.

Of course, if everyone is responsible then no one is ultimately responsible. Another group member saw the avoidance of personal action that could be implicit in this statement and responded:

The ultimate responsibility is mine isn't it really? Unless I choose to ignore it.

SURVEY RESULTS – ‘SCRUB’ SCENARIO

You are a surgeon. Your complex elective operation requires two specialty teams. After you have commenced, the surgeon from the other team arrives. He scrubs for about 20 seconds and then commences to gown and glove. What are you most likely to do?

a) say nothing because you don’t think it really matters – 7 per cent
b) say nothing because it will cause ill will and make the teamwork in the theatre awkward – 12 per cent
c) try a gentle correction only such as ‘It’s OK John, we’re not in that much of a hurry, you’ve got time to re-scrub’ or ‘Did the water run out?’ – 52 per cent
d) insist on a full scrub – 20 per cent
e) other – 5 per cent
f) no response – 5 per cent.

Of the scenarios posed this was one of the few with a clearly correct answer – ‘d’. The survey respondents too sought to avoid confrontation over the issue and preferred to approach the matter in an oblique or humorous way. One of the most interesting focus group statements was:

*If you said that to me, I’d sort of blush and run out and have trouble coming back in.*

Embarrassment is an ‘emotional reaction to unintended and unwanted social predicaments or transgressions’ (Higuchi and Fukada 2002). There are a number of psychological models (Higuchi and Fukada 2002), but two seem of particular relevance.

The first is the transgression of others’ expectations model. When people transgress expectations, they perceive negative evaluations and feel embarrassed. It is natural to overestimate both the extent to which others notice one’s errors and the extent to which they will judge them harshly (Savitsky et al. 2001). This may have been of adaptive value in our tribal past and it is said that there are ‘few punishments as painful as banishment from one’s social network’ (Savitsky et al. 2001).

The second is the dramaturgic model. Embarrassment occurs when there is no acceptable character that one can perform or act. Consider the response, ‘What you could say is “Did we run out of water out there?” That would be sort of a win-win situation. Like you’d say, “I know what you did” and he can say “Oh bugger, they saw me. Better go and do a scrub”. “Oh, I didn’t know how to operate the switch: it just turned off.” That way it’s a win-win, but you have to be quick.’ What the respondent is actually describing is two ways of acting an escape out of the embarrassing scenario.

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**FOCUS GROUP SCENARIO**

You are near your hospital, waiting at traffic lights, and you notice a medical colleague ahead of you. He changes lanes mid-intersection to ‘push in’. He nearly causes an accident for two other cars although you were not affected. You then share the lift at the car park with him.

Doctors’ cars can be distinctive, expensive and powerful. One surgeon used to tell with some pride of being stopped by the police several times for dictating patient notes as he slowly drove home. The notes were propped against the steering wheel and there is ‘no law against dictating’. He did abandon the practice but this again is a story suggesting that doctors do not feel that normal rules of behaviour really apply to them. There was another surgeon, a serious ‘motorhead’, who raced the police up the expressway to Newcastle and then rushed into the operating theatre before the police caught up. It was always an ‘emergency’. (The law in NSW now prohibits speeding to emergencies.)
What did the focus group members think about the dangerous doctor driver? They acknowledged that such behaviour is not unusual:

_We’ve got a urologist who drives like that. He’s a bloody menace._

They also indicated that they try not to break rules in front of colleagues:

_I must say whenever I drive past a colleague I tend to try to obey the rules a bit more._

As with behaviour that causes a risk of harm to patients, they suggested trying humour:

_I’d say ‘Were you in a bit of a hurry this morning, or did you have a fight with the missus?’_

_I’d say, ‘Gee you’ve got a snazzy car.’ What you’re saying there – you’re not accusing them. You’re saying to them, ‘I saw how you drove’._

It was not considered that there was a responsibility to act:

_I wouldn’t consider that it’s our responsibility to police people’s behaviour outside of work._

_If I thought I was going to achieve this person becoming a much better driver by saying, ‘That’s a ridiculous thing you did’, then I’d say it. But in most situations like that I don’t think I’d achieve anything._

Likely failure to achieve change was given as a reason to avoid conflict. The focus groups often expressed the view that attempts at change will fail or that they do not know how to proceed. The groups were largely indifferent to this scenario but it was posed to provide a comparison. How likely was a doctor to intervene when a colleague’s non-clinical behaviour had the potential for harm to the public at large?

**SURVEY RESULTS – ‘DRIVING’ SCENARIO**

You are near your hospital, waiting at traffic lights, and you notice a medical colleague ahead of you. He changes lanes mid-intersection to ‘push in’. He nearly causes an accident for two other cars although you were not affected. You then share the lift at the car park with him. It is most likely that you will:

a) say nothing – 40 per cent  
b) use sarcasm or humour to make the point that their driving was observed such as ‘You’ve got a snazzy car’ or ‘In a hurry this morning, eh?’ – 49 per cent  
c) other – 8 per cent  
d) no response – 2 per cent.

It would have been expected that doctors felt less responsibility to monitor or censure their colleagues’ behaviour outside of work than in the work environment. But tellingly, more were willing to comment on a doctor’s driving (over 50 per cent) than were willing
to ask for a full scrub (20 per cent) or a public audit (40 per cent). Humour was the preferred method for comment, just as for the scenario dealing with hand washing.

FOCUS GROUP SCENARIO

You hear one of your medical colleagues has been suspended for bullying nursing staff. He has been a supportive colleague to you and while he can be extremely assertive, it is always due to his passion to obtain the best care for his patients.

Surgeons in particular may behave aggressively when the quality of the instruments or technical assistance they are given is poor. They throw tantrums at the front desk of the operating theatre, trying to get priority for their cases. It can represent a display of frustration or be a deliberate strategy to try to obtain better care for their patients or to reduce the inconvenience of their working hours. One of the focus group members mentioned this inappropriate use of aggressive behaviour:

I think what doesn’t happen often enough is for [the surgeon to say] ‘I want to be out of here tonight because I’ve got something on, and I know I’m asking a favour but can we move this operation on a bit quicker?’ To actually say that rather than losing your temper.

Part of my work as an anaesthetist was to find solutions to reduce tension in the operating theatre and control this behaviour. I accepted this behaviour as normal until I heard of an incident involving a highly respected and very dedicated doctor who verbally abused and physically menaced a member of the ward nursing staff over a resource issue. Outside the operating theatre such behaviour seemed somehow totally inappropriate. His apology was accepted as ‘He was only trying to help his patient’.

When 700 US healthcare staff were asked about their co-workers, 77 per cent had a co-worker who was condescending, insulting or rude, and 33 per cent worked with someone who was verbally abusive – yelling, shouting, swearing or name calling (Maxfield et al. 2005). In the UK, 18–37 per cent of junior doctors reported being bullied in the previous year (Quine 2002, Paice et al. 2004). A smaller survey of 461 US nurses reported that 90 per cent had suffered verbal abuse in the past month, with the most common aggressor being a doctor (Sofield and Salmond 2003). However, most bullying of nurses is by other nurses (Lewis 2001, Randle 2003). Far more subtle communication failures are thought to be contributors to medical mishaps (Sutcliffe et al. 2004). Staff are not able to ‘speak up for safety’ in such circumstances.

Study of doctor-bullies suggests the classic bully who gets satisfaction from the use of power is rare (Kelly 2004). The obsessive personality types who are common in medicine may cause interpersonal conflict due to their insistence on a very high level of care (albeit not always with regard to ensuring their colleagues wash their hands). Thus ‘the accusation of bullying is due to a disagreement over what represents normal social behaviour’ (Kelly 2004). Other causes suggested for bullying in the medical profession are the lack of training in leadership and management skills and that the ‘hierarchical system [means] … punitive and insensitive behaviours are passed down from teacher to learner’ (Kelly 2004).
What did the focus group members say about the bullying colleague? While the lack of detail of the incident was a little unsatisfactory for the focus groups, they were able to recollect similar situations. Groups pointed out that being a good doctor and being assertive were not incompatible:

*Everyone hated him but he was an excellent surgeon and at the end of the day was a great asset to the department.*

*Just as there are people who may be very good to their peers and do bully juniors and people they see as inferior, equally there are people who are just assertive in their manner and they’re not actually being rude. And there are very sensitive people – overly sensitive people who then say ‘You’re bullying me’ when it’s absolute crap … They just don’t like being told what to do and they get offended very easily by someone who uses maybe strong words without being rude.*

The speaker was clearly one of the more assertive members of his profession!

*I know tons of people who are brusque in their manner and sensitive people take offence … In the nursing staff you’re more likely to get a bunch of sensitive people … It’s a clash of cultures.*

While one focus group member did suggest:

*I think most good doctors do not bully nursing staff*

another group member quickly chimed in with an excuse:

*One colleague I think gets very anxious in theatre and is therefore short and unpleasant … It’s actually just a fairly stressful situation.*

A surgeon in the group was honest:

*I’ve done this myself. I have lost my temper and I’ve really let go at somebody. The next day … I thought ‘Yes, I behaved out of line there’. I will seek that person out and say, ‘I’m sorry I said what I said. It was in the heat of the moment. It does not reflect what I think now’.*

Support for the alleged bully was advocated:

*It’s a dreadful thing to suspend a senior colleague who is a good doctor if they’ve been accused wrongly.*

*I don’t think suspension is necessarily the right action to take … I would probably write a letter in support of him not to be suspended and to be re-instated, but then have the issue investigated in some other way.*

*It’s usually coming from the nursing staff and levelled at a solitary surgical practitioner … It’s a really serious thing. You want to make sure that the isolated practitioner is supported and he’s not being victimized by someone with malevolent intent.*
In essence, it seemed that bullying behaviour was acceptable for a dedicated doctor and that doctors would actively support colleagues who bullied.

**SURVEY RESULTS – ‘BULLYING’ SCENARIO**

You hear one of your medical colleagues has been suspended for verbally bullying nursing staff. He has been a supportive colleague to you and while he can be extremely assertive, it is always due to his passion to obtain the best care for his patients. How will you react?

a) write a letter to hospital management stating that suspension is not an appropriate way of managing this situation – 32 per cent

b) suspect his assertiveness had been misinterpreted as bullying by an overly sensitive staff member and attempt to rally support for him – 35 per cent

c) avoid him, as you know that policy in this area is clear and would be sure he had badly overstepped boundaries – 4 per cent

d) other – 20 per cent

e) no response – 8 per cent.

For this scenario some respondents needed to know more about what exactly had happened. They wanted ‘to ascertain the validity of the complaint’ or ‘get the complete story from both sides first’ or they opined, ‘I was not there. I do not know whether he was assertive or inappropriate … or if he was truly aggressive’.

Some stated clear support for anti-bullying processes: ‘Policy is clear, discuss with the colleague and authorities’ or ‘Support the person not the behaviour’. However, the general lack of trust in management action in such a case was notable.

Despite the scenario’s lack of relevant detail, the great majority of respondents selected options supportive of their colleague. If a colleague is ‘good’ to the respondent, explicitly supportive as here, then ‘just world theory’ (Hafer and Begue 2005) suggests that it would seem less likely that this colleague really has been ‘bad’ to others.

It is suggested that ‘Wherever possible we tend to forgive those within our alliance for making mistakes – we don’t want to cause them the emotional pain that is associated with blame and criticism’ (Firth-Cozens 2002). The efforts to forgive and justify made by the respondents were substantial. Focus groups and respondents chose to guess (and this was made likely by the wording of the scenario) that the bully of the scenario was an obsessive personality type in conflict with ‘overly’ sensitive staff. The implications of this conflict for the organization or for patient safety were ignored.

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**FOCUS GROUP SCENARIO**

You see a new patient in your rooms. In the course of the consultation she reveals she has left her previous specialist after sexual intercourse occurred in the surgery. She asks for your advice whether she should take any action.
This scenario was designed to cross taboos. While I had no personal knowledge of sexual exploitation of patients by colleagues, I had heard rumours of this happening. While public report of cases is sporadic (Wallace 2005), 3–10 per cent of doctors admit to a sexual relationship with a patient (Galletly 2004) and in Australia more than 7 per cent of male psychiatrists admit to erotic contact with patients (Leggett 1994). Such boundary violations are often initiated by patients (Farber et al. 1997), but doctors who use patients as a source of self-affirmation – for instance those with deteriorating relationships at home – are especially at risk (Riley 2004).

Australian State medical board publications reveal that sexual matters form a surprising percentage of their deliberations. However, medical boards respond to complaints, and given the lack of systems for the measurement of the quality of clinical care at the individual practitioner level, much poor clinical work will not be identified and so will not result in complaint. On the other hand, sexual involvement with patients is readily identified as an ethical violation (Peternelj-Taylor 2003). Complaints are therefore made and boards are also far more able to arrive at judgements in such matters while allegations of poor clinical care are more difficult to determine.

What did focus group members think about management of an ethical violation? Members considered that there was the need for some public airing of the issue:

Oh, this is very tricky. I think you’d have to get it out in the open very quickly, because she has to make a formal complaint.

Spread it around because it’s potential for blackmail if you keep it quiet.

It was generally agreed that the patient should be advised to report the matter:

Clearly it’s a criminal thing to have happened to this person … My advice would be that they should report it. I’m not the appropriate person to tell this to.

I would say ‘OK here’s the phone numbers, here’s the addresses, here you go madam, this is where you need to write. And leave me out of it’.

While the preferred course was to encourage the patient to take action, as discussion continued members became increasingly willing to take action (or moral ownership) themselves:

Either the patient has it [a psychiatric problem] or their doctor has it. If either one has the problem, they need help.

Perhaps you have to then get involved in at least ensuring that the woman has made a complaint.

This was then developed further:

It’s part of our civilized culture – there are certain behaviours that are taboo that you act upon. You see someone beating a child in the street, you’re not going to stand by and watch. You see two thugs at a football match having a fight, you might stand back. But this is a clear … [violation].
You’d have to do something.

Some would choose to speak to the accused doctor.

If I knew them personally – I’d talk to the complaints board first – but I would certainly be
tempted to speak to them and say this is what happened and this is what I have to do about
what you’re doing.

There was a self-protective theme as well, with groups seeing the need for protection
against a possibly deranged patient, or being held accountable for failure to take action:

There may be some obligation on you to report it as well.

Yes, because you’re putting yourself in danger. Once she’s told you, I think it’s like a child – once
a child tells you they’ve been sexually abused it’s mandatory to report it.

Psychiatrists get into a lot of trouble if they don’t take a complaint further.

Before I did any of that I’d bring the secretary in.

In both focus groups this situation was seen as mandating action by the doctor. Moral
repugnance dominated over suspicion about the patient’s motives. Not all members were
sure about the type of action they were able to take, but would discuss options with the
medical board and Healthcare Complaints Commission. Most were unclear about their
legal obligations.

Toward the end of the focus group discussions anecdotes were shared about known
cases:

A whole lot of doctors in New Zealand have been struck off for this sort of reason. Most of them
had a very unhappy family life.

An out-and-out fruit loop … She was running around saying he’d had a fling with her in a
broom closet somewhere in the nursing home and she was now carrying his child.

This latter anecdote refers to a false accusation by a mentally unstable nurse, yet the one
below relates to behaviour closer to being acceptable:

She went off and saw this person who then invited her out … He invited out a lot of his patients
… And she married him. I had no idea whether it was right or wrong and they’ve had a very
successful marriage so far … But it just wasn’t professional.

SURVEY RESULTS – ‘SEXUAL INTERCOURSE’ SCENARIO

You see a new patient in your rooms. In the course of the consultation she reveals she
has left her previous specialist after sexual intercourse occurred in the surgery. She asks
for your advice as to whether she should take any action. You will advise the patient of
the appropriate routes for complaint and avenues for support and then it is most likely that you will:

a) warn the previous specialist of the complaint – 7 per cent
b) warn the previous specialist of the complaint only if they are a close colleague – 6 per cent
c) leave actions to the patient – 39 per cent
d) strongly encourage the patient to make a complaint as ‘there are certain behaviours that are taboo’ – 39 per cent
e) other – 5 per cent
f) no response – 5 per cent.

The scenario was neutral on whether the patient was possibly dishonest or unbalanced. Two respondents did make comments of such a nature: ‘The patient could be lying’ and ‘Ensure a nurse sits in’.

Of those surveyed a great majority favoured leaving the patient to initiate a complaint or encouraging the patient to do so. From the moral repugnance the scenario evoked in the focus group, one might have expected the survey group to show a higher agreement to strongly encouraging the patient to make a complaint.

FOCUS GROUP SCENARIO

A colleague you share the on-call roster with is called to the hospital for an emergency. He never arrives. You are then called in by the frantic staff. As you leave, you notice your colleague’s car in the car park. He is in it, in a drunken stupor. You are not aware of any previous incidents and no one else is around.

This scenario contained behaviour that I believed would ensure action. I had been aware of consultants drinking heavily (and sometimes not having their phones or pagers with them) when on call. Abuse of alcohol by medical practitioners is recognized (Firth-Cozens 2001, Harrison and Chick 1994) as a method of self-medication for stress, and problems can exist for many years before colleagues recognize the risk (Brooke et al. 1991). It is not the subject of frequent discussion among doctors, perhaps because alcohol is a socially acceptable drug, although abuse of alcohol and other drugs forms 50 per cent of cases referred to the New South Wales Medical Board (Wilhelm and Reid 2004).

What did the focus group members say about management of the drunken colleague? It was agreed that such events happen:

I’d just been to a hospital dinner and I was really – you know – tight. They rang me and they had an emergency situation … Couldn’t find the surgeon, couldn’t find the registrar … Would I come and deal with it? I said, ‘Well to be quite frank, I’m drunk’. They said, ‘Well he’ll die if you don’t come’. So it’s the only operation I did when I was potentially pretty heavily under the weather and it went well. I let everybody know I was impaired, and they said, ‘Well – you’re all there is’. 
Both groups agreed that they would conceal the event and discuss it one to one next day:

*If it's the first time it's out of character. You'll just cover for him. And say to him the next day that he put you in a difficult situation.*

*I would definitely give him a lift home. And then I would do something. I would say, 'Look I had to cover your backside and I'm very unhappy about it'.*

*You have to have some discussion. You can't just sweep it under the carpet.*

*I'd take his car keys away from him and then talk to him after. His wife might have just left him or something. If he's an alcoholic ... there's ways of dealing with that ... [If he doesn't want to, then we all know there's not much that can be done.]*

Other possible justifications were postulated such as ‘Perhaps being tired [and not recognizing additional effects of alcohol]’ or ‘Perhaps they made a mistake about their call date’. An additional comment of interest was made:

*Breaking up with your wife is no excuse to get drunk. You've got to get on with it. If you're on call you keep on doing it. Having been there, my first marriage break-up under similar circumstances, there was no one to cover. I had to put her on a plane back to Australia and I kept on working. I was on call that night.*

This scenario rang true with the focus group and they were prepared to make excuses for such a colleague. Yet the focus group members set extraordinary, almost superhuman, standards for themselves. The doctors’ sense of competence and their own coping personalities may cause denial of the effects of stress on their professional performance (Firth-Cozens 2001).

The interview groups were then asked: ‘If you hadn’t got there in time to prevent harm, would that change your views?’ Responses varied:

*That takes it into a different dimension. But that person then is going to be up before the medical board.*

One interview group was even less sure, with the following discussion occurring:

*Probably I think I'd report it to my head of department.*

*But in this situation there's a drunken woman/man in a car.*

*Yes, someone died because he was drunk behind the steering wheel.*

*You're the only one who knew.*

*Well, that would come out in the wash. But if no harm was done I'd ignore it.*
The argument was thus made by both groups that reporting a colleague would not be necessary because when harm occurred, formal investigative processes would follow. It was suggested that if this was a repeated occurrence they would then make a report.

If it was happening all the time I would report it to the HOD [Head of Department]. But the first time, out of character, wife, husband just left. You know, personal tragedy ... ‘That’s the reason, I’m dreadfully remorseful, it will never happen again’. I wouldn’t report it to the HOD.

This offence could, of course, be repeated but witnessed (or not) by other observers. Interestingly, the fact that if and when a patient did die and an investigation was done, focus group members did not consider that their failure to act on this occasion might be uncovered.

SURVEY RESULTS – ‘INTOXICATED’ SCENARIO

A colleague you share the on-call roster with is called to the hospital for an emergency. He never arrives. You are then called in by the frantic staff. As you leave, after a successful clinical outcome, you notice your colleague’s car in the car park. He is in it, in a drunken stupor. You are not aware of any previous incidents and no one else is around. It is most likely that you will:

a) drive him home, say nothing – 1 per cent
b) drive him home, discuss the issue with him one-to-one when he is sober – 71 per cent
c) report the matter to your HOD only if you became aware of other issues, as ‘everyone can make a mistake or have emotional problems’ – 8 per cent
d) report the matter to your HOD the next day – 19 per cent
e) other – 0 per cent
f) no response – 1 per cent.

The results of this particular scenario were surprising, with the focus groups discussing possible reasons and thus perhaps developing empathy (Batson and Oleson 1991) with the drunken doctor. The survey groups were not given a period of discussion and reflection, yet still the great majority chose to handle the matter privately on a doctor-to-doctor basis.

No respondent suggested immediate reporting of the transgression. This makes possible the development of a situation of a shared guilt, where such secret knowledge becomes more and more difficult to expose (Hart and Hazelgrove 2001). The witness to the drunken episode may not share the alcohol problem, but perhaps the drunken doctor is or has been witness to other secrets and real or perceived failures in others.

Referral for alcohol misuse to the medical board usually occurs later in a doctor’s life. Typically these doctors are in their fifties, possibly ‘reflecting the unreliability of early signs and the degree of denial by ... those around them’ (Wilhelm and Reid 2004). The responses to this scenario make this easy to imagine. Meanwhile patients could also suffer from alcohol-related neurological effects on doctors’ cognitive function and fine motor skills. The doctors in the focus and survey groups showed little focus on the need to protect future patients.
As I became more involved in investigation of error I sometimes sensed surgeons with whom I’d had no specific interactions of this nature would avoid sitting next to me at meetings. It seemed as if I had become dangerous company.

Whistle blowing is a deliberate non-obligatory act of disclosure made by a person about non-trivial wrongdoing (actual, suspected or anticipated) to an external entity having potential to rectify the wrongdoing (Jubb 1999). Whistle blowing in health settings has received considerable attention and has been portrayed in both medical literature and the media as something to be valued and encouraged (Faunce et al. 2003, Fost 2001, Dudley 2005, Lacayo and Ripley 2002). The whistle-blower anaesthetist Steve Bolsin’s role in precipitating the Bristol Royal Infirmary enquiry into substandard paediatric cardiac surgery was widely discussed and the Bundaberg whistle-blower nurse Toni Hoffman was given the 2006 Australian of the Year Local Hero Award.

Bolsin claims the image of the whistle blower as a ‘... disaffected, antisocial, incompetent pariah, “not a team player”, who fails to appreciate the damage he or she is causing to the hard-earned reputations of their professional colleagues and employer’ (Faunce et al. 2003) is incorrect. One could differ – while whistle blowers may be acting to protect others (like vulnerable patients), they certainly are disaffected and antisocial from the frame of reference of their work groups. The members of the organization that then comes under investigation usually view whistle blowers as traitors, and they are vilified or ostracized (Faunce and Bolsin 2004, Kennedy 2001, Martin and Rifkin 2004). The results of whistle blowing can be devastating to the morale of an entire hospital staff and to the trust of a community in their local hospital (Johnstone 2004).

The majority of employees in any industry who discover individual or corporate wrongdoing do not report this to anyone (Miceli and Near 1992, Near et al. 2004). Medical students who would refuse to report others for academic misconduct proffered two reasons (Rennie and Crosby 2002). One was the desire to maintain group trust, as belonging earns and obligates support. A second reason was the possibility that they themselves were unwittingly engaging in misconduct, that is, the motive of self-preservation. By definition, self-preservative instincts are of primal importance.

A US study revealed that 81 per cent of doctors had significant concerns about the competency of a nurse they worked with, and 68 per cent were concerned about another doctor’s competence (Maxfield et al. 2005). Of the doctors concerned about a doctor, 21 per cent claimed that this person had done something dangerous at least once a month, 66 per cent said the problem had been present for more than a year and 21 per cent stated that a patient had been harmed by the physician’s actions in the last month. Discussion with co-workers and the use of ‘work-arounds’ to keep patients safe were the common actions and less than 1 per cent had spoken to the doctor concerned. Reasons for not speaking included the futility of doing so and the risk of retaliation.

What did the focus group members say about whistle blowing? A whistle blower was ‘damaged’ as a colleague and ostracization was to be expected:
Well, the damage has been done, hasn’t it?

I suppose ultimately I’m still doing it for the right reasons. And if that means people are cool to me because I’m a whistle blower – so be it.

You’ve got to cop it sweet [accept the outcome] and if you have the courage of your convictions, you’d see it through.

Focus group members noted that they would feel very insecure about making such a report:

But I would have to know that my perception is actually correct before I did anything so extreme as to dob a colleague in [report a colleague]. I would have to have reassurance.

In fact, group members considered it necessary to have spoken to colleagues first:

I wouldn’t have spoken to any director before I’d spoken to some of my colleagues. I’m not saying if they’d said, ‘No, no, don’t do it’ I wouldn’t have done it, but I may go for some degree of response from their reaction before doing it.

But you wouldn’t do it in isolation anyway.

People generally don’t do this – somebody who does this out of the blue is generally pathological themselves.

If you’re sitting in Grand Rounds [a large departmental clinical teaching meeting], not everyone is going to be cool toward you because there would be someone there to whom you’ve been chatting with before you even took the step.

Yet they were all familiar with Steve Bolsin and the issues at the Bristol Royal Infirmary.

It’s just about that English fellow ... [who] made the complaint without support ... and left the country?

I don’t know about personal support. I think it was supported by facts.

But no peer support. In that case he was ostracized. Eventually he’d been vindicated by an investigation.

This scenario was not put to survey groups as the focus group members simply could not imagine being in the situation of acting or reporting without support from some or all of their colleagues. They felt ostracism was both expected and appropriate, and that such a reporting doctor would be most likely to be abnormal.

It is also likely that staff are aware that there are significant differences of opinion on what constitutes dangerous care, and that matters are rarely indisputable. Doctors may be aware that they themselves perform in ways that others may think dangerous (in Chapter
6 the fact that medical practice is intrinsically uncertain is discussed) and hence there is a genuine fear of ostracism.

**Doctors’ Reluctance to Engage with Colleagues where there is a Patient Safety Issue**

These scenario responses show a generalized reluctance on the part of many to act, influence or engage with colleagues where there is a real or potential patient safety issue. The focus group transcripts provide insight into the professional culture. The use of the focus groups to derive the survey answers proved sound as, for most scenarios, the use of the ‘other’ response option was rare. Compared with the larger survey group, the focus group members made statements more suggestive of empathic identification with both the colleagues and patients portrayed in the scenarios. They were also more likely to claim the need for personal action, perhaps due to the longer period they had available to imagine the scenario and through the play of group process.

Rosenthal’s descriptions of how doctors handle error (Rosenthal 1995: 16–28) (described early in this chapter) were reflected in the discussions and survey responses. While Rosenthal’s work focussed on doctors’ responses to grossly errant colleagues, these scenarios elicited similar responses to more subtle organizational and personal dilemmas. Three major conclusions emerge from considering the scenarios discussed in this chapter and also those discussed in Chapter 4, ‘Professionalism’.

1. For their own patients the doctors are prepared to make every possible effort, while acknowledging the detrimental effect this had on the quality of their own lives and that of their families.
2. Doctors are able to admit to personal frailties and errors and that their own behaviour might not always be ideal as evidenced by their failure to be willing to regulate others. ‘I don’t think I would, but I’d love to say I would.’ There is evidence of reflection and insight.
3. Doctors are reluctant to initiate disciplinary action against colleagues. They preferred to confine their attempts to control peer behaviour that is potentially or actually harming patients to humorous remarks. Responsibility was diffused. Whistle-blower behaviour was rejected.

Depending on the issue, a proportion of respondents were willing to act, or felt obliged to act, personally. This is summarized in Table 5.1 opposite.

These results are troubling. Doctors would attempt to regulate the behaviour of colleagues, but confined their means of doing this to mechanisms that allow them to preserve a positive relationship with the colleague, for instance through the use of humour. They were clearly unwilling to imperil these relationships. Humans will punish others for the public good rather than for personal benefit even where the infliction of that punishment incurs a cost (Bowles and Gintis 2002). This ‘altruistic punishment’ is believed to underlie much cooperative human behaviour (Fehr and Gachter 2002, Bowles and Gintis 2002). However, from the responses to the scenarios in this chapter the cost to the doctor of punishment of colleagues appears to be too high.
### Table 5.1 Most Popular Response to Each Scenario

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Too busy’</td>
<td>Try to persuade a colleague to attend M&amp;M by telling them that their input was valuable</td>
<td>38</td>
</tr>
<tr>
<td>‘Investigative procedure’</td>
<td>Discuss case with disastrous complications only with other doctors</td>
<td>44</td>
</tr>
<tr>
<td>‘Harm by a colleague’</td>
<td>Support an audit only if support were able to be discreet</td>
<td>42</td>
</tr>
<tr>
<td>‘Complaint by nursing staff’</td>
<td>Talk to the doctor working dangerously long hours only so they could protect themselves</td>
<td>51</td>
</tr>
<tr>
<td>‘Scrub’</td>
<td>Attempt gentle correction only</td>
<td>52</td>
</tr>
<tr>
<td>‘Driving’</td>
<td>Use sarcasm or humour to demonstrate disapproval of dangerous driving</td>
<td>49</td>
</tr>
<tr>
<td>‘Bullying’</td>
<td>Rally in support of the colleague</td>
<td>67</td>
</tr>
<tr>
<td>‘Sexual intercourse’</td>
<td>Leave actions entirely to patient or strongly encourage the patient to make a formal complaint</td>
<td>39, 39</td>
</tr>
<tr>
<td>‘Intoxicated’</td>
<td>Drive the colleague home and discuss it one-to-one the next day</td>
<td>71</td>
</tr>
</tbody>
</table>

Some see conspiracies of silence when:

… professionals, faced with the unethical behaviour of a colleague, collude not to see what is going on, ignore their intuitive feelings, dismiss rumours as gossip, minimize or trivialize the behaviour of the deviant [colleague], or adopt a variety of rationalizations in an attempt to avoid having to speak out. (Peternelj-Taylor 2003)

Do the responses to some of the scenarios represent a conspiracy of silence? While it is not collusion with express intent, there is a socially shared silence (Hart and Hazelgrove 2001). It is not produced by coercion and indeed there may be devices designed to encourage speaking out, such as whistle-blower legislation and reporting systems. Nor does the silence necessarily represent acceptance of dominant norms. There are varied motivations for remaining silent, including the need to minimize psychosocial tension (Hart and Hazelgrove 2001).

This chapter has illustrated that the doctors who are committed to the fiduciary duty (Chapter 4) are also unable and/or unwilling to act to keep patients safe from medical colleagues. Chapter 2 outlined the safety and quality problem, the large and unacceptable
gap between the care patients do receive and the care they should receive. The dominant players in health care, the smart and powerful, allow this situation to continue. Why are these things so?

*Does the uncertainty of medical practice limit doctors’ abilities to engage with systemic healthcare problems?*
A Short Drama

SCENE 1: IN A LIVING ROOM

A couple are watching television, dishes drying in the rack. A medical show is on.

A heart transplant is needed for a young mother. The couple are refugees with two small children. The symptoms of an impending stroke are ignored by an old man and his wife until he has a catastrophic bleed and crashes his car while driving. He mounts the pavement and hits a 10-year-old who is truanting school.

He turns the volume down while ads unfold: the carpet warehouse flashes up images of its closing-down sale, followed by this week’s fresh produce specials.

He looks at her as she shifts uncomfortably on the couch. ‘I’ve still got that pain … a deep sort … in my side,’ she says. He sighs.

He’s irritated. ‘What’d I say last time? Go and see the doctor, even if you have to wait.’

‘The pain does keep coming back.’

No heart is available in time for our young mother. She dies. The old man also dies. The boy who was run over survives. The old woman bonds with the refugee husband and his children in the intensive care unit waiting room and in the final scene they leave the hospital together.

Fresh produce tempts them with $1.99 avocados.

They turn off the television and go to bed.

SCENE 2: IN A GENERAL PRACTICE

‘The pain in my side isn’t there now, but it was on and off for a few days last week.’
'Well, I didn’t find anything abnormal on the physical examination,’ says the doctor. ‘Are you sure you can’t give me any more details?’

‘Not really, just thought I should get it checked out to make sure,’ she says.

The doctor sighs and reaches for a radiology referral pad.

SCENE 3: IN A RADIOLOGY PRACTICE

Two radiologists are lit by the images in the darkened reporting room.

‘Thanks for coming by. I thought there might be something just there, but the sonographer didn’t see it so that’s the only image I’ve got.’

‘It’s probably nothing. I guess the patient’s gone?’

‘Yes.’

He sighs. ‘Do we get her back or not? Err … What was the history on the request?’

SCENE 4: IN A SPECIALIST’S CONSULTING ROOMS

The couple are in the consulting room. The doctor’s desk is littered with scans, scrawled surgical diagrams, survival graphs and tissues. She is crying quietly and looks dazed.

The man leans forward, frowns and fixes the doctor with his gaze, ‘So if she has the radical type of surgery and the chemo we can be sure?’ He awkwardly reaches back to hold his wife’s hand. ‘If that’s the case I know we can get through the side effects.’

The doctor sighs and wonders whether to begin the explanation again or give them the answer they want.

Why Do They Sigh?

Medical television drama adheres to narrative conventions to provide satisfying resolutions. However, in the real world of clinical care, symptoms are elusive, test results unclear and decisions complex and distorted by emotion. ‘Getting it wrong’ can mean patients lose their lives. The doctors can be left with devastating uncertainty about the parts played or not played in the outcome. Patients pressure doctors to make it ‘all right’, to provide solutions.

The interval involved in these four scenes could vary from days to years. Was there a critical delay in making the diagnosis? If so, there are many possible causes. For instance, it is unlikely that the concerned husband made the appointment for his wife the next day. The radiologists may call the patient back in Scene 3 or there may be another round of
symptoms, visits and repeat investigations before we get to Scene 4. The neat resolutions of television drama are lacking. Instead there is uncertainty and people seeking assistance in deciding what to do.

**Practising with Uncertainty**

Medical students find adapting to the uncertainties of the doctor’s world uncomfortable (Becker et al. 1963, Haas and Shaffir 1982). A study of student diaries revealed three major types of uncertainty: incomplete mastery of available knowledge, limitations in current medical knowledge and the difficulty of distinguishing between personal ignorance and the limitations of current knowledge (Fox 1957). Young doctors have to take responsibility when they are insecure about their levels of both knowledge and experience:

*I can remember writing my first paracetamol prescription worrying whether I was going to kill the patient.*  *Paediatric surgeon*

Specialization is viewed as one way of reducing uncertainty:

*The only honourable thing for them to do is to become more skilled in some one branch of medicine so that they may thereby hope to give their patients the best possible medical care.* (Becker et al. 1963: 426)

While uncertainty exists in all forms of responsible human action, doctors’ actions have profound and directly observable consequences for their patients. This makes doctors particularly prone to anxiety over their decisions. The use of the word ‘honourable’ in the quote above illustrates that uncertainty can be seen as a personal and professional failing.

Tallis summarizes:

*Clinical medicine is always about probabilities, about making definite, often irreversible, decisions with incomplete certainty. The general template we bring to our practice from our knowledge and experience never quite fits the problems presented by the individual patient. The mesh of evidence internalized by the most assiduous evidence-based practitioner is still sometimes quite coarse, leaving a penumbra of uncertainty around the singular patient.* (Tallis 2004: 211)

Doctors bring powerful analytical skills to bear on uncertainty. One study of nurse decision making about critical events revealed poor and inconsistent performance due to a lack of linear reasoning (Thompson and Yang 2009). Unlike doctors, they are not trained to deconstruct uncertainty into constituent parts and pose it as questions to be solved, thus creating a rationale for reasoning.

However, doctors are not scientists. Biological laws are too imprecise to be simply applied to the patient. Instead, doctors reason from the particular problem to their general understanding and then back again to the particular (Montgomery 2006: 32). They also construct narratives to interpret illness. Doctors are thus defined by their ‘pedagogical and mnemonic use of single particular, chronological accounts of illness’ (Montgomery Hunter 1991: 28).
An understanding of the ways in which uncertainty moulds medical culture is necessary if doctors are to be engaged in improving patient safety (Rosenthal and Sutcliffe 2002). This may be difficult, as Montgomery suggests:

*Uncertainty is ritualized, professionalized, and then for the most part ignored by both the patients who seek help and the physicians who must act on their behalf.* (Montgomery 2006: 4)

Perhaps doctors deny their own doubts and feelings as there are limits to the uncertainties and difficulties people can reasonably face: doctors do have to get up the next day and see the next patient. Of course the patients collude in this as they have no interest in the doctors being sad or tired or worried. For patients, illness is a period of ultimate egocentricity.

There are two views on doctors’ denial of uncertainty in the application of medical knowledge. One suggests the denial of uncertainty by the individual doctor in the practice setting is ‘normal and inevitable’ (Gerhardt 1989: 128). Doctors rarely acknowledge fallibility in routine clinical encounters (Christakis 1999: 61) and may hold unrealistic expectations of their ability to combat disease (Christakis 1999: 25). Such denial of uncertainty may not merely be expected but often be demanded by patients (Haas and Shaffir 1982, Montgomery 2006). It has been hypothesized that acquiring the ‘cloak of competence’ – really the pretence of competence (Haas and Shaffir 1982) – is a central part of the process of medical socialization. The cloak was essential to legitimize the practitioners’ ‘claim of trustworthiness in serious or fateful matters’ (Haas and Shaffir 1982).

Doctors are reluctant to make predictions to patients, such as how long patients might live. Palliative care physician and sociologist Nicholas Christakis found that in this circumstance they may ‘cultivate ambiguity about the future, thus attempting to convey accuracy, honesty and hope simultaneously’ (Christakis 1999: 91). He considered that, while uncertainty might be ‘manipulated as a predicate to hope’ (Christakis 1999: xix) and to give the patient encouragement, the practice was ethically wrong.

This brings us to the alternative view of medical uncertainty which is that ‘such a disavowal is to the detriment of the patient which is why uncertainty awareness ought to be demanded’ (Gerhardt 1989: 128). Recent efforts to achieve patient involvement in decision making using this view have been substantial. There are suggestions that this policy has gone too far (Dobson 2002). A recent *New York Times* article focussed on the patient distress that this can produce, with one patient commenting on the 20-page printout he received: ‘At 57, it’s a little late to be starting medical school’ (Hoffman 2005). The reaction of another patient was described thus:

*Ms Gaines, bald, tumour-ridden and exhausted from chemotherapy, was reeling. ‘I’m not a doctor!’ she shouted. ‘I’m a criminal defence lawyer! How am I supposed to know?’* (Hoffman 2005)

The balance can be difficult, particularly when patient options are complex or their illness limits the patient’s ability to participate in decision making. Some place their hope for the future in ‘shrinking the borders of uncertainty’ (Rosenthal and Sutcliffe 2002: 259) by knowing more and having more evidence. Surely, evidence-based medicine (EBM), the formalized product of volumes of international research, has helped remove some uncertainty.
EBM is ‘the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients’ (Sackett et al. 1996). EBM values epidemiological and bio-statistical assessments of knowledge when making decisions about patient care (Cohen et al. 2004). The randomized controlled trial (RCT) and meta-analyses\(^1\) of such trials are the forms of evidence most highly prized by EBM (Sehon and Stanley 2003). Many reviews using the strict methodology of EBM (such as the Cochrane Collaboration, see http://www.cochrane.org) are inconclusive. However (and a reality often disregarded), an estimated 50–80 per cent of all medical treatments have never been validated by trials. Therefore the ‘absence of evidence regarding the effectiveness or safety of a particular health intervention does not mean the intervention is not safe or effective’ (Steinberg and Luce 2005).

Australian doctors were recently surveyed on their views about EBM. Of these doctors, 74 per cent thought EBM improved patient care, 70 per cent thought they had the skills to search for evidence, but only 21 per cent thought they had sufficient time to do this.

*There is so much for these guys to know ... Medical knowledge goes up by something like 20 per cent a month in terms of publications. Who is going to keep up with that? But what you have to learn is how to learn.* Renal physician

For the statement that ‘There is not enough evidence relevant to my specialty’, 40 per cent agreed or strongly agreed (Toulkidis et al. 2005). Interestingly, 70 per cent agreed that ‘Patients demand treatment despite a lack of evidence for effectiveness’ (Toulkidis et al. 2005), yet only 30 per cent disagreed with the statement ‘Patients have fixed expectations which influence my treatment choices more than evidence’. The implication is that brokerage of evidence to patients is now a regular part of doctors’ work.

Promotion of guidelines has been a popular approach to increasing the practice of EBM. Guidelines make specific authoritative recommendations about medical practices (Hayward et al. 1993). In the UK, 75 per cent of surveyed doctors disagreed with at least one of their new national guidelines and 85 per cent said that they would ignore a guideline if they disagreed with it (McLoughlin and Leatherman 2003). UK clinicians were suspicious about the independence of the national body that produces national appraisals and guidelines (McLoughlin and Leatherman 2003) as it was thought the government might wish to reduce financial imposts. Implementation of any guideline is difficult, even in the absence of suspicion about motive, and much literature attests to the difficulty of changing medical practices. One cause for implementation difficulties for any guideline is often ignored, but relates to the persistence of ambiguity:

*It is difficult to produce clinical practice guidelines that are completely evidence-based. In fact, opinion often fills in gaps in the evidence base related to a chain of reasoning that underlies a clinical guideline* (Steinberg and Luce 2005).

A continuing problem is what is regarded as ‘the’ most correct evidence changes over time. This leads to two problems – how to define error in the treatment of patients in the light of changes to the evidence and when should it be considered that the revised evidence has been sufficiently disseminated to become the new doctrine.

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\(^{1}\) A method of consolidating the results of a number of different studies.
After noting the strong recommendation of peri-operative beta blocker therapy (to prevent dangerous heart rate rises in hypertensive patients during anaesthesia) by the quality editorialists (Mangano et al. 1996, Leape et al. 2002, Wallace et al. 1998), I presented a talk recommending routine use of such therapy. However, a week later I found new literature stating that ‘... the most recent data on this safety intervention suggest that not only does it fail to improve outcomes, it may in fact worsen them’ (Forster et al. 2005). Examination of the basis for this change in recommendations revealed a new Canadian review (Devereaux et al. 2004) claiming that evidence for the value of beta blockers in non-cardiac surgery patients was weak. However, a more recent US review suggested good evidence for beta blocker use in high-risk patients (Lindenauer et al. 2005). Conversely, UK patients on chronic beta blocker therapy were shown to suffer an increased rate of peri-operative myocardial infarction (Giles et al. 2004). All these conflicting papers were published within the same 18-month period, along with work showing under-utilization of beta blockers in peri-operative patients that was based on the previous recommendations (Siddiqui et al. 2004).

The ephemeral nature of ‘best practice’ and the potential absurdity of defining an error as ‘a failing to deliver evidence-based care’ are evident. Clearly EBM raises new uncertainty issues for medicine about the relationship and nature of good medical research and of good clinical practice (Fox 2002: 245–246). Instead of creating certainty, EBM may sometimes make decisions harder. The interviewees were asked the following questions about EBM.

<table>
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<th>INTERVIEW QUESTION</th>
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<tr>
<td>EBM has been a prominent concept for the last 10 years.</td>
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<tr>
<td>How evidence-based is your specialty?</td>
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<tr>
<td>Do you think there is much room for improvement?</td>
</tr>
<tr>
<td>Do we need more evidence?</td>
</tr>
<tr>
<td>Does the emphasis on evidence distract from the ‘art of medicine’?</td>
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The level of support for EBM was generally high:

The best way to describe that is the revolution which has taken place literally in my lifetime.  
**Endocrinologist**

The expression ‘art of medicine’ was interpreted differently by the subjects. This included a way of working with uncertainty:

I don’t understand EBM, medicine is always evidence-based ... people always make decisions on the basis of what evidence they could get hold of. No matter how much evidence you get, how scientific it becomes, it will never become certainty ... What they mean by art is in dealing with this lack of certainty.  
**Emergency physician**
Others defined ‘art’ as the addition of the patient’s biosocial needs:

The way you treat people really can’t be subjected to evidence and if you make decisions based purely on evidence I think you may treat people in a bad way sometimes. Colorectal surgeon

Thirty per cent thought that their specialty had a strong evidence base, 20 per cent thought it was poor and the rest found it to be partially evidence-based. This was one of the few questions where the responses showed a variation between specialties. Cardiology and oncology were mentioned as richer in evidence, and there was sympathy for doctors working in specialties still short of evidence.

I’m particularly lucky that my specialty in cardiology has measurable outcomes like death and ejection fractions etc. So I think our specialty is the most evidenced-based specialty of any … Part of that is because of the enormous amount of patients and money that gets put into trials and having measurable outcomes which is really difficult to have in rheumatoid arthritis or hernia repairs … I think where you can get it … evidence-based medicine … should always take precedence over what you think might be a good idea. But I am sympathetic to other practitioners who don’t have that level of evidence base and they may never have that. Cardiologist

Our specialty is strongly evidence-based. In fact, we’ve just published a list of guidelines for NSW on the management of cancers … All the recommendations are referenced, depending on the level of evidence that is available. Oncologist

Neurology … was always a specialty where you could make exotic diagnoses and not do anything about patients’ illnesses. But there is [now] a lot more evidence available. Neurologist

Psychiatry has lagged behind but it’s changing very rapidly and you know, if you were to compare it to when I started as a Registrar, 17–18 years ago, it is clearly almost unrecognizable. Psychiatrist

The two emergency physicians in the group both described regular frustration when being requested to use non-evidence-based investigations or treatments by their other specialty colleagues:

Even though we know that those things are a waste of time … that’s what the inpatient team expect us to do … It’s no use trying to argue. Emergency physician

The plastic surgeons considered themselves to be artists and that EBM was not a basis for improvement to their work:

You’re applying basic principles to unique problems. A lot of it is experience. Microsurgery is a good example. It doesn’t matter what evidence I get from someone else, it only matters what happens in my hands. Plastic surgeon

This seems initially reasonable but is disturbing when the implications are considered. What if your results are poor? Might not improvement be possible? Might not your patients have a right to know or seek an alternative surgeon?
Interestingly, five of the six anaesthetists also felt EBM was not very relevant to their field:

_"I think it is becoming more evidence-based like all professions but I still think there still is a whole lot of mumbo jumbo … Looking at our safety record, you would think that maybe it’s not that important … You would say that it is art [in that] someone uses their brain’s fuzzy logic to turn the dial roughly to the right place … Maybe we can never take it to the stage of evidence that we would like to, because there isn’t the money to do it whereas there are brains sitting in heads that are very cheap."_ Anaesthetist

_"I’ll contend my specialty is not evidence-based at all … I have to challenge the registrars to come up with any aspect of clinical anaesthetic practice that satisfies level one evidence [requirements]. I think there are [a] very few areas of medicine [such as cardiology, oncology] that really look at this seriously. Anaesthesia just doesn’t lend itself to evidence-based medicine but as long as we realize that we forge on. … I’d love to see more evidence-based medicine in our practice but I think we also have to recognize that it’s very difficult to come up with and the current sort of plethora of studies that involve statistically inadequate numbers is a distraction and filling up the journals with junk."_ Anaesthetist

In answer to the question ‘Do you need more EBM in your specialty?’, 60 per cent agreed while 40 per cent disagreed. Some of the latter were supportive of EBM, but did not think acquisition of more was a priority. Some of the former felt very strongly about the crucial need for more evidence:

_"I think there is never enough evidence, number one, in our specialty."_ Haematologist

_Outcome measures … to build an evidence base … it’s got to be done. We can’t be allowed to waste money on treatments that don’t work._ Physician

There were some polarized views of the ‘art of medicine’ versus EBM issue:

_"If something works for me and there isn’t evidence for it, I am not going to stop doing that."_ Rheumatologist

_Personally I regard it [art] as a trap._ Orthopaedic surgeon

_People say medicine is an art but what I think they mean by art is actually experience. There is no substitute for experience, absolutely no substitute for experience._ Haematologist

The importance of expertise for good care, developed by experience and by reflection on experience, will be discussed in Chapter 10. However, most interviewees felt that the art of medicine (whether interpreted as intuition, experience or consideration of specific patient circumstances) should be added to EBM:

_"I think the art of medicine involves looking at the patient who is sitting in front of you and working out if it is the right treatment for them, because everything you get from the trials or the evidence refers to a cohort of patients. It doesn’t refer to the person sitting in front of you. You’ve
got to weigh up the risks and benefits of treatment, whether it’s appropriate for them and that’s where the art of it comes in, I think. You know, [it is] talking to the person and deciding if it really is the right treatment for them or not, even after weighing up the evidence. **Neurologist**

There is still room to discuss with a patient the options, because whilst you might have a treatment recommendation, sometimes that’s inappropriate. Or they feel that because of their circumstances, they don’t want to pursue that particular treatment so I think whilst the guidelines are good, they are not mandatory … [Y]ou have to discuss with a patient and come up with something that they are prepared to go through and experience as well. And making sure that if they’re unsure, that you refer them to somebody who might give them a different viewpoint so that they’ve been exposed to all options. **Gynaecologist**

This last speaker makes an interesting point – that it is acceptable and expected that colleagues will have different views and make different recommendations.

A number of problems with the EBM movement were identified. The economic basis for the construction of evidence was recognized:

> A lot of the EBM in our specialty is driven by the dollar – by pharmaceutical companies. So the ‘best’ treatment for a person with a heart attack is the world’s latest beta blocker. **Geriatrician**

> The drug companies no doubt love it: ‘You will be obliged on evidence to fund our drug’. **Intensivist**

The emphasis on randomized control trials (RCTs) and especially meta-analyses of RCTs was criticized:

> If the gold standard is a double blind randomized control trial, then there are a lot of questions that can’t be answered that way … Being able to identify how strong the evidence is that’s being presented, that is an important issue. **Paediatric surgeon**

> I think it’s a very valuable thing where someone says ‘This is what I do, here are 200 cases, here are my results’. It doesn’t fulfil those criteria of being evidence-based but it has merit. **Anaesthetist**

> Meta-analysis can just be a series of crap and you get a bigger pile of crap: it was just silly. **Intensivist**

Some recognized that EBM could add uncertainty and make it more difficult to make decisions.

> I’ve done two evidence-based reviews and I review them regularly … It took so long to write these, a couple of years … At the end of it you come down to the conclusion that we really don’t have adequate evidence … It’s one of those rare diseases. **Dermatologist**

> What worries me is that we are tending to get paralysed if it isn’t evidenced or if the evidence isn’t compelling. **Physician**
There is loads of clinical work for people ... You almost need a separate branch of your service that can determine what is the evidence ... and recognize the best practices for you ... There is no time if you want to be part of that process. Psychiatrist

High anxiety caused by intolerance for uncertainty results in over-testing and generates increased costs (Ghosh 2004). Interestingly, women and older medical students were shown to be more tolerant of uncertainty. Perhaps uncertainty tolerance should be assessed or screened for as part of the medical student admission process. Clearly this is a significant psychological issue for practice and EBM does not provide a simple answer.

Litigation Crises

For US doctors it has been said that there is a general perception that ‘Because there are so many frivolous claims, it is near random and largely out of their control whether any given patient will file a claim against them’ (Mello and Hemenway 2004). The following US statistics underlie this perception (Mello and Hemenway 2004): negligent injury occurs in 1 per cent of hospitalizations, but only 2.5–3 per cent of these injured negligently file a claim; only 17–20 per cent of those who do file a claim have actually suffered a negligent injury. (For Australia it has been estimated that 39 per cent of claims result from adverse events not resulting from negligence – see Tjiong 2006.)

There have been numerous situations when a medical litigation crisis has occurred. This refers to an environment when the cost of litigation (the number of lawsuits or the size of the amounts awarded or usually both) resulted in very high insurance premiums for doctors. Practice in high-risk specialties becomes unaffordable. The earliest crises were in the US, and Australian doctors observed these anxiously for some years before there was a similar crisis in Australia.

The frequency of claims in Queensland and New South Wales increased four-fold between 1989 and 1996 and the costs per claim in NSW increased 4.5-fold in the same period (Tjiong 2006). By the late 1980s it became apparent that the medical defence organizations (MDOs) had inadequate reserves to meet known claims (Wheatland 2005). Ensuing events included calls being made on doctors to address funding shortfalls. The problem was compounded by the collapse of a significant re-insurer (Wheatland 2005) and, in 2002, the major MDO was placed in voluntary liquidation. This crisis was eventually resolved by a complex taxpayer-funded rescue package (Luntz 2003).

Crises aside, there seems to be anxiety associated with the seemingly random pattern of litigation that is associated with the practice of medicine. How does this affect doctors?

A 2005 survey of 640 Australian anaesthetists revealed that the medico-legal climate was still of major concern. Of the respondents, 24 per cent had personal experience of litigation and 74 per cent expected to have a claim made against them during their medical careers. It was suggested that litigation concerns are leading some to retire earlier and others to give up high-risk areas of practice (Beckmann 2005). A more recent Australian survey with 2,999 GP respondents suggested that many had changed their practice due to medico-legal concerns, 43 percent of doctors stating that they made more referrals of patients and 55 per cent stating that they ordered more tests (Nash et al. 2010). Respondents also reported improved communication of risk (66 per cent), increased disclosure of uncertainty (44 per cent), better systems for tracking results (48...
per cent) and for identifying non-attenders (39 per cent). Concerns about medico-legal issues led to 33 per cent considering giving up medicine, 32 per cent considering reducing their working hours and 40 per cent considering retiring early. These proportions were all significantly greater for doctors who had previously experienced a medico-legal matter compared with those who had not.

**INTERVIEW QUESTION**

Do you feel anxiety about the potential for medico-legal litigation?

The outstanding feature of these interviewee responses was their brevity: doctors did not want to contemplate this question. Regardless of how anxious they were (see Table 6.1), all were resigned or even fatalistic regarding the possibility of future litigation.

### Table 6.1 Anxiety Ratings for All Scenarios

<table>
<thead>
<tr>
<th>Anxiety rating</th>
<th>Sample statements</th>
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| Very anxious – 26% | I think it is in nearly every decision I make … if not in the forefront of your mind, in the back of your mind. Unfortunately, parallel to how well the patient is or what the result for the patient will be, [there is the thought] of how will this be viewed later if there is a problem. Anaesthetist  
Yes, absolutely. Very big. Forefront of my mind, every single patient has a potential to litigate. Ear, nose and throat surgeon |
| Anxious – 15%      | It mainly is part of my thoughts when I am doing difficult things. Gastroenterologist  
Of course, I think everybody in medicine does. Anaesthetist |
| Yes/No – 18%       | Most of the time no, but I guess it’s always there in the background. Neurologist |
| Not anxious – 41%  | I’ve become a bit more philosophical that what will happen, will happen. Sometimes you can do your best and this will happen. Anaesthetist |

Some of those who said they were not anxious really felt rather strongly about litigation:

*Well it doesn’t anymore because I’ve stopped private practice completely ... But it was responsible for me stopping the little bit of private practice I did altogether.* Plastic surgeon

*I don’t, no. Except that if I was sued I’d probably leave [medicine].* Gynaecologist
Some accepted both error and potential litigation as an inevitable part of clinical practice that could be managed emotionally. (This is in significant contrast to those who said they would give up practice.)

Oh, it’s an expectation that I will be sued. Yes, I will make a mistake at some point and I do all the time, but they’re all little errors of judgement and one day it might be a big one … If I get sued, well I will wear that, because if I make a mistake it is because I am human. **Renal physician**

For another the inevitability of litigation was also accepted, but personal responsibility was not automatically assumed. The ‘I’ used by the previous speaker is replaced by distancing phrases such as ‘when adversity does come’ and ‘you’ve had an adverse event’:

When adversity does come, say, ‘Look, I’m sorry, you’ve had an adverse event. This is really bad, I feel really horrible … You’ve had a haematoma that’s still causing pain and I am really, really sorry. It’s dreadful but you are in the fine print of the textbooks and let’s just get through it as best we can, and we’ll get through it.’ And that’s how I’ve always managed it. **Gynaecologist**

Others expressed anxiety about being responsible for the care delivered by others.

Because I am a consultant, I basically have a team of people whose work I am trying to trust. **Geriatrician**

There have been a couple of things which just recently I felt were totally out of my control. **Plastic surgeon**

One pointed out that the time constraints of public hospital work were not conducive to practising medicine in ways that are safe:

That is helped by familiarizing yourself completely with the patient before you do anything to them. That can be difficult in the public system when you might have 20 patients on a ward round and then they say there are 15 consultations and you’ve only got two hours … That’s what drives me crazy, I worry about those patients. In private practice I will spend half an hour with them. Five minutes will be taking history … and another 15 will be explaining the patient’s condition to them and what we can do for them. That goes a long way to reducing medico-legal anxiety. **Cardiologist**

There was a significant fear of public humiliation:

It worries me because what we do with the best intent, can look bad … One of my mates … was suspended for inappropriate clinical care. He was a good guy. [He was a] good doctor and the media stalked his office and it really upset him. **Obstetrician and gynaecologist**

A number of subjects went to pains to point out that they were very careful. ‘Taking care’ was the way they managed their anxiety, while generally admitting that it could never be sufficient.
I write everything in my notes and I get them [the patients] to sign my notes ... I get my secretary to call up the cat, the dog and get everybody to come in ... to countersign. I have a system for checking up every test that I order and I have a system for following up every referral that I make ... If they don't come, they get a registered letter ... We over-investigate quite a few of them. **Ear, nose and throat surgeon**

It’s changed the way I practice ...[Suppose] you come in to see me [and] you have a ... mole you want off. I spend ten minutes ... chit chat to establish rapport with you, and at that stage it’s taken me the first ten seconds to figure out what you need and I spend the next eight minutes in the consultation in a vain attempt to try to cover my butt for this 3mm–5mm scar you’re going [laughing] to have. **Plastic surgeon**

The dominant and disturbing theme was that ‘my world is uncertain’ and that ‘I am frequently apprehensive or fearful’. This anxiety was expressed with emotion and the apt metaphor used was that of the iceberg. Some were sure that they would be sued – the only uncertainty was when:

> It’s like an iceberg, it’s below the surface. You can’t, you don’t feel it’s going to hit you. And that’s what I suppose happens. In other words, you wouldn’t want to spend your life worrying about it but it’s there. **Emergency physician**

> I think it’s there just waiting. **Anaesthetist**

Some were able to find value in this menace – an encouragement to preparedness:

> I have accepted, and it took me a while [to realize] ... that no matter how good you are, it’s pretty inevitable in Australia that you will get sued some time or other. I am sure that that it will be extremely disturbing for me when it happens but I am preparing myself in a way by already thinking that it probably will ... You try to do your best ... It’s unpredictable. I think that I have accepted it. Just part of life, and maybe it keeps us on our toes. **Anaesthetist**

> I try to see the adverse events coming and say, ‘Now listen, there is quite possibly going to be an adverse event here. You know, let’s get ready.’ **Gynaecologist**

For many, though, the anxiety was merely pervasive and disturbing:

> The uncertainty provides anxiety, and certainly ramifications for both your professional and personal life are fairly significant and with those ramifications always in the back of your mind and the inability to control the situation means you’re going to get anxiety ... There is no way of dealing with that. **Paediatric surgeon**

> I am scared that it could happen to me about something that I’ve done 10–15 years ago in some other environment. **Emergency physician**

> My worry is that the one who is going to slip through is going to have the problem. **Ear, nose and throat surgeon**
The range of possible things that could have ‘slipped through’ are vast for any patient care episode. Thus, Major Burns goaded Hawkeye, ‘Was it something you did, or something you didn’t do or something you forgot to do?’ (see Chapter 4).

Practising with Uncertainty

It has been suggested that the high degree of uncertainty in medical work may be a reason for the focus on the qualities of doctors that made them especially able to make judgements and to be trusted in doing so, that is professionalism (Traynor 2009). Maybe there are some particular problems associated with the risk taking necessitated by clinical uncertainties. Compared to nurses, doctors prefer verbal communication (Brown et al. 2004), are poorer record-keepers (Berg and Winthereik 2003, Hicks and Gentleman 2003), have less regard for rules (McDonald et al. 2006), are less likely to report failure to follow protocol (Lawton and Parker 2002) and take more risks (McDonald et al. 2005a). Nursing staff hold more systematized concepts of clinical work and are more fastidious about conforming to procedures (McDonald et al. 2005b). These differences affect teamwork and prevent shared conceptualizations of error and patient safety. Operating theatre studies have suggested doctors (unlike nurses) are not interested in trying to manage risk because they view adverse events as unpredictable occurrences (McDonald et al. 2005a, McDonald et al. 2006).

Risk taking in everyday life can also have positive meanings – captured in expressions like ‘go for it’ (Parker and Stanworth 2005). A risk-taking role can earn social recognition and esteem. It has been suggested that, while doctors complain about inadequate resources, conversely they are prepared to work in circumstances of increased risk to the patient and then ‘claim even greater credit for a successful outcome’ (McDonald et al. 2006). US doctor Charles Bailey was one of the pioneers of mitral valvotomy. Four patients died before he had a survivor. The extract below describes the drama of the times and the audacity of the surgeon:

Bailey’s home base, Hahnemann Hospital, refused to allow him to attempt any more mitral commissurotomies after two deaths. He became known as the ‘butcher of Hahnemann Hospital’. However, his cardiologist, Dr. Durant, continued to support him. On June 10, 1948, Bailey scheduled cases 4 and 5. The patient operated on at Philadelphia General Hospital in the morning died (case 4). The surgical team regrouped and rushed to Episcopal Hospital, where the second operation was started promptly before the bad morning news was known and before the hospital administration forbade the procedure. The surgery was completed, and 1 week later Bailey brought the patient by train 1000 miles to Chicago, where he presented the woman to the American College of Chest Physicians (Stephenson 2008).

The interviewees rarely spoke about risk, but one remarked:

I decided I wasn’t suitable for obstetrics … I didn’t want to deal with getting out of bed in the middle of the night for the rest of my life and having the problems of being isolated in hospital with no one to help you at 1 o’clock in the morning when there is a disaster. And that’s what obstetricians are faced with. Being entirely alone with no one around to help, no back-up and all the things going wrong. And that’s not a great place to be. Oncologist
Who would choose this place? Many doctors do. In many clinical fields patients need brave risk takers. Often ‘risk management’ presumes only that risk should be reduced, avoided, or perhaps tolerated. However, the uncertainty inherent in all clinical work necessitates risk taking.

The excerpt below is a conversation between two surgeons who attended a focus group. It gives their views on the behaviours and rationalizations of doctors about high-risk work:

**Surgeon 1:** I think the way that the individual surgeon has the ability to rationalize an adverse outcome is incredibly interesting and I think it defines almost what type of surgery a surgeon chooses to do. In other words, if you can't handle the truth, and you can't handle a few problems then you're just going to be a toenail surgeon, or take out tonsils. On the other hand some of the other guys that do the real big-time stuff that no one else would do ... are not restrained by any complications because it's just 'water off a duck's back'. Now you might say that person's a psychopath or something but in fact, that's what it takes to do those jobs.

**Surgeon 2:** Absolutely.

**Surgeon 1:** If you cast out their demons you lose their angels as well. I think that's why it's very complicated actually.

**Surgeon 2:** That's one of the reasons why it's really important to try to get a culture where you do actually get to accept people – we've all got our faults – what we're good and not good at, and we have people who are extraordinarily good at something but clearly have other major faults. You still try to keep them in the system. You have to work with that rather than lose it. They might be hard to manage but you don't want to lose that skill.

Society might have some tolerance for pioneering radical surgeons to be ‘unrestrained by complications’, but modern public expectation is generally of complication-free care. The surgeons suggest that it is not possible for some kinds of doctors to be normal or obey rules. Senior surgical leaders have even suggested that ‘having too much insight can be destructive and denial is one way to deal with problems successfully’ (Hall et al. 2003).

The sociologist Charles Bosk suggested that the ‘aggressive healing’ that surgeons perform requires a certain personality and one frequently hostile to management regimes (Bosk 2003: 246). Australian surgeon and author Mohamed Khadra complains of ‘a cancerous growth in the bureaucracy of health’ and that ‘The basic aim of the bureaucracy is to avoid making mistakes. And what that creates is a paralysis of decision-making throughout the system’ (Cresswell 2009). A view such as this, inherently dismissive of management and managers, can serve to legitimize disruptive organizational behaviour by doctors. However, the attention given to unsafe care by the safety and quality movement is now challenging medical rationalizations around risk taking.

If the sociological view that professional groups have power and status due to their ownership of knowledge or expertise is correct, then EBM poses a threat to professional autonomy and power (McLaughlin 2001). Yet the doctors interviewed were supportive of EBM and grateful for the small amount of scientific ‘scaffolding’ that now exists in some areas of practice and they hoped for more. Brokerage of EBM to patients is now a regular part of medical work (Toulkidis et al. 2005). This introduces new uncertainties.
It is hard to know how much medical literature should be researched, how it should be presented, or how much a patient should and or could understand. We can give patients more information than they want or need.

**Learning from the Airlines?**

The 5.30pm flight from Melbourne to Sydney is late ... again. We board after six and while waiting for clearance to taxi, the pilot explains in some detail why it is late.

‘Sorry about the delay, folks.’

‘When I was doing my pre-flight check, I had a look at one of the tyres and asked to have it changed: it just had a bit more wear than I would have liked. Normally that’s just a 10-minute job, here at the Gate, but because the winds at the airport this afternoon are more than 25 knots, regulations prohibit that, so we had to taxi to a hangar to have it replaced.

‘As you know, your safety is our priority.

‘We’ll be moving onto the runway soon and trying to make up some time. We do have a tailwind.’

When we are airborne, I look outside and grit my teeth. It is still very windy. I am not an anxious flyer, but I am now irritated. My problem is that I’m buckled into my seat with no options at all. The stewardesses eventually struggle round the bumpy plane with the complimentary wine and beer. I prudently drink my Chardonnay straight from its plastic bottle rather than risk the cup. I reflect on what the pilot said.

The pilot looked at the tyre? Surely they have some kind of a system, a log of tyre wear and timed replacement? Did he kick it or what? Is my safety dependent on this kind of random act? If it was too windy to change the tyre, how safe was it to take off, to fly? Have they got rules about that? What are they? How close were we to the margins of safety with this wind?

In Sydney we land very heavily, forcing gasps even from seasoned commuter flyers.

Is our pilot some form of a hero? Perhaps the old tyre would have shredded during that kind of landing and led to an accident.

I received too much information and had no opportunity to ask questions or be a partner in my safety in any way. Sometimes decisions about risk may be mine as well as that of the airline. If they are not and we cannot be partners, then I think the better announcement would have been a lie, perhaps the usual announcement: ‘We apologise for the late departure of this flight. It was due to the late arrival of an in-bound aircraft’.

The argument that ‘replacement of paternalism by proper informed consent allows the patient to make risk decisions’ cannot be supported. Should patients be given as much information as they want and need in appropriate formats when there is an elective decision to be made? Of course. While patients cannot ever have the knowledge the doctor has, they bring their values, views, preferences and physical experience to the
decision. However, when the doctor is trying to make a diagnosis, the patient cannot easily participate in the risks associated with choosing diagnostic tests as illness, at its beginning, is usually undefined. Patients cannot participate in acute risk decisions during surgery. Patients therefore require doctors not just to manage uncertainty but to assume risk. Freidson says:

*Physicians tend to have an individualistic conception of autonomous clinical judgement that lead them to resent examination, evaluation and commentary on their work by anyone, even colleagues.* (Freidson 1994: 196)

Perhaps a different construction can be drawn from this fiercely guarded autonomy – one rooted in uncertainty. Medical care may have dramatic effects on another human being. Doctors may need to close their minds to uncertainty if they are to provide that care unhesitatingly (Montgomery 2006: 39). Doctors make decisions that have enormous consequences and require the acceptance of great personal responsibility (often in the absence of a full set of evidence about either the patient or ‘best practice’). Doctors’ ability to do their work could be eroded if they are led to doubt their skills in making decisions based on incomplete evidence, or if their feelings of responsibility are raised to incapacitating levels. Some of those interviewed preferred not to think about litigation, perhaps out of denial or fear of its paralysing effect on performance.

Placing high value on the collective social identity seems likely if there is so much uncertainty in a doctor’s world (Lepofsky et al. 2006). If the so-called ‘cloak of competence’ (Haas and Shaffir 1982) is hiding an extremely fragile interior, no wonder the cloak may be pulled tightly and attempts to look beneath it resisted. The practice of denial of uncertainty necessitates limited ability to learn from harm and error and even to improve.

Richard Smith, former editor of the *British Medical Journal*, wrote an editorial wonderfully titled ‘All Doctors are Problem Doctors’:

*After qualification, doctors work absurdly hard, are encouraged to tackle horrible problems with inadequate support, and then face a lifetime of pretending that they have more powers than they actually do* (Smith 1997: 842).

In the same article he directly attributes doctors’ failure to critique colleagues to the uncertainty of clinical practice:

*We cannot defeat death, sickness, and pain. Everybody within the priesthood knows its vulnerability. But the public doesn’t want to know too much about that vulnerability. They hope we can deliver, and we want to. Indeed, our privileges depend to some extent on us being able to. We are thus permanently conflicted: expected and wanting to deliver but often not able to. Against this backdrop we can understand why doctors have such difficulties dealing with problem doctors. We are all problem doctors. And even if we aren’t problem doctors today we might be tomorrow. Who wants to criticize a colleague in such circumstances?* (Smith 1997)

*Is this the reason for the strong collegiate bonds among doctors?*
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The Consultant’s Tale

It happened to me when I was a registrar. I was fairly senior and my boss (the consultant anaesthetist) was in her first year as a boss. We had come through things together and we were fairly good friends. She was doing a list for a very senior ENT [ear, nose and throat] surgeon who was quite a forceful guy.

I went to see this lady and she was listed for a biopsy, a micro-laryngeal endoscopy ... She was about 85, really sweet and reminded me of my grandmother (who had recently died), and she had no other health problems at all, but had this mass in her larynx [that required examination and biopsy].

I’d looked at the CT [computerized tomography] and I’d done a really thorough pre-assessment on her and I’d spoken to her and her daughter and said, ‘I’ll go back, speak to my boss, and chances are we will do an awake [non-anaesthetized] fibre-optic procedure because I think that is probably the best way to go’ ... And I said, ‘If worst comes to the worst we might have to do a tracheostomy’.

I went back to my boss who spoke to the ENT surgeon. He had never seen this lady before the planned procedure. He’d taken a quick look at the scans and said, ‘Oh it’s fine. With my laryngoscope, I’d be able to see anyway. It’s all right, just put her to sleep’. My gut feeling was we should do a fibre-optic [intubation] on her and my boss’s feeling was to go with mine, but we allowed ourselves to be overridden by this senior guy and so we put her to sleep. I had a look [for the trachea, in order to put a tube in and secure an airway] and couldn’t see a thing. I gave it to my boss, she had a look, couldn’t see a thing either.

Eventually the ENT surgeon put a tube down, initially obtained a CO₂ trace which went down and obviously it was in her stomach [not her trachea] so he pulled it out. By this time the sats [oxygen saturation] were 66. He tried to have another look but still couldn’t see anything. We’d given sux [suxamethonium – a muscle relaxant] to start with and because she was starting to clamp down we did probably the wrong thing and gave her another dose of sux but he still couldn’t find it [the trachea].
So then he asked for the knife. The surgical trays were in there but not open. By this time we’d pressed the red [arrest/emergency call] button, people [staff from other operating theatres] were starting to flow. This is a 16-theatre complex. He asked for the knife, did a big slash, thought he’d found a hole and put the tube in. But no [still not the trachea]. He performed another slash higher up, no, thought he’d found something.

By this time there was another ENT consultant who was having a look. The senior ENT surgeon was getting really aggressive and was saying, ‘She’s fucked! She’s dead! Fucking dead’.

I sat back and thought ‘that was my grandmother’. The ENT registrar was there and he said, ‘Ummmm, Mr so and so, I think it’s the trachea over here’ and she’d probably had sats way down. We’d been 15 or 20 minutes, never lost output which I think was the saving grace. He went ‘Oh yeah’ and got the tube in, got the sats up. Everything stabilized – everyone was like, ‘Phew’ – it was probably 25 minutes by this time.

I said to my boss, ‘I’ve given a fair bit of Midaz [midazolam – a sedative] to this little 85-year-old lady’ and I said, ‘She’s not going to wake up for a while’.

And the ENT surgeon said, ‘She’s never fucking going to wake up’.

The ENT surgeon then got on the phone to the patient’s daughter and he said, ‘We’ve had an incident. She’s been down for a long time: she’s all right now. You know she probably has a bit of damage to her brain’.

Just then this old lady started going like this [mimes patient waving arms] and I asked ‘Are you okay?’

We went out the door saying, ‘Oh she’s all right, she’s all right’.

It was an extremely traumatizing event. My boss and I talked about this for a long time and the whole thing was that we were very influenced by the surgeon. We went completely against what our instincts were.

This story was collected as part of a study on the teaching tales told by young anaesthetic consultants (Iedema et al. 2009a). (In Chapter 10 the issues of developing and valuing expertise and the power of narrative for teaching are further discussed.) This is a powerful story, the primary teaching message of which is to value tacit knowledge – ‘going with your instincts’.

The senior ENT consultant is portrayed as the antagonist – an arrogant bully pressuring more junior doctors into making bad choices but who is unable to salvage the situation (the ENT registrar is the one to finally locate the trachea). The consultant boss is a comrade: the two had ‘come through some things together’, suggesting a bond forged in previous adversity. The multiple uses of the term ‘my boss’ reminds us that specialty training is an apprenticeship. The old lady is ‘sweet’, otherwise healthy and grandmotherly – all details that build the drama by fostering sympathy. The heroes make a number of errors, including agreeing to put the patient to sleep (rather than take the time to secure the airway awake) and giving the second dose of suxamethonium.
The vivid depiction of the near-disaster makes the patient’s recovery a miracle. Even after the airway is secured the suspense is prolonged: ‘She’s never fucking going to wake up’. The duo’s relief is theatrically portrayed: ‘We went out the door saying “Oh she’s alright, she’s alright”’ – exit stage left with waving patient!

Why are Doctors’ Colleagues Important to Them?

Group belonging provides the feeling that members matter to each other and to the group, and that the group will meet members’ needs (Masterton and Stamper 2003). Belonging is a basic human need, and threats to our social attachments are extremely disturbing. Social networks provide the individual with a sense of acceptance and self-worth; social companionship and emotional support; and practical advice (Haslam et al. 2005).

Groups are defined by a collective identity narrative (Rappaport 1993, Currie and Brown 2003). The existence of such a narrative was illustrated when doctors interviewed frequently spoke for each other – using ‘we’ rather than ‘I’ in many responses and even volunteering excuses for the failings of other doctors. The focus group members were confident that they knew what other doctors would think, and this proved to be so when tested in the survey.

There are ‘functional interdependencies’ between members of any organization and the stronger the degree of interdependence, the stronger the reliance peers have on each other (Van de Bunt et al. 2005). Social identification with a workgroup is associated with lower levels of work-related stress (burnout) and higher levels of job satisfaction (Haslam et al. 2005). Satisfied doctors have satisfied patients (Clever 2002). Perceived control over the working environment and support from colleagues results in higher levels of satisfaction and participation in quality improvement activities and conversely poor collegial relations are associated with burnout (Freeborn 2001).

People seek out and form ties with others with whom they share many characteristics – a concept known as homophily. Doctors are considered especially ‘prone’ to homophily (West 2000) and this was exemplified by the fact that they saw it as likely that specialist colleagues would be present at the birthday party of a doctor’s child (as in the scenario discussed on page 57). The addition of the social context to work relationships makes it even more likely that the mistakes of fellows are forgiven and ‘whistle blowers’ cast out (Firth-Cozens 2002).

The interview groups were unable to imagine acting in ways that might result in social exclusion. Hence, the scenario involving whistle blowing was not able to be developed for the larger survey group. The interview groups displayed empathy toward their fellow practitioners. It is normal for people to have more empathy for those who are ‘like us’. Unfortunately, some empathic behaviours – such as not supporting an audit or not reporting a drunk colleague – are far from desirable for ensuring patient safety.

Analysis of the scenarios made obvious the grave difficulties facing doctors where action was required involving their colleagues. A new series of questions was therefore introduced part-way through the interview schedule in order to explore relationships with professional colleagues in more detail.
INTERVIEW QUESTION
How important are medical colleagues to you?

Several subjects immediately asked ‘Professionally or socially?’ and many went straight to discussing the importance of other doctors in their social lives and how this integrated with their professional world. The ways doctors’ social and professional lives interweave is complex:

Medical colleagues are extremely important to me. I guess I consult [them] a lot. I am very interested in all of our meetings. They’re not important from a social point of view. I have a big life away from the hospital and university that my medical colleagues don’t enter into at all. My friends in that circumstance are medical, in that they were friends from university … whom I see very regularly, but I don’t really see them as medical professionals. Gastroenterologist

The fact that we spend so much time here means you should have friendships here. I have been blessed in having a great lot of people to work with and, out of that, to have grown a number of good friendships. Renal physician

I don’t have a lot of time to have my own friends out of medicine which is kind of sad but a reality … I say to people ‘You can’t, as a plastic surgeon, you can’t be half-time: you play this full on or nothing’. Plastic surgeon

It’s very important, I think, [to socialize with] people who understand where you’re coming from, on a professional basis, but also who know you professionally and you can talk to on a personal level as well. Neurologist

Over 90 per cent of doctors interviewed agreed that colleagues were very important. Many used reiteration to give emphasis to their strength of feeling:

Extremely important actually. Extremely important. Ear, nose and throat surgeon

Essential. Essential. Geriatrician

Very important. Very important. Emergency physician

INTERVIEW QUESTION
Why are medical colleagues important?

Doctors considered their colleagues important for a variety of reasons. The themes mentioned in order of increasing frequency and significance included holiday cover, mentoring, teamwork, education and emotional support.
Mentoring was a package of teaching, practical clinical support and role modelling. The descriptions also imply the teaching of professional virtues or professionalism:

> For difficult cases often I would call the senior professors ... We would have a long talk ... in the middle of the night and so on. **Ear, nose and throat surgeon**

> I think training and culture with senior mentors where the patient's requirements are ... sacrosanct instils that it is really the patient who comes first ... If you act in the patient's best interests at all times then that's really a much safer sort of thing, and I think it's more rewarding as well. **Cardiologist**

> Those guys have been a great influence as mentors not only to teach you how to do surgery but to teach you how to behave and practise and whatever ... You know, 'Steady, boys, this is the right way to do it' and ... young guys, we're all free-thinking and might even have our own ideas and stuff, but we are influenced by our mentors, which is very good. **Plastic surgeon**

The need for the development of wisdom, judgement or expertise to make good decisions in the presence of uncertainty is the foundation for the hierarchical nature of medical culture. It is suggested that ‘Residents have two primal fears: they do not want to hurt anyone and they do not want to appear stupid’ (Leach 2009: 100).

Teamwork, while obviously important for specialties such as emergency medicine and intensive care, was mentioned by quite a diverse group:

> Good communication with a variety of colleagues helps short-circuit a lot of problems in that you can often deal with issues quite quickly without having to go through formal channels. **Paediatric surgeon**

> I'm part of a teaching hospital anaesthetic department purely because of the medical colleagues I have there, surgeons and anaesthetists and others. I've recently formed a private practice group, purely to have that. I mean there are practical issues and financial benefits but it's really being part of a group of colleagues that are supportive of each other ... covering periods of illness, holidays, people bounce ideas off people ... I guess it was probably that social environment of the operating theatre that attracted me very much to anaesthesia in the first place. I could never have worked like an isolated GP in a busy city practice who sees 60 patients a day, but actually doesn't have time to interact with medical colleagues, even if there is another one in the office next door. I couldn't stand that. I think anaesthesia particularly lends itself to those tea room conversations, which are sometimes just social but there is also quite a lot of discussion about clinical work. **Anaesthetist**

Indeed, for US doctors, working as a sole proprietor of a practice was significantly associated with career dissatisfaction (Leigh et al. 2009).

Sometimes formal educational processes were mentioned or sometimes the educational value of colleagueship was expressed more informally:

> Invaluable, for many reasons I suppose – learning, reflection, debriefing, support, advice. **Renal physician**
Colleagues are very important. You’ve got to be able to reach out and get someone good to help … with a problem. Very important. **Gynaecologist**

Emotional support was highly valued:

Being aware that other colleagues are feeling similar pressures to yourself in different areas of life [is important] … I get a lot of comfort out of hanging around Hospital A because I have been there almost 20 years. **Paediatric surgeon**

They are important because they can relate to the job in the way it affects your life and the events that happen. Why medicine often becomes a bit of a clique is because there are people who can often understand directly things that you need to talk about and debrief on … My lifestyle choices don’t revolve around conservative things like buying a house, having a family, a BMW, playing golf. My politics are quite left-wing … so on many levels I don’t bond particularly well with doctors as a whole … but I’ve always had one or two very close medical friends who have been very important in terms of having somebody to debrief with. I think one of the big issues of medicine is coping with stress and your medical colleagues are very important, very important in preventing it happening in the first place by providing an environment where you might not necessarily be judged, and they’re also important when something does happen … But in terms of having that process very formalized, many people find that hard. … Better to talk with good friends over a bottle of wine. If somebody like [an anaesthetist we both knew] was to be your mentor, he’d be a very bad person to talk to about a mistake you’ve made because he’d feel that he probably never ever made one! Whereas a friend of mine, he’s made plenty of mistakes. He’s a good person for me to talk to because he understands: you can have a bit of guilt and you can make a bad decision. **Anaesthetist**

Emotional support and intellectual support clearly go together.

**Interviewer:** So would it be more to do with debriefing and support or to do with working out hard clinical problems?

**Neurologist:** I feel the two go together because when you’re talking about a difficult case, that’s a way of debriefing as well and often you know what the answer is, or you think you know the answer and they either reassure you or they say, ‘Well, I wouldn’t have done it that way’ and you think well ‘That’s fine because I’ve done it my way’. It’s a way of confirming your thoughts, or if there is something you really have no idea about then it’s a good way of getting other opinions.

The majority (73 per cent) of doctors in US teaching hospitals discuss errors with colleagues (especially if major harm has resulted) and most errors are likely to be discussed informally (Kaldjian et al. 2008). A large number also share errors with friends and family. Most doctors, if not all, count colleagues among their significant friends. In the television series *M*A*S*H*, the surgeon hero Hawkeye’s best friend is a fellow surgeon. In the script of the *M*A*S*H* episode that is discussed in Chapter 4, a range of other clinicians, including those who characteristically display personal animosity to Hawkeye, provide emotional support for him as he struggles to save his patient.
Subtle social signals may form a surrogate for explicit feedback and support:

*Positive feedback or negative feedback is sometimes a bit abstract … Sometimes the way people relate to you, like you get a feeling that they trust you or respect you, is feedback even though they don’t come up and pat you on the back and say ‘That was a great intubation’ or, you know, ‘You looked after that case really well’. Anaesthetist*

One subject described the respect of colleagues as essential for sustaining self-esteem and therefore suggested that a ‘good’ doctor is both sparing in his criticism of colleagues and takes such criticism seriously.

*I think every doctor, good doctors in my opinion, values the respect of their colleagues above anything else. And they may not get on with their other colleagues but they value their good name amongst those colleagues extremely highly. And, therefore, I only try to refer people to the best people that I know. Having said that, if they thought badly of me or they criticized me I’d take that, I would take it very seriously. It’s very easy with colleagues to nitpick but there is no point in that, and if you really respect somebody then you don’t do that. Good doctors don’t do that. They only say bad things if there is a serious problem. And therefore, it behoves you to listen very carefully if they think there is a serious problem. Obstetrician and gynaecologist*

The issue of collegial respect was further investigated:

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<th>INTERVIEW QUESTION</th>
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<td>If you did something that was considered really ‘bad’ by your colleagues and you were shunned, how hard would it be to work?</td>
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This question was accompanied by the explanation that, despite this ‘bad’ action, you were still able to work. Four subjects unexpectedly stated ‘It has happened to me’:

*I’ve already experienced that [shunning] … Yes, it’s hard but you can survive … if you believe in yourself and what you’re doing is right and what people said about you is hearsay … I think it would be different if you really have done something that was wrong and I haven’t experienced that and it would be terribly difficult for me. Sydney specialist*

*Been there, done that. I was a director and made some hard decisions. Some of them were right and in the long run, I’ve been proven correct, and some of them were wrong … I still communicate with [the colleagues from those times]. I will continue communicating with them but occasionally it creates some form of barrier to good work. But I’ve got to accept that I think. Sydney specialist*

The situation was perceived by all to be unpleasant or worse than unpleasant:

*God, you’d be a man of iron, I reckon. Emergency physician*
If I felt isolated I think I’d find it very difficult to work. *Anaesthetist*

Depending on the situation, it could be something that you never get over and difficult for you to work within the hospital where you remember that episode. It could be very difficult. So yes, extremely difficult. *Emergency physician*

The most extreme response was the statement made by some interviewees that they would give up medical practice:

I suspect that I would give up. I practice medicine very collaboratively. I know that there are a lot of people who are very self-sufficient, very confident and I suspect that they could just brazen that out. If I couldn’t sit down and talk about a medical problem, call a colleague in from the next room to give me a hand, if I couldn’t go to a meeting and be welcomed, then I don’t think I would continue to practice. *Gastroenterologist*

I think, personally, I wouldn’t cope with it. I really like quite a lot of ‘pats on the head’ – people saying I’ve done a good job. My colleagues in particular who do my sort of work will say, ‘Look I can’t do that particular case. Can you do it for me?’ That’s where I get my sense of who I am as a doctor and a proceduralist and if I had no respect from anybody I wouldn’t do it: I’d do something else. *Cardiologist*

I’d resign. If I couldn’t hold up my head … I couldn’t [continue]. *Gynaecologist*

Interviewees thus gave two quite different reasons for giving up practice – the centrality of collegial respect to self-esteem and the need for working relationships to help with hard clinical problems often encountered.

**INTERVIEW QUESTION**

Do you think we are good at giving feedback to our colleagues? If not, why not?

This question was put to fewer interviewees and late in the course of interviews. Occasionally it was judged too sensitive to ask. While the great majority believed they were deficient in giving feedback to colleagues, most were extraordinarily inarticulate about the reasons. Below is an example:

*This is going to be heavy, um. I think we’re not, no, and that’s in general really, or not accepted that we’ll sort of no, no we’re not, we’re not that good at all and, um, again it’s sort of being worked on and hopefully will improve. But we’re not good communicators amongst ourselves generally and I think a little bit too, probably afraid of you know, um … [could not define what he was afraid of, but then moved on to talk about litigation] … But actual talking to each other about even minor things before they become even bigger, I think there is a big gap there. I don’t know why, um … Infectious diseases physician*

This interviewee was not a ‘good communicator’ on this particular topic!
Others returned to feedback from seniors even after reminders that the question was about peer feedback. Many were unable to provide any reason at all why doctors were not good at feedback although they agreed it was so:

Not really. We tend to close ranks if there is a problem ... It’s harder, of course, when it’s another specialist. When it’s a trainee, we’re quite willing to tell them .... From time to time there are going to be differences of opinion and people are just going to under-perform, including myself. There are anonymous incident reporting systems of course, but I think behaviour is best adjusted by diplomatic personal communication, which will always be difficult, particularly amongst colleagues of the same seniority or from a more junior specialist, to a more senior specialist. Anaesthetist

The phrase ‘differences of opinion’ reflects the inexact and uncertain nature of much medical decision making. Similarly, one interviewee who focussed on positive feedback alluded to his own need for reassurance:

I suppose, maybe, no one actually really feels the need for it [feedback]. I think a lot of people are quite confident in themselves ... Sometimes people need it. Like you or I can be told that you’re good at your job, but not everybody is like that ... but sometimes you can go through periods where you feel you’re struggling a bit. Anaesthetist

Reasons given for poor feedback included lack of formal processes and a perceived lack of interpersonal skills or modelling on how to give feedback:

We just don’t seem to have those processes. We certainly have it for our juniors. Psychiatrist

If there is an issue that you could be critical of; what then is the next step? Anaesthetist

You don’t like to criticize people so I don’t do it. I’m not good at it. Not good at all. Rheumatologist

I don’t think I have the skills in order to tell them ... If they don’t listen, what do I do about it? I don’t have the power to say, ‘You’re fired’. Geriatrician

I think we’re very good at stabbing people behind their back [laughing] ... and talking about what our colleagues have done inappropriately. I think that often. But I think it’s sad that it is very difficult, you know, to come up face to face with them and say, ‘It’s time to maybe reassess what you’re doing, or stop what you’re doing’. I don’t know whether it’s your place. Nobody likes telling people bad news. I think maybe that’s going to be the role of the director of your unit or your most senior member. But, I can’t imagine that I would be the one [laughing] to be doing it. Obstetrician and gynaecologist

This last subject then talked about a case with which we were both familiar where an incompetent doctor was moved out of the public hospital and eventually out of practice, but neither of us knew the mechanics of the process.

Some perceived that providing negative feedback to colleagues carried material personal risk:
You realize you’re only one case away from another complication or another disaster, another catastrophe … so you don’t want to point the finger at someone else. **Plastic surgeon**

People are too scared to mention names or say it, in case you get branded as a doctor who thinks he’s better than the rest. **Oncologist**

If it’s in a negative way … [you] could get repercussions on yourself. **Anaesthetist**

As a specialist you can’t afford to be honest. If I get sent some patients by some shocking surgeons and I tell them they’re shit, that’s the end of my practice. We depend on referrals and you cannot criticize anybody because if you do, your practice suffers. **Oncologist**

Subjects suffered from anxiety that perhaps they themselves could be making errors they do not know about. The next two exchanges exhibit hesitant responses and the need for interviewer clarification or reassurance. Both demonstrated personal anxiety about their own, possibly unknown errors and bad outcomes:

**Renal physician:** You just don’t know, you don’t know, that is the problem – you don’t really know if you’ve made some boo-boos that people have spoken about and not told you about … That is a concern I sometimes have.

**Interviewer:** And would that constrain you from speaking to other people about other people’s mistakes?

**Renal physician:** Yes, I think it does.

The next exchange is amusing, illustrating again the extreme reluctance to consider this issue:

**Interviewer:** Do you think we’re good at giving feedback to our colleagues?

**Emergency physician:** Oh yes, I think so. I think so.

**Interviewer:** About errors and things?

**Emergency physician:** About errors?

**Interviewer:** About things of that nature. Yes.

**Emergency physician:** It’s different. You really don’t know, do you? In other words, you hope, um, let’s put it this way, if there is a bad outcome from something that you do, you hope that you find out about it. But, um, you don’t know. How do you know?

There was an understanding that working relationships were necessary, both for the individual and for the processes of patient care:
Do I cause great friction between me and another consultant when we’re working otherwise well together or what? **Geriatrician**

In general you don’t criticize people unless it is something that’s really, that’s going to have some significant outcome and you try to maintain a decent working relationship with your colleagues and criticizing people generally doesn’t tend to maintain that sort of amicable relationship in the long run. **Emergency physician**

Because we work together so well as a team, it is sort of hard to criticize each other. **Plastic surgeon**

Negative feedback was viewed as emotionally destructive, as two anaesthetists explain:

**Anaesthetist 1:** I’m acutely aware of my speciality senior colleagues’ sensitivities … If I was to provide critique in professional practice, I’d unduly upset them emotionally.

**Anaesthetist 2:** The reverse of that very supportive environment is that we’re very reluctant to criticize when people have made a bad judgement … People will come to the realization themselves generally. And they say, ‘Well, I did this and that was a bad decision and I wish I hadn’t done that’ … so there isn’t a lot of point putting the boot into them and saying, ‘Yes, absolutely’. If they come to that realization themselves, then you need to do nothing more than be supportive and say, ‘Well, you know’.

**Interviewer:** But did they always come to that realization?

**Anaesthetist 2:** Well, I don’t know. I don’t know that they do.

Doctors struggle to acknowledge errors to themselves personally (Jones 2002: 86), to other doctors (Pierluissi et al. 2003) and to patients (Alia et al. 2001, Gallagher et al. 2006a, Gallagher et al. 2006b). A study of US emergency nurses, doctors and technicians revealed an attitude of ‘see no evil, hear no evil, speak no evil’: error disclosure and reporting were problematic for all (Hobgood et al. 2004).

The few suggestions for improvement required resources, outcome data and the maintenance of tight peer group environments for review processes:

**I think there is a huge scope for this. One of the things that was quite nice was that trauma nurses used to come back to the Department once a month and just sit down and say, ‘Remember that guy with the gunshot leg? This is what actually happened to him’. And getting that sort of feedback is fantastic. Feedback from the worrying side of things where complications or an error in management is concerned is poor. And when it comes to average feedback, you have to really research just to follow up anything. **Emergency physician**

We have a meeting every week where we look at the results – you can use that as either to show off, which is useful at times, or how you cocked up a case or how you could have done it differently. I think the intellectual honesty of our meetings is still fairly good so people can say, ‘Why did you do that, you idiot?’, or ‘Oh, there was nothing else you could have done, you know’. I think that is very good for ensuring quality – you don’t learn from your
mistakes if you don’t show them to someone. I think if you’re a physician giving medications to patients where the outcomes are not really life or death it is very hard to ensure quality.

Sydney specialist

It has been suggested that collegiality may be essential to enable medical staff, who have generally been identified as perfectionists (Davidoff 2002), to admit to professional uncertainty. The literature on quality improvement and health system reform increasingly calls for interdisciplinary teamwork and education (Barker and Oandasan 2005, McNair 2005). However, many doctors are not comfortable with scrutiny by non-doctors and this next extract gives a reason:

I think we’re very poor at giving negative feedback and we’re very poor at giving positive feedback as well. I guess a lot of that has to be within your own peer group, because they are the only ones who can appreciate, at times, the skill or the management required to get to the endpoint. Gynaecologist

The Uncertainty of Clinical Practice means the Expertise of Colleagues is Highly Valued

Imagining a scenario where they were shunned caused some interviewees to become distressed and claim that they would ‘give up’ practice. Intellectual and emotional support from colleagues was considered necessary to the practice of medicine. The uncertainty of clinical practice engenders peer consultation (Montgomery Hunter 1991: 33). The individual doctor may mould the vague needs of a patient into puzzle pieces (Berg 1992) but meetings and discussion with colleagues were critical for solving these clinical puzzles (especially for physicians). The subjects thus described a high degree of functional interdependence with fellows.

An interesting recent study described the process of change in the prescribing behaviour of UK GPs (Armstrong and Ogden 2006). It was not founded in a decision to apply a published guideline, but was a much more delicate business where patients acted as a communicative medium between doctors. The GPs observed the practices of their GP colleagues when they saw their colleagues’ patients. They studied the letters and practices of the specialists who had seen their own patients, and they watched how a few patients responded to the new drug regimes (that is, they studied the results of small observational experiments which they did not initiate). Then they began to change their own practice! The authors point to the role of personal experience or experiential learning in medical identity, but of equal interest is the role of colleagues – the socially mediated nature of the change.

The long and hierarchical training for specialists results in senior specialists being accorded a high status (Montgomery 2006: 152). Long apprenticeships mean that powerful vertical bonding occurs between mentors and mentees. The wording of the Hippocratic Oath is illuminating.

To consider dear to me as parent him who taught me this art; to live in common with him and if necessary to share my goods with him; to look upon his children as my own brothers; to teach them this art if they so desire without fee or promise. (Cassell 1998: 213)
These relationships may be seen as a symbolic parent–child relationship (Cassell 1998: 213). The plastic surgeon who said ‘Many young guys, we’re all free-thinking …’ was far from a teenager, but in his forties! It would seem these relationships also involve what Bosk described as the ‘social control of moral performance’ (Bosk 2003: 175), including the requirement for dedication and the understanding of role obligations. This results in the described inability to give negative feedback to a more senior doctor.

Clinical judgement has been described as:

... not so much an mathematical or logical ability of determining causes as a fundamentally interpretive one, a capacity for identifying and understanding the significant elements of multifactorial solutions in the process of change. In narrative terms it is the ability to discern a plot. (Montgomery Hunter 1991: 45)

Most of the respect between clinicians is based on the demonstration of expertise and good judgement. Experience is necessary for development of expertise (Montgomery 2006: 49). The evaluation of an individual’s competence by peers is the result of close observation over a period but, of course, not all aspects of practice are visible to their scrutiny. The interviewees described peer regard as central to a doctor’s self-respect. A good reputation is earned over many years and produces an expectation of freedom from scrutiny in both the individual concerned and by colleagues. There was a pragmatic understanding that these collegial relationships are necessary, both for the individual and for the processes of patient care.

Doctors in Queensland interviewed about the disputed management of patients with gastro-intestinal bleeding described ‘accommodative stances’, where care of the patient between groups and by different kinds of specialists (emergency physicians, general physicians, gastroenterologists, surgeons) was facilitated by the degree of interpersonal communication history and respect that existed (Hewett et al. 2009). This was greater for senior specialists and as one subject said, ‘It’s always easy to be nice to someone you know personally …’ (Hewett et al. 2009).

Emotional support and intellectual support were clearly intertwined. The respect of colleagues was essential for a working life, and a ‘good’ doctor was both sparing in criticism of colleagues but prepared to take any such criticism most seriously. The need to preserve these relationships explains the veiled nature of communication between colleagues. One interviewee who had failed in management initiatives described the difficulty of re-establishing relationships with colleagues with whom he had to continue working.

In summary, the subjects’ views captured in both interviews and scenarios suggest that the supportive network needed for the current practice of medicine renders reliable self-regulation impossible. Social controls can be invisible to outsiders and clearly social sanctions exist and can be subtle (and may or may not be effective). However, when social sanctions failed there was little else offered. Many discussed their lack of ‘skills’ at difficult interactions with colleagues, but the real issues seemed to be the lack of a framework or permission for such interactions to occur. Over 20 years ago Freidson described the lack of forms of punishment or sanction in the space between ‘talking to’ and dismissal (Freidson 1988: 149). These intermediate forms are still lacking. Further, negative feedback, even of the ‘talking to’ nature, was viewed as unacceptably risky for both parties.
The young anaesthetist who told the story that starts the chapter has a bond with that ‘boss’ such that it is hard to imagine her ever speaking or acting critically towards that boss over future behaviour or an organizational or patient safety issue. The need to maintain supportive colleagues is one obstacle to facing failures in patient safety and to engaging with the organization for improvement. The individual doctor–patient relationship forms another. This was discussed in Chapter 4 (‘Professionalism’) where some interpretations of fiduciary duty could act to prevent doctors taking managerial or organizational roles. Perhaps there may be another obstacle to good care.

*Does the doctor–patient relationship itself hinder the recognition of error by doctors?*
The Doctor–Patient Relationship

Gift Giving

‘Hi’, he shoulders through the door, clutching coat, briefcase and a white gift bag. He kisses those in the kitchen, leaving the bag on the bench, and goes back to the car to bring in patient notes for dictation, some printer paper and a spare pair of shoes.

The bag is quickly investigated: ‘Oh, chocolates as well as wine. Can we have them after dinner?’

The card is extracted and placed on the shelf above the bench. It sits there for a week maybe, casually perused by family members as they stand making tea or chopping vegetables. ‘I’d never call a baby that …’ When it has two or three companion cards, they are filed – it hardly seems right to throw them away:

‘It has been three years since my cancer operation, and I still want to say thank you at every check up … It could have worked out so differently for me …’

‘Thank you so much for the time and compassion you have given us over the past years. You always answered our (over-)anxious enquiries and put our minds at ease. We are so fortunate to be under the care of such a wonderful doctor and person …’

‘Mum, Dad and I want to say a big thanks for helping to bring me safely into this world, with love …’

Gifts include ties, CDs, books of jokes and cookbooks. There is a stream of jars of sun-dried tomatoes and stuffed olives (from the wholesaling family where all three sisters have been patients). The variety surprises – a bushwalking magazine subscription, hand-knitted slippers, shirts. They are tokens of gratitude and affection, often marking a relationship milestone (the operation is done, the baby born).

I think about the purchasers, putting in effort and thought in shopping centres: ‘That would make a nice present’, ‘Bet he’d tell some of these jokes to patients’, ‘Which colour do you think he’d be more likely to wear?’ . They are choosing something that will make the doctor remember them and think fondly of them in the future.
As an anaesthetic registrar I once heard a vascular surgeon discussing his handmade brogues. ‘Yes,’ he said, ‘I have a couple of pairs. They were from a patient. We were the same size. After I amputated his leg he brought them in as he wanted me to have them.’

‘Creepy,’ I thought. Looking back, the gift of the shoes would have merely been part of a long relationship. Several years of attempts to save the leg, with ischaemic toes and feet being nibbled away before the amputation became inevitable. The wealthy and successful businessman journeyed into old age and disability with a surgeon who treated him with humour and respect and preserved his dignity. The history explains both the gift and its acceptance.

Doctors and Patients have Relationships

Doctors are given access to patients’ bodies, troubled thoughts and highly charged emotions. It is a cliché that ‘every woman falls in love with her obstetrician’. The common query ‘Doctor, if it was your wife/father/prostate, what would you do?’ (Tallis 2004: 55) is a plea by the patient to be treated in the manner of someone the doctor deeply cares about. (It also illustrates that true informed consent will only ever be an ideal.) Patients want to be cared about and cared for (Potter 1996), and from the doctors’ responses, it would seem they usually are. Doctors experienced ‘deep satisfaction’ (Larson and Yao 2005) from their relationships with patients. This was explored in Chapter 3, when subjects were asked if medicine had met their expectations. Many were highly enthusiastic:

It’s been a rewarding experience intellectually, emotionally. **Colorectal surgeon**

I guess what I am trying to do is to find out why people come to see me with their particular complaints. Try to understand what their problems are and try and find ways, try to find solutions for them, for their particular symptoms, complaints or problems and whether that’s finding solutions by doing scans or giving medication or just talking to them or even reassuring them. There is a lot, but the main thing I am trying to do is to help understand what their problems are, what the causes of their problems are and what we can do to explain them and relieve them of their problems if that is possible. **Neurologist**

Despite suggestions otherwise (Coulehan et al. 2003, Lester and Tritter 2001), it was apparent that the experienced doctors interviewed retained compassion, curiosity and altruism. Some researchers have suggested that peak experiences in medicine occur at those times of strong emotional connection to patients (Montgomery 2006: 180). For some there was a non-professional, almost sheepish, aspect to their descriptions of their relationships with their patients:

*I do enjoy having people come back to the office, the private thing, where you can just have a chat to them about what they did at work and if you have fixed up their heart. At the same time you find out about people so that there is a human interaction which is important in sustaining your job satisfaction.**Cardiologist**
The Doctor–Patient Relationship

I like to take a sort of laid-back approach especially with the obstetric patients, because you get to know them. You like to have a bit of a chat with them which I don’t see as being very professional. Obstetrician and gynaecologist

Because of the relationship that I have with my patients when I say ‘Slip behind the curtains, slip your clothes off and put the gown on opening at the back’, they do that because of the trust and because of the perception that I am endeavouring to make a difference with them. Rheumatologist

The subject quoted below was vehement in his opposition to what he saw as trends to de-personalize care and deny individual relationships:

I dislike this bureaucratic structure where people are called clients in the system. I detest the term ‘system’. I think it de-personalizes the whole process of health which, when it comes down to it, it’s actually a very personal process. It’s basically a … medical team but … they’re not faceless people. For the patients, they’re ‘my specialist’, or they’re so-and-so’s registrar and they call them by names. It is a very personal process and this whole depersonalization of health and [the way] we look after clients I think it’s bollocks … Health is a commodity, it’s got a budget, numbers and stats … but at the end of the day it’s a personal thing … The thing that really irritates me is that I look after patients and systems focus on clients and they’re different and the system does a lot of disservices to patients. I mean it’s not like going to buy some petrol or getting a plumber to fix your tap or going to an accountant to get your tax done. I mean this is like, this is hell, this is different. This is really different …. Haematologist

The relationship between doctor and patient is an evolving one. Knowledge sharing has enabled increased patient autonomy and patient consumerism. Assertion of individual rights in connection with health care is increasing (Schulman 2002: 209) and while all patients may not want an active role, the passive role is no longer perceived as acceptable (Stevenson and Scambler 2005). When large amounts of technical medical information are available to patients, the subjectivity of clinical decisions is revealed. Only half the population have sufficient health literacy to make informed health decisions, and only the highly educated are able to share responsibility with their practitioner throughout decision making (Smith et al. 2009).

The rhetoric of ‘patient choice’ may have reduced the trust the patient needs to get the best result from working with a doctor (Stevenson and Scambler 2005). An uneasy and unsatisfactory attempt to share risk may be replacing the courage required to make medical decisions. Allowing the patient to choose from a range of options can be an abdication of professional responsibility (Tallis 2004: 240). A moral bankruptcy is created when doing what is believed to be ‘right’ or ‘best’ for patients is replaced by doing ‘what the customer wants’. Most patients still ‘experience the need for care as well as cure, the hope that the doctor will show concern for them, as well as an interest in the disease and that, from the doctor’s intervention comfort and psychic relief will flow’ (McKevitt and Morgan 1997).

Sharing of medical knowledge and power by patients and doctors is frequently discussed as if it were both inevitable and possible (Nancarrow and Borthwick 2005, Say and Thomson 2003). The doctor–patient relationship involves considerable power asymmetry, and exploitation by doctors can occur, whether of a financial or personal
nature. The power asymmetry itself appeared to form part of the pleasure of helping. Respect is another reward from power asymmetry

Ten or twenty years ago it was probably the time when patients … respected you as a doctor … Nowadays, you don’t get that anymore. I mean not always: I do have lovely patients. Not that I am in this for that, but I think it is just a bit sad that doctors get criticized more now than they used to. Obstetrician and gynaecologist

The inherent professional accompaniment to power asymmetry is fiduciary duty and self-sacrifice:

The professional has to get the job done no matter what. No matter what the circumstances are, no matter how tired you are, how distracted you are by family, no matter how uncooperative the patient is or whatever, you get the job done, no matter what. Paediatrician

Doctors have a high degree of belief in their personal power in their relationships with patients. This may be realistic. It has been demonstrated that enhancing patients’ expectations through positive expectation about treatment or illness significantly influences health outcomes for a number of disparate conditions (Di Blasi et al. 2001). A trusting relationship between provider and patient has a direct therapeutic effect (Gilson 2003). Doctors also have a powerful belief in self-fulfilling prophecies and avoid prognostic pronouncements lest they hasten a death (Christakis 1999: 160). In a relationship, of course, both parties can be betrayed. Litigation was viewed by doctors as a betrayal:

Plastic surgeon: If I was sued I’d probably leave because so much of what I do is based on trust. By the time I end up doing an operation, and you try to prepare somebody for it and if they then turned around and sued you for a decision that you’ve made … I would probably have a great deal of trouble still working because you do make decisions based on what you think is best at the time.

Interviewer: But you do have thousands of other patients you have helped?

Plastic surgeon: Oh, absolutely.

Interviewer: So you still think it would throw you that much?

Plastic surgeon: Because it’s such a personal assault on your integrity.

This answer is complex – the practitioner needs to continue to rely on his/her own judgement, and litigation may destroy their confidence. The use of ‘integrity’ alludes to deeply held beliefs about being a good doctor. Litigation, though, is viewed as betrayal of a relationship. In the extract below, another subject associates ‘liking’ with avoiding litigation:

I would never operate on somebody I didn’t like unless I really had to … [Three patients who sued were] … all patients I had a bad feeling about from the outset, but when you’re young you just think, ‘Oh well, you know, help them anyway’. Plastic surgeon
All relationships are transactional and the next quote illustrates a view on the nature of the transaction (or the doctor–patient contract):

> You make decisions for your patients ahead of yourself and I missed a hell of a lot of social functions and hell of a lot of late nights and whatever … One part of being professional is that your patient has to come first. There is no compromising that. And litigation breaks that.

**Plastic surgeon**

In short, interviewees believed ‘If I sacrifice and I have good intentions then you shouldn’t sue’. However, it has been suggested that in contradistinction to doctors’ hopes, ‘good intentions’ are of far less significance to patients than good performance (Millenson 2002a). A lawyer opines:

> Some physicians think that the essential nobility of what they do in their professional lives (offering their many years of education and training together with their long hours of effort and sharply honed curative skills for the benefit of the sick and dying) somehow should shield them from accountability even if their medical performance was faulty or their clinical judgement, in hindsight, was erroneous. (Litvin 2005)

### How do Doctors Feel about Medical Error?

The interview subjects were not asked about errors they had made or patients they had harmed. I was not willing to ask for uncomfortable or painful memories. I knew how doctors felt about personal errors:

As a junior anaesthetic registrar I was asked to put a central line into a seriously ill patient scheduled for cardiac surgery the next day. I was inexperienced, it was difficult for the patient to lie still, let alone tolerate a ‘head down’ position [with the foot of the bed raised] to allow for the filling of his internal jugular vein and safe cannulation. It was not an ordinary line that was required but a Swan Ganz Sheath [about 1cm in diameter]. Eventually, sweating in my gown and gloves, I seemed to be in the right blood vessel. I discussed the blueness of the blood and the nature of the flashback [blood entering the syringe] with the nurse helping me and got the wire in. The patient screamed when I inserted the dilator; I put the sheath in and connected it to the transducers to discover an arterial wave form. It was in the carotid artery, supplying half the blood to his brain. Time really did stand still while I waited for him to lose consciousness. The patient’s scream was now echoed by a silent one in my brain. The nurse’s eyes were wide and she backed away from me, away from any joint decision or shared responsibility. I took the line out and waited for air and plaque that might have been introduced into the artery to reach his brain. I waited to see if I had killed him or rendered him hemiplegic. There was lots of blood, the patient gasping.

I told the vascular surgeon and the cardiac surgeon (who was very angry and shouted and told me I was incompetent). There was discussion about patching the carotid, whether the cardiac surgery would have to be cancelled. The carotid didn’t need patching, the cardiac surgery was delayed a day and the patient survived. I nearly gave up specialty training; that patient scream echoed in my head for weeks.
The story above is a ‘small’ tale. I had no emotional connection with this patient. The patient was seriously ill (hypoxic, low cardiac output). I was under-supervised. I did not kill him. Most interview subjects would have many ‘small’ stories like this and some that were much more serious. The expressions ‘you know’ and ‘you understand’ occur frequently in the interview transcripts. Anyone who has ever experienced the utter shame and horror at realizing they have harmed a patient would not choose to take friends and colleagues back to their own moments of that nature.

Here’s another ‘small’ story (a near-miss tale) from the interviews.

**Ear, nose and throat surgeon:** I was doing a EUA [examination under anaesthesia] on a young guy with a big cancer on his neck and he had this ulceration on his tonsil. He was a smoker, hepatitis B, a drinker and at 35 he was a sad human being … I was doing a biopsy and at the end I just lost a swab. A great mystery. Had a look in there and sucked around and couldn’t find it and said, ‘We’ve got to make sure it’s not in the patient’. So the anaesthetist got an endoscope and looked through the nose and there it was. It was wedged right up the back of the soft palate. We talked about that at our M&M meeting this week and the ENT guy said he routinely at the end of any case like that puts a feeding tube down each side of the nose and checks, which I always do now too, so that’s good I learned something from that.

**Interviewer:** Mmmmmm.

**ENT surgeon:** Up the back of the soft palate.

**Interviewer:** And the consequence of breathing in the swab during recovery, taking that big breath and it blocking the trachea.

**ENT surgeon:** Oh no! Obstruction, you know what I mean, it’s terrible.

The subject takes pleasure in his new learning and how it has been shared with colleagues. Significantly, the interviewer and the interviewee both share the horror of the potential disaster, the ‘big breath’ that could result in death from asphyxia.

The topic of how doctors manage error has been studied by non-medical social scientists who can observe and question more dispassionately than doctors (Rosenthal 1995, Bosk 2003, Freidson 1988, Mizrahi 1986, Mizrahi 1984). The perception of having made a mistake creates significant emotional distress for doctors (Christensen et al. 1992, Schwappach and Boluarte 2008, Waterman et al. 2007). An Australian study of 566 GPs found that doctors currently involved in a medico-legal matter have increased psychiatric morbidity, impaired function and hazardous alcohol use (men only) compared with their fellows (Nash et al. 2007).

Thirty-four per cent of a group of US internal medicine trainees reported making at least one major mistake over a 12-month period (West et al. 2006). Those that reported an error were more likely to suffer a reduced quality of life and suffer from burnout and depression. Unfortunately, personal distress and depression may result in a consequent increase in the numbers of self-perceived errors, which depress the doctor further and negatively affect patient care, thus generating errors (West et al. 2006).
Of 114 US junior doctors who described their most significant mistakes, a third reported that their mistakes had resulted in the death of the patient (Wu et al. 1991). The authors cautioned, ‘Many patients were terminally ill and medically unstable, and the mistakes may not have caused the adverse outcomes.’ Similarly, Swiss safety researchers have suggested that junior doctors identify only intrinsic causes (such as their lack of knowledge), and not extrinsic causes for errors, and thus attribute the error unfairly to themselves alone (Schwappach and Boluarte 2008). The impact of mistakes may be exaggerated when the sense of personal responsibility is strongest, for instance following invasive procedures (Wu et al. 1991).

The following tale also comes from the series of educational narratives told by young anaesthetists (Iedema et al. 2009a):

This was an 11-month-old child of Sri Lankan background, just having a suture for a laceration on the forehead. He was a big boy, about 12.5 kilos and I felt confident. I rang the boss but he wasn’t that keen to come in and he said ‘go ahead with it’. I felt great about this … [but after extubation I could not ventilate the child] … This child went an awful awful colour, being Sri Lankan background from the start. It was a terrifying moment … I heard the anaesthetic assistant say, ‘Do you want me to start CPR [cardiopulmonary resuscitation]? There is marked bradycardia, with hypoxia.’ And when I looked in, the normal tissue definition you see, lovely pink tissue, was not there in this severely desaturated child …. Found the right place to put [the endotracheal tube], pinked the child up again and finally managed to extubate him and everything seemed to be okay.

Now I was severely traumatized by this event … I went searching for an esteemed consultant to confess my sins to and get some feedback and I told him my story. He said to me, ‘Well, you handled it quite quickly, and that sort of thing will happen to every paediatric anaesthetist no matter what skill grade each year and it’s not so much that it happened, but it’s the fact that you’ve got a plan and that you can handle it.’ And I felt very reassured by this. He was giving me permission for the fact that mistakes happen.

Then when he finished that part of it, he looked at me with a little glint in his eye and said, ‘Did you notice how quiet that child was in recovery?’ and I said, ‘Yes, he was one of the quietest children I’ve ever seen’. And he said, ‘They’re always like that after they have had a significant hypoxic episode’ [laughter from the group].

Many of the young anaesthetists recounted experiences that had been extremely traumatic and sometimes they were ashamed of their own actions. The responsibility required of these young doctors meant that their experiences were unforgettable. The critical supportive role of colleagues revealed by the scenarios and interviews is again evident. Note the phrase ‘confess my sins to’ indicates the storyteller has re-interpreted his procedural difficulties as a moral failing. Later in the extract he recounts how his senior consultant revealed to him what was to remain a shared secret – how close the patient had come to dying (Iedema et al. 2009a). It could be inferred that the support given verged on collusion between the two doctors.

Shame is an extremely unpleasant emotion: the experience of shame requires recognition of failure and a judgement that an accepted standard has been breached (Cunningham and Wilson 2003). Avoidance is understandable and even those with
high self-esteem have been shown to modify their thinking about situations to reduce unpleasant emotions such as shame (Wood 2000). Doctors are not enthusiastic reporters of error and sometimes try to replace ‘error’ with terms such as ‘unfortunate side effect’ or ‘incident’ (Schwappach and Koeck 2004). Denial, discounting and distancing are all mechanisms used to minimize the personal impact of medical mishaps (Mizrahi 1984). Discounting includes externalizing by blaming ‘the system’ for such factors as high workload or bureaucratic excesses (Mizrahi 1984). However, the residual doubts and guilt experienced by young doctors suggest that these defence mechanisms are not effective strategies for coping with error. The emotional impact of error on practitioners may limit error disclosure.

**Disclosing Error**

It is believed that full disclosure of errors to patients may be uncommon (Gallagher et al. 2003, Walton 2004, Kaldjian et al. 2007) despite current belief in the correctness of this approach (Cantor 2002, Lamb 2004, Berlinger and Wu 2005, Mazor et al. 2004). When US emergency medicine trainees were asked about an error they had made, while 83 per cent had disclosed the error to someone, only 28 per cent had informed the patient (Hobgood et al. 2005a). The severity of the outcome increased the likelihood of disclosure (Schwappach and Koeck 2004) and those for whom forgiveness was an important part of their spiritual or religious beliefs were more likely to disclose an error (Kaldjian et al. 2007).

US surveys found that 30–40 per cent of patients who recognized that they had experienced an adverse event had also been informed (Blendon et al. 2002, Lopez et al. 2009). However, patients suspect ‘human nature’ may lead healthcare workers to hide errors (Gallagher et al. 2003). Some doctors believe there is no need to disclose error if harm was trivial and the patient was unaware, and that some patients would not want to know about an error (Gallagher et al. 2003).

There is little research on the decisions, processes and consequences of informing patients of errors (Mazor et al. 2004, Manser and Staender 2005, Mazor et al. 2009). What do patients want? When parents attending a paediatric emergency department were asked to consider a series of error vignettes (Hobgood et al. 2005b), 99 per cent of parents said they wanted disclosure regardless of the severity of the error. The parents also claimed that they would be less likely to sue if an error was disclosed than if they found out another way. Patient trust is eroded when there is discovery of deception by doctors (Schwappach and Koeck 2004). Patients may not, of course, make this discovery, and there is other work suggesting that disclosure of errors carries a risk of increasing litigation and costs (Studdert et al. 2007). As yet there have been only two small studies examining actual patient experiences of disclosure (Iedema et al. 2008, Duclos et al. 2005).

The requirement to provide honest explanations to affected patients and families was formalized in Australia by the ministerial endorsement of the National Open Disclosure Standard (Australian Council for Safety and Quality in Health Care 2003b). The Standard defines open disclosure as including an expression of regret for what happened, keeping the patient informed, providing feedback on investigations and advising the steps taken to prevent a recurrence of an adverse event (Australian Council for Safety and Quality in Health Care 2003b).
The Standard was developed in 2003, and implementation has been slow and resisted. Perhaps there is something about disclosure that is anathema to doctors. The fact that a standard was even required is worrying. A seminal Australian textbook *Ethics and Law for the Health Professions* (Kerridge et al. 2009) is a weighty 895 pages, but the chapter on veracity (truth telling) accounts for a mere 16 of these pages. ‘Admitting mistakes’ and ‘apology’ fill just over a page, and the National Open Disclosure Standard is not mentioned. Authors who struggle with the subtleties of defining both harm and error in complex medical care are rare, yet error is ubiquitous in any intensive care unit (Boyle et al. 2006). This might suggest that disclosure of error should simply be a regular part of updating the relatives of a patient who is seriously ill. Perhaps defining the scope of truth-telling that disclosure of errors requires has proven too formidable a task, even for ethicists.

**Is Disclosure always the Right Thing to Do?**

An alternative view is that:

*While confession is good for the soul, it’s not always best for the doctor–patient relationship. While some bonds will grow stronger after a mistake is confessed to, others will falter. This is the chance one takes when confessing an mistake … No one can tell you whether or not you should confess a mistake to your patient or not. In the interest of regaining trust (especially if the patient has had his or her suspicions of your error) and regaining honest communication, then it usually is best to confess to the mistake.* (Anonymous 2009)

If you love someone, it is not easy to admit you have harmed that person. If that person does not know unless you confess, should you? There are parallels between confessing to patients and to your own loved ones. The issue of honesty about an extra-marital affair is the subject of countless ‘advice to the lovelorn’ columns. The advice is divided – to conceal or reveal? Who are you helping or hurting? The quote above is adapted from such a column, where the author advises: ‘While confession is good for the soul, it’s not always best for the marriage’ (Anonymous 2009).

When I trust you as a friend, I trust that you care for my well-being and that you will make decisions in my interest. Because you care, you might be tempted to lie, and in fact I may expect you to lie, but I do not want to know about it. Often the lie that we expect is a deliberate omission of a fact or the truth. Think of ‘It’s just what I always wanted’ as the bizarre or inappropriate gift is unwrapped, or the answer to the situation comedy staple question of ‘Does my bum look big in this?’ Expectations around truth telling vary between cultures and situations.

Counterfactual thinking is important in determining how we respond to a lie if it is discovered later. Counterfactual is ‘if only’ thinking with the generation of alternative outcomes based on retrospective consideration of the current outcome and the process that led to it. Counterfactual thinking is a major issue in error analysis. For instance, a severe or tragic outcome like the death of a child results in a harsher judgement of the staff involved than if the outcome was less tragic.

If a lie is discovered later it may be considered a betrayal of trust. The lie may have altered subsequent actions. Yet the determination that ‘I would have taken different
actions’ is largely based on the future outcome. It is our counterfactual thinking that determines the severe emotional impact of being denied the truth after an adverse event.

Did the young anaesthetist tell the family about their son’s hypoxic event? Let it be assumed he did and that neurological follow-up testing was within the normal range. The parents may have been somewhat reassured, but with every poor school report they would wonder about the consequences of that hypoxic episode. Is the error then something that the parents should or should not know?

When I was an anaesthetic registrar, seeing children and their parents before elective procedures (such as tonsillectomies and circumcisions) was an uncomfortable experience for me. Parents would ask ‘It’s quite safe, isn’t it, doctor?’ Telling them that ‘Very occasionally a child dies or is left with a disability after anaesthesia. Are you really sure that he needs this operation?’ However, the parents did not want to discuss risks but rather they wanted my assurance of safety and a good outcome. I was aware that no prior discussion was ever going to be considered adequate in the event of a complication. In addition, I suspected my own anxieties about my competence and my limited experience were distorting my perception of the situation.

Certainly the care in the therapeutic relationship implies an acceptance of some discretion with the truth, just as in any other caring relationship. Hence for doctors, who are requested daily to give hope and certainty, concealment can seem normal. This paternalistic approach to honesty can, of course, be a slippery slope, and detailed examination of oncologists’ practices revealed that patients were denied information they wanted and needed (Christakis 1999).

It has been suggested that when ‘things go wrong, the professional is well placed to retain trust by guarding, filtering and even concealing information about error’ (Quick 2006). Is this ever appropriate? Is open disclosure of adverse events always in the patient’s best interest? Situations where formal open disclosure is promoted fall into a number of categories:

- Serious harm that is obvious to the patient and family. They need to understand how and why this happened. They also want a tangible apology (Berlinger 2005). This may include financial reparation and evidence of improvement or punishment. Managing this well restores their trust in the health system.
- Harm, whether serious or minor, where it is important for the patient’s future health care to understand what happened. Examples include an anaphylactic reaction to a known allergen or an accidental drug overdose.
- Minor errors, with perhaps no associated physical harm that the patient is aware of. An example is being given another patient’s medications. These concern patients because they indicate a lack of thoroughness or caring (Mazor et al. 2009). Consideration of patients’ experience of safety – whether they feel safe – is important (Wakefield and Jorm 2009).
- Serious harm that the patient is oblivious to, such as delayed diagnosis. Finding out causes anger: ‘If I’d had the operation sooner, it mightn’t have spread’, when in fact it might have spread anyway, as the course of any illness is uncertain. However, impending death is a sure stimulus to counterfactual thinking about error.
- Error associated with no or minor harm to which the patient is oblivious. A good example would be staff forgetting to reduce the sedation in intensive care, so
the patient ends up being ventilated an extra day. Providing information about these matters is likely to reduce trust in the health system, with no gain for the patient.

For all of the circumstances above, it can be argued that disclosure is simply the right thing to do. However, this approach devalues the complexity of trust. It is frequently assumed or argued that complete and sensitive disclosure will restore trust. This may or may not be the case, as disclosure itself will damage trust where the error was unknown to the patient prior to disclosure.

**Trust and Disclosure**

Trust has been defined as ‘a voluntary action based on expectations of how others will behave in relation to yourself in the future’ (Gilson 2003: 1454). These expectations exist when an individual has incomplete knowledge about the probability of an event and insufficient control over the event. Trust is hopeful and it may lead to disappointment, so trust always involves risk (Gilson 2003).

Some argue that trust only exists between individuals, and that confidence characterizes relationships between people and systems (Harrison and Smith 2004). Trust has been characterized as having a cognitive element (based on rational judgements) and an affective element (based on relationships, interaction, empathy) (Calnan and Rowe 2006). Clearly the mix will vary and the chronically ill patient’s trust (or distrust) in the health system will be based on his or her interactions with many providers. These may or may not strengthen their trust in the healthcare system. Diabetic patients who had high trust in an individual health practitioner contrasted this with their lack of trust in the system in general (Calnan and Rowe 2008). Their lower trust in the broader system was based on both personal experience of dirt and inefficiency, and from media discussion of government targets and infection rates.

Patients have to trust individual doctors. They trust them in times of fear, urgency and intimacy. They trust them to match their mysterious problems and symptoms to the right diagnosis and then guide them through difficult treatment decisions.

The trust relationship between doctor and patient is crucial for the therapeutic relationship (with its asymmetry in the distribution of knowledge and power). The vulnerability associated with being ill results in this trust having a stronger emotional component than in other settings where it may be more a matter of calculated judgement (Goudge and Gilson 2005). In illness the outcome is uncertain for any patient: ‘Is it serious?’, ‘How long until I am well?’, ‘How long will I live?’. The science the doctors have to rely on is poorly defined and rapidly changing.

Affective trust is based on ‘the emotional bonds and obligations generated through repeated interaction, empathy and identification with the other’s desires or intentions, or the desire to treat the other as I would wish to be treated myself’ (Gilson 2003: 1456). The story of the surgeon with the amputee’s shoes is a tale of affective trust. The nature of the trust between doctors and patients introduces the moral requirement of ‘being worthy of another’s trust ... [so] ... that one takes care not to exploit the power one has to harm the trusting person’ (Potter 1996: 331). Disclosure that creates fear or anger may be such a harm.
The Doctor–Patient Relationship may be Harming Patients

Open disclosure of adverse events requires doctors to admit to themselves that they have caused harm and endangered a trusting relationship. Doctors care deeply about individual patients and take their responsibility both to safeguard and to care for patients very seriously:

*If you’ve done something to harm the patient ... that’s your worst fear ... As an intern I remember running the hospital on night duties ... hoping that you survived ‘til the morning without doing anything really bad ... not to hurt them. Infectious diseases physician*

We lie easily in our ordinary lives and in minor matters. In major situations like infidelity, commentators disagree on what to recommend. The advice to ‘preserve trust’ in this circumstance seems to be to lie and conceal unless it is thought discovery is inevitable.

The bonds between doctors and patients (together with their doctors’ tendency towards perfectionism) make it hard for doctors to accept that they have delivered unsafe care. US expert Tom Gallagher suggests that it is the open disclosure of error to the patient that necessitates acceptance of error by the clinical team and stimulates subsequent investigation and improvement. Concealment prevents this ever happening (Gallagher 2009). Concealment may mean it never becomes known why the test results were lost and the diagnosis delayed.

The advice to the lovelorn columnists suggests ‘You can admit it to yourself but you might not want to put him through the truth’ (Horrocks 2007). Even these columnists admit that perhaps personal honesty and reflection are required to uncover the factors that led to an affair. When an error occurs in modern health care, it would be extremely rare for there not to be lessons to be learned (about processes and the roles of the individuals involved) that would be of wider relevance. Even where a single practitioner may be responsible for harm, denial of inappropriate work practices such as those associated with greed, speed and fatigue are likely in the absence of disclosure and analysis.

In short, ‘You don’t learn from your mistakes if you don’t show them to someone’ (focus group member), and patient disclosure makes it more likely that proper analysis of the adverse event will occur and that lessons will be sought and learned. To be this brave requires doctors to learn to look beyond the individual patient (and the unpleasant discussion to be had) toward the lives and experiences of future patients. Our system does not make it easy to look beyond the individual patient.

We need the results of research on patient and clinician experience that come with disclosure. Disclosure imperatives must also be tempered with a more detailed understanding of the role of trust in health care and recognition of the intimate and caring relationship that exists between doctors and patients. In 1926, a dying US physician Francis Peabody gave a famous lecture series on what it means to serve as a doctor; the final lecture concluded with these words: ‘For the secret of the care of the patient is in caring for the patient’ (Peabody 1927). Open disclosure must necessarily be difficult because doctors care for individual patients. Imagine the difficulty of calling back one of the long-term gift-giving patients to disclose an adverse event for which you may have some responsibility. Even if it is not the doctor’s ‘fault’, he/she has not averted it, has not kept the patient safe.
Complex, dynamic environments (for instance, in an intensive care unit) are replete with averted or corrected disasters. It is probably not necessary for patients to know every painful detail or for organizations to launch extensive investigations into each and every incident. Determining where to focus productive and meaningful investigative and improvement efforts requires intelligence and thought at the system level.

_How do doctors understand the healthcare system? Are they able to participate in change and improvement to this system?_
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CHAPTER 9

Doctors’ Alienation from the Healthcare System

Staff Bemoan Paperwork, Reshuffles and Lack of Concern

A registrar at Royal North Shore Hospital yesterday claimed there is ‘no commitment to care’ at the hospital, while other doctors blamed an obsession with paperwork and ongoing management reshuffles for sending staff morale through the floor.

Simone Matousek, a plastic surgery registrar, said the hospital was disorganized, with staff leaving shifts before their patients had received proper care.

Dr Matousek said management’s ‘obsession with filling out useless forms and mindless application of protocol’ meant operating theatres were not fully utilized, with surgeons forced to take an hour’s lunch break rather than perform more operations.

‘I could do three to four more operations a day if I did not have to deal with this grossly inefficient system,’ she said.

‘All this paperwork wastes the time of doctors and nurses and creates huge delays. Patients have had infected wounds left uncovered for hours because someone went to tea and “handed over” the task to someone else.

‘Many people work shifts in the hospital and leave when their time is up, not when the patient has been properly cared for. Fire all the middle management in hospitals who have created this environment and contribute nothing and you will have plenty of hospital funding.’

A former medical registrar at the hospital, Nick Coatsworth, said low morale was not only due to underfunding but because of a ‘constant change of middle- and upper-level management’ and clinicians losing their decision-making power to bureaucrats.

(Kate Benson and Natasha Wallace, Sydney Morning Herald, 29 September 2007)

The above article quotes some very angry doctors who are, rightly or wrongly (issues of fatigue are certainly ignored), highly critical of the non-doctors in the hospital. They do not see themselves as part of either the problem or the solution. Is this a general phenomenon?
Organizational Citizenship Behaviour

Policy makers are increasingly interested in the effects of organizational culture on healthcare improvement, performance and safety (Mannion et al. 2005), but evidence is limited (Hoff et al. 2004). Modern interpretations of medical professionalism suggest an obligation for doctors to participate in teams and to be involved with the greater health system (Surdyk et al. 2003). As discussed in Chapter 4, there is no resolution of the perceived conflicts this may cause with responsibilities to the individual patient.

A complementary and helpful concept exists in organizational psychology – that of organizational citizenship behaviour (OCB) (LePine et al. 2002). For organizations to operate successfully, their employees must be willing to do more than the minimum specified technical aspect of their jobs (Rioux and Penner 2001). As organizations move away from strict hierarchies and individualized jobs towards team-based work structures, such individual behaviour that is ‘discretionary, not directly or explicitly recognised by the formal reward system’ (Organ 1988: 4) is likely to be increasingly important.

There are five OCB dimensions (Schnake and Dumler 2003, Organ 1988):

- altruism – helping behaviours toward an individual with a specific problem (this ultimately benefits the organization)
- courtesy – preventing problems by keeping others informed
- conscientiousness – as shown by such behaviour as punctuality and attendance
- sportsmanship – amiable toleration of minor annoyances
- civic virtue – responsible participation in the political life of the organization in ways such as attending meetings and keeping abreast of organizational decisions.

Personal traits of altruism (Rioux and Penner 2001, Borman et al. 2001), conscientiousness (Borman et al. 2001) and happiness (Brief and Weiss 2002) predict an individual’s OCB. However, where employees have a satisfying relationship with their employing organization (characterized by trust and an expectation of fair treatment) they are more likely to display OCB (Brief and Weiss 2002, Mark 2005, Deluga 1994). Two scenarios were designed to assess OCB.

FOCUS GROUP SCENARIO

The nursing staff at the hospital ask you to sit on the infection control committee. What would be your reaction?

Hospital-acquired infections are a major source of patient harm (Graves 2004, Pellowe et al. 2005, Australian Council for Safety and Quality in Health Care 2003a). The literature on hand washing suggests that some doctors have little interest in infection control and are inclined to break rules (Pittet et al. 2004, Seto 1995, Whitby et al. 2005). While major MRSA (methicillin-resistant *Staphylococcus aureus*) outbreaks do provoke medical involvement and interest in infection control, doctors generally hold a dim view of meetings and those who attend them:
I don’t want to occupy myself with non-productive activity. I’ve been on committees where there is really nothing to talk about … and the person who does the talking is probably the least productive, least astute, least clinically active. Endocrinologist

What did the focus group members think about a place on the infection control committee? Some accepted the necessity for involvement in hospital committees:

In this day and age it’s an accepted thing that you have to be involved. Seven years ago you just practised in isolation and did your bit.

To some degree you’re obliged to be part of the system. It would be nice to be involved in ones that you’re most interested in, but that’s not always going to happen.

Most were rather reluctant:

I can’t stand sitting on useless committees, so I’d have to be convinced that it was something that I could actually contribute to and be worthwhile.

There are a lot of useless committees in the hospital. A lot of people in the hospital bureaucracy are looking for things to do to fill their day up. We’re not that group of people.

I’d go along, on the condition that it didn’t turn out like the committees I’ve been on because they’re just a manifest waste of time. On the understanding that I would walk out if that’s what it proved to be.

No one admitted that they would refuse to join the committee: however, involvement in committees was considered to be inevitably unproductive. A committee is a formal way of involving a group of staff in the management of an issue or process. There was no discussion of ways to educate, drive or influence a committee if an issue was important.

SURVEY RESULTS – ‘COMMITTEE’ SCENARIO

The nursing staff at the hospital ask you to sit on the infection control committee. It is most likely that you will:

a) accept – 26 per cent
b) try to find someone else to go, but accept if it was ‘my turn’ or no one else could be found – 31 per cent
c) accept but only remain on the committee if it is immediately obvious your views will influence real change – 21 per cent
d) refuse, as such committees are a general waste of time – 12 per cent
e) other – 6 per cent
f) no response – 5 per cent.

Of the doctors surveyed, only a quarter accepted a role on an infection control committee, despite infection control being a central issue in patient safety.
However, a third would participate if no one else was available. A third would either refuse to participate or reserve the right to withdraw if dissatisfied with committee outcomes.

FOCUS GROUP SCENARIO

Your hospital has recently had an expensive implementation of expanded information technology. You receive a letter from the hospital director asking you to produce some referenced guidelines on your specialty area for the junior medical staff. These will be placed on the intranet. There is, however, no money or time allocated for you to do this.

In contrast to the previous scenario, involvement would require a greater number of hours but would be relatively autonomous work. However, the lack of time or money for the task in the context of an expensive new system was expected to elicit negative responses. I had witnessed doctors doing such work energetically, refusing to do it, or doing it incredibly slowly.

What did the focus group members say about writing guidelines? Some said they would try to do this extra unpaid work, possibly by involving others including junior staff:

Even with no money or resources I would make an effort to try to get them. But, what’s the time frame? May end up getting some help or delegating it to someone who will have the time.

That is always the case in the public hospital system at the moment: we’re trying to do more and more with less.

Others were reluctant and displayed considerable bitterness towards the hospital:

Say I’ll do it but it’s going to cost money or time.

They’ve just spent a whole lot of money on computers but they’ve got no money to give you the resources to make them useful ... Only this morning I spent an hour talking about departmental organization for the future, an hour that I would normally have spent with my family. And I resent that. And I resent the fact that the hospital is not going to pay for it, and increasingly won’t pay for things, and increasingly question call-back times ... Every passing occasion when someone queries me about something I get less and less willing to do this sort of stuff.

SURVEY RESULTS – ‘GUIDELINES’ SCENARIO

Your hospital has recently had an expensive implementation of expanded IT. You receive a letter from the hospital director asking you to produce some practical guidelines on your specialty area for the junior medical staff. These will be placed on the intranet. There is, however, no money or time allocated for you to do this. It is most likely that you will:

a) do it – 45 per cent
b) organize a team to do it – 27 per cent
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c) suggest a registrar or senior registrar does it – 16 per cent
d) decline in the absence of payment – 5 per cent
e) other – 5 per cent
f) no response – 2 per cent.

Survey group answers revealed a greater willingness to be involved than would have seemed likely from the interview group comments, with almost three quarters of the survey group responding positively. This seems to represent a high degree of OCB for the scenario described. However, the guidelines in this scenario specified ‘in your specialty area’ which would mean the specialist would be the authority in control. This would not have been the case for the infection control committee scenario.

Follow-up interview questions sought to elicit formal activities that could reflect OCB and probed the relationship between the doctors and the hospital.

INTERVIEW QUESTION
Aside from your clinical load, what other activities are you involved in at the hospital?

The great majority of interviewees volunteered that teaching was their major additional activity. A few mentioned that they ‘used to be heavily involved’ in administration or on hospital committees, implying they had done their share. A couple of active researchers did not mention their research, suggesting that research was not seen as a hospital activity. Participation in State or Health Area processes was mentioned by some, and these roles often merge with hospital roles where doctors were supervisors on clinical training schemes or heads of departments.

INTERVIEW QUESTION
How does the hospital treat you?

A few were positive:

_I come to work, I get paid regularly. Now that I have been around the hospital long enough, I know whom to ring to ask for what. I’ve got a nice office and lovely staff to work with. So I would be pretty comfortable with the way I am treated._ Renal physician

Some doctors’ relationships with the hospital hinged on the care provided for patients:

_I don’t think the hospital treats me badly. I think the hospital treats my patients badly, which in a way I take personally._ Plastic surgeon

_I get incensed every time I go to the hospital clinic because of not being able to find forms and the organization of it is much worse than my own practice and it’s frustrating. I don’t feel_
proud that I’m a consultant there, and the patients come along and think, ‘He must be a really
good doctor’. I don’t care what they think because I know I’m not giving my best performance.

**Obstetrician and gynaecologist**

For these clinicians the hospital was limiting their ability to be a ‘good doctor’ and take
care of their patients. Most doctors were negative about their treatment by the hospital,

describing a deficient relationship with the hospital:

I don’t think it’s anything personal … I don’t think they would care if I was there or not, to be
honest. I think that applies to just about every doctor in the hospital. **Cardiologist**

Unfortunately I am employed by some bureaucrat or some minister … This was a hospital for
the community when I started here as a registrar in 1985 and our mandate and our motto and
everything else was to look after community welfare first. Not now. **Physician**

This is not a relationship of allegiance or loyalty between employees and employers: this is
pawns on a chess board being moved around … The purpose of management is to protect
those above, not to manage those below in the health system. And so Hospital A is a pawn
in Area Health Services game, which is largely about the bureaucrats justifying their jobs
and what is forgotten is the purpose of the hospital in providing care for the community.

**Paediatrician**

They don’t seem to care very much. A typical example of this was when I had been working
in the hospital for 26 years, they offered me a certificate to mark my 15 years of service.

**Gastroenterologist**

Medical staff did not consider that they were sufficiently supported by the hospital with
human resources and physical and administrative infrastructure:

This is a really good example, very petty – petty cash. We go to meetings quite a bit and the
parking fees are $6 or sometimes $15. I accumulate the tickets, and my secretary could go to
petty cash … to get the money back but now the doctor has to go personally. Believe me! Apart
from the fact I can’t get to this office (It’s open between 9 and 5 you know … I actually went
there at 10 one morning and there is a sign saying ‘Sorry not open til 1pm today’.) They told
the receptionist that if the doctors have to co-sign getting the money from the petty cash area,
there is … this feeling perhaps they won’t claim as much. It’s kind of amusing at the outset but
then it’s very frustrating. **Infectious diseases physician**

Well, I wasn’t paid for about four months. It made it very difficult. You know, they don’t make
life that easy for you or there is nothing that they make you feel that you’re proud to [be part
of] … So [my relationship is more with] colleagues and the staff you work with … Perhaps if
they gave us a proper office and proper secretarial staff and just actually supported us. **Plastic
surgeon**

Then we get all these emails about what we should be attending … But does anyone say ‘How
can we make this happen for you? How can we give the time? How can we backfill it? How can
we do that?’ Nobody gives a shit about the medical staff. **Intensivist**
In short these speakers are suggesting that they are not treated fairly or kindly by the hospital in which they work (for some up to 26 years). They think this relationship needs more effort – by the hospital!

**INTERVIEW QUESTION**

How appropriate is the amount of communication of change, policies, etc., that you receive from the hospital?

Communication was felt to be poor, and planning barely existent:

> The entire distillation of the problems of this hospital, this health area ... [is poor] communication. Communication falls down all day, every day between everybody ... I just feel like we're ... little groups of people all doing stuff separately. There is no kind of overall driving plan ... There is very little communication between the doctors and non-doctors. **Anaesthetist**

> Well, I see in the media that there is going to be an amalgamation [of certain services] but nobody has come up to me and said, 'Well, this is what its going to mean for you'. **Anaesthetist**

> It's like Brownian motion. There is no planning and there is no foresight and there is no communication. **Gynaecologist**

Brownian motion refers to the seemingly random movement of particles. The picture is of an unsupportive and chaotic organizational environment. One communication problem highlighted was excessive and poor use of email:

> Some communications aren't important and so they appear excessive, whereas sometimes we find out about a major change that is going to occur at the very last instant. **Anaesthetist**

> When something really crucial comes along it's in a thicket of emails that you probably don't read so that most of the important things don't even impinge on my consciousness because they're buried in heaps and heaps of verbiage. **Gastroenterologist**

> Group emails are not proper communication. Centralization activities are just bureaucratic neatness. It's got nothing to do with proper management. It moves just even further away from what's needed in hospitals and that's where people have a real sense of belonging and know that they can go knock on Fred's door and if their pay is not right, you know, all that sort of stuff. **Renal physician**

The focus on email is interesting. I was aware that quite a few doctors refused to give the hospital their email addresses in order to prevent this method of communication. Doctors in NSW receive around one policy circular per week (personal communications). They also receive occasional newsletters with details of organizational activities. This is a very small amount of email for any modern employee, so their irritation seems surprising.
One explanation may be that ‘For some staff the content of policy directives may become like the “small print” on a banking document – what could be described as “white policy noise”, something not for me to read or act on, yet whose existence provides a veiled threat’ (Jorm et al. 2008). Doctors are relatively autonomous and compliance is rarely enforced. Another explanation is that email may also have become the symbol for the loss of ‘Fred’s door’; that is, of far more personal organizational interactions. Such interactions produce both an experience of greater control and more workplace satisfaction.

**INTERVIEW QUESTION**

How appropriate is the level of involvement of the specialist medical staff in the running of the hospital?

Most interviewees found the professional administrators to be of poor quality. The dominance nurses held over hospital administration was also remarked on:

> I think the quality of administrators has been particularly uninspiring. The bottom line is they probably need to be smarter and paid a lot better. *Orthopaedic surgeon*

> Nursing administrators, they’re the ones who hold all the power and call all the shots. And quite a few of us feel quite powerless. *Psychiatrist*

However, there were opposing views on the appropriateness of doctors’ personal involvement in administration. Some thought doctors lacked the necessary skills and that an administrative role conflicted with that of a clinician.

> I don’t think you can be good at both. People try to be, but I don’t think they are, so I think you have to decide if you’re a clinician or an administrator. *Paediatrician*

> I know that there isn’t a lot [of doctor involvement] and I know that the medical staff council perception is that we should have more. We should have a forum to air our views in a reasonable fashion. But, at the end of the day, I don’t think we can run hospitals. *Intensivist*

> I remember when we had medical superintendents and their job was to run the hospital and my job was to look after the patient. Now it’s a blurring of who does what and how we’re supposed to worry about how much it costs, the budget, and so we don’t know where our allegiance lies anymore. I think it is hard to be a good administrator and a good doctor … I’ve never been trained in administration yet I do a lot of administration. *Oncologist*

Yet others thought doctors should do more:

> The level of involvement of the medical staff specialist in the running of Hospital A is inadequate. The doctors are actually divorced from policy making. There are a number of people who are hanging in there, like you and a few other people and we tried to do things … But if I went and asked one of my doctors ‘What do you think the long-term goals of Hospital
A are? [The reply would be] ‘I don’t know’. [If I then asked] ‘Alright, where do you think we’re going to be in three years?’ [I’d be told] ‘I haven’t got a clue’. There is both a lack of willingness to participate and a lack of willingness to engage. 

**Geriatrician**

I think they should be more involved and their role should be more clearly defined and I think we should be paid for administrative work. 

**Orthopaedic surgeon**

We, as clinicians, should take more of a role in making sure things are done properly. It’s easy to say that, to devote the time to it is another issue. 

**Anaesthetist**

Therefore conflicts over appropriateness of management activity for doctors or lack of organizational skills were not barriers for all. The issue for the doctors who wanted to see greater engagement was the lack of roles that supported clinician-administrators (including with time and salary). A recent survey of doctors at the Royal Melbourne Hospital revealed a low level of participation in systems-focussed safety and quality activities (Brand et al. 2007). Reasons given for this included a lack of time and money and a perceived lack of skills in dealing with managers. This led me to question whether or not specialists felt able to influence change in their hospitals.

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**INTERVIEW QUESTION**

Has there ever been a time when you felt powerless to influence an important decision about the running of the hospital?  
What did you do?

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Professional autonomy was clearly not accompanied by a satisfactory level of institutional authority and power for most of the interview subjects. Approximately half of interviewees claimed that they were powerless:

**Anaesthetist**

I don’t believe I have any power over anything. But that is mostly because I don’t think there is a pathway for me to do it. A few times I have wanted to do something not even big, but small, I have not had any idea of the process required to go about it.

**Plastic surgeon**

The medical staff have been marginalized and the hospital is being run by the administrators and the bean counters in order to balance the books. We write letters to people and warn about things that we don’t think are satisfactory. Nothing gets done, no feedback.

**Orthopaedic surgeon**

The system doesn’t allow doctors to make contributions. I mean we all can run our private practices and make them hum and as doctors we feel very proud. But when we step outside of that and try to something similar in, say, the Emergency Department, it’s impossible … [because we are not] given the authority and power to do that.

**Geriatrician**

Oh, for years … I’d go along and say ‘Look we’ve got 60 inpatients. I haven’t got the staff. Help me, help me’, that sort of stuff. And most of the time, they said, ‘Well, there is no money’ or whatever.
The last interviewee on the previous page uses the past tense, indicating he has stopped trying to effect change and that this is attributed to learned helplessness.

On the other hand, about a third of interviewees thought that they could influence change but it was very difficult:

*I have often felt that it isn’t worth what it would cost to bring change.* Paediatrician

*There is always something you can do to try to address change. It’s a matter of finding the right people to help you, the right buttons to push and knobs to twist. Sometimes it feels like a huge amount of inertia just to try and get something very simple done.* Haematologist

A small proportion of interviewees felt readily able to influence change:

*I think if I felt strongly enough about something … you tend to be able to direct it to an area that’s already involved or that agrees. And it’s put forward eventually and so on. So, I don’t feel powerless, no.* Infectious diseases physician

Two interviewees mentioned the pursuit of systemic excellence in their mission statements: there was a part of the organization of work they thought they could control and improve:

*My goal is to ensure that the patients that come through the Emergency Department are provided with the best care that we can afford to provide and the staff who are working there are working in an environment which is supportive, which is safe, where they can do what they’re trained for and they can get satisfaction out of the job.* Emergency physician

A question was posed to interviewees specifically about ‘the system’. This term is used in different ways to describe aspects of health service organization. It could be defined as:

*The logic of work practices, the cooperative orientation of cross-disciplinary relationships, the interdependence of many health services and their products, and the centrality to clinical safety and quality of organizational management.* (Jorm et al. 2006)

The safety and quality movement has also equated ‘learning from error’ with ‘fixing the system’. The use of the term ‘the system’ represents a deliberate effort to allow clinicians to learn from error by de-emphasizing personal responsibility and thus reducing blaming and shaming.

**INTERVIEW QUESTION**

It has been said by others: ‘I give good care, but the system often lets patients down.’

How do you feel about this? Is this true in your case? Would you like to be more involved in improvements to the system? What are the barriers to this?
There was a minority view that the system was functioning well:

The system in general provides good care. A sick patient will be seen reasonably on time. If they need to go to theatre, they go to theatre. If they need to go to ICU [Intensive Care Unit], they go to ICU. And there are the hiccups in the process … but when you're looking at 47,000 patients a year, the percentage of patients actually being let down by the system is very small.  

**Intensivist**

However, two thirds of interviewees thought the statement was true and that the system prevented good care:

*I think the system is falling down and falling apart with inexperienced people and bandaid solutions.*  
**Plastic surgeon**

*I think most doctors feel that way. They try to do their best in their little niche but they struggle to make contributions. The system doesn’t allow them to make contributions.*  
**Orthopaedic surgeon**

Some were willing to go to remarkable (and exhausting) lengths to subvert the system:

*Every way in which I can see that the system is going to possibly fail, I just work my way round it. I am not prepared to say that I couldn’t work out the system enough to protect my patients from it: I’m not prepared to say that. I won’t do that. I’ve worked a way round a lot of the things that have holes in the floor that people … slip through and I just plug the holes up.*  
**Gynaecologist**

The expectation of failure and thus a culture of doubt and scepticism is one of the important properties of ‘high-reliability organizations’, like aircraft carriers. Such organizations manage to carry out risky work with a high degree of safety (Weick 2002, Schulman 2004). The gynaecologist above had this scepticism and cared enough to try to secure his patients’ safety in this system.

Some doctors acknowledged that as a professional group they could do more:

*I think for the most part that often is the situation. We’re probably deluding ourselves if we don’t think that part of giving good care is trying to improve the system. I think we insulate ourselves from the difficulties in the system by saying ‘Well, all I can do is what I am doing right now because I can’t control those other things’.  
**Anaesthetist**

*I think that’s true. I think there’s only so much that you can do as an individual to ensure the care of the patient … but I think every anaesthetist in particular could do more as an individual. The idea of giving some sort of perfect … anaesthetic and then leaving the patient to the mercy of the system where you know junior people are left to look after the patient … [is unacceptable]. The system does sometimes fail but we just have to keep working to improve it.*  
**Anaesthetist**

The last speaker showed an insight that there is a need to consider patient care beyond the quest for single specialty perfection. It is less clear whether doctors are provided with
the skills, tools and mechanisms to enable them to do so. Clinicians may feel little control over the relationship between themselves and the system in which they work, but they do feel responsible for their patients. This situation can place doctors in a state of tension and moral conflict (Little et al. 2003).

While some interviewees managed this tension by distancing themselves from the system, some denied there was a moral conflict at all. Rather they saw a moral responsibility to act:

*The main person responsible for the care of my patients is me, so if there are potential problems in the system for providing care for the patients, I just need to be there more frequently.* **Paediatric surgeon**

No, it’s not the system. It’s the people. People blame the system but people lose sight of the fact that they do not put in the work. That’s the problem. People clock on and clock off and … don’t come in and see sick patients and patients are sicker and sicker and sicker … Despite a system that is terrible we should be able to rise above it. Night residents don’t hand over and there are no rounds … I don’t think it’s fair to blame the system. I think it is the individuals. **Rheumatologist**

As a geriatrician we are the system. Good care is systemic. It’s longitudinal … So if I make a good diagnosis, I don’t pat myself on the back and walk away … I’ve then to do the next step and that’s treatment and the next step after that. And so, we are the system and giving good care has to involve the system. Now there may be difficulties with other people handing over … but it’s something we have to work with … So I could say, look I’m delivering good care but [community services are] … not my problem. But, in fact, it is my problem and so I’m whinging and whining, to engage, to fix up the problem because I feel it is my responsibility, this is my field and my patients. **Geriatrician**

Two different interpretations of ‘we are the system’ are thus given. The rheumatologist and the paediatric surgeon quoted above believe doctors should work harder to protect their patients. Contrary to other interviewees, they see the system as being defined as the care given by doctors. The geriatrician, on the other hand, while accepting a personal role in the system, is also wrestling with other components of the system to seek better care for patients. He sees it as the doctor’s role to be engaged in this broader task.

The extract below shows the conflict implicit in assumption of responsibility for patient outcomes. The senior doctor understands the many participants involved in patient care but feels solely responsible for the work of other team members over whom he would have little control:

*I think you’ve got to take full responsibility … There are times when the registrars or residents make mistakes or the nursing staff … but we’re part of a team and if the team fails we let the patient down. We’ve all got to take responsibility for it.* **Gastroenterologist**

A few interviewees gave reasons why doctors were not more involved in improvements to the system. These included a lack of authority, energy and time:
You just stress out because there is just too much to do and you can't do it all. So it's trying to get the balance and ... cope. It's all about coping and being happy with your life really.  

**Anaesthetist**

The doctors often objectified and in many cases distanced themselves from the system (Jorm et al. 2006). Interviewee responses contained highly physical language including such terms as ‘niches’, ‘holes’, ‘something to be got around’ or ‘something to rise above’. This language seems to represent their frustration. They definitely see the health system problems; sometimes they see solutions, yet are unsure how to engage:

**Interviewer:** It sounds like you’d like to be more involved in some of the systems stuff?

**Anaesthetist:** Um ...

**Interviewer:** Theoretically.

**Anaesthetist:** Yes, theoretically. If, if I felt there was a system that was truly trying to analyse what was going on .... there should be all players involved and then when you decide to make changes you monitor it and see how it goes. Also you shouldn't have to reinvent the wheel each time ... The other day I was in the operating theatre and thinking how silly it was that the phone was above where the sterile gowns and the scrub sister were. I just laughed at it. It’s so stupid. If I go near the phone I might desterilize the gowns. And I thought we’ve been building modern hospitals for 40 to 50 years. Surely someone could have designed an operating theatre that was shaped the right shape, and the phone was in the right spot, and we just keep building them. Instead, every time we build an operating theatre we make it up and parts of it don’t work. We shouldn’t have different systems everywhere in all hospitals as, for a large part, they pretty much do the same thing. So there should be some effort to try to do that, so a system that had all those things in it and then I would plug into it at the appropriate spots.

**Interviewer:** Yes. With your observations and knowledge.

**Anaesthetist:** And whatever I wanted to do.

**Reasons for Problems with the System**

Reasons for system problems were proffered, although this was not specifically asked of interviewees. This was the only question that led to a discussion of nursing, its importance and its problems, including shortages in nursing numbers, loss of nursing skills and dedication, and inadequate teamwork with doctors.

[Years ago] you saw every patient with the charge sister in the morning. You told them you expected everything would be done expertly and when you turn[ed] up at the ward you probably expected that the charge sister knew a hell of a lot more about looking after plastic surgery patients than you did and if you had a problem you asked her. No one has a plastic surgery
ward anymore, they're all amalgamations. Half the nurses are agency staff and have no idea what they're doing. You feel the standard of care is sort of slipping out. It's not that you need to make improvements. It's just that we have to stop losing ground. You know it goes back to the system which may not have been perfect but was certainly able to reliably and consistently produce what is perceived by most people as better outcomes. More reliably, more consistently ... I don't think we need improvements, I just think we need to stop the slide. Perhaps we need to go back up the slippery dip a bit. **Plastic surgeon**

More and more of a problem is lack of nursing staff to run things. We are going to be facing a huge crisis. The average age of nursing staff is 45. **Gynaecologist**

Nurses doing ward rounds with doctors – that's a thing of the past ... I'm not interested in me being at the top of the pecking order and putting these people down. I think you get a lot of good interaction with the nurses. In the Coronary Care Unit they know me and I know them and so that's quite rewarding and they get something out of it too because they have patient concerns. But up on the general wards they don't really know who you are because they're all coming and going and they're agency staff and I think there is too much writing on clipboards for the nurses. So if you go up there when they're doing their handovers or whatever, they just totally ignore you. So I think that is a systematic thing that probably can only be changed by reinventing the culture [and] probably employing more nurses so that they have time to get through all their work and talk to the doctors. **Cardiologist**

Reality is that the nursing staff treat the patients 24 hours a day ... We might see a patient for five minutes on ward rounds if they're lucky twice a week. We're there very seldom. You have to be unwell and once you are you realize the important players are the nursing staff. They are undervalued, underpaid. Working conditions are bad for them and we're just losing nurses everywhere. They are overworked and demoralized. The nurses are our most important resource. **Plastic surgeon**

While blaming poor-quality administrators and administrative practices was common, there were some intriguing nuances to this view. One even suggested doctors were at least partly to blame for the politicization of health:

> I think the Federal–State system is the biggest impediment to changing the culture in medicine. At the next level below that, the politicization of medicine produces a reactionary process rather than a planning process and that has been caused by doctors saying ‘If I can’t get what I want I will go to the press’. For the last 20 years the doctors have been doing that. How could you have justified a liver transplant before Hep B vaccination? Doctors are very good at justifying what they’re interested in doing. **Paediatrician**

Complexity was suggested as a problem:

> I suppose the system tries but ... the larger any system is, the more imperfect it’s got to be. **Emergency physician**

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1 Liver transplants are costly end-stage procedures, whereas Hep B vaccination saves many from chronic disease and liver failure.
However, poorly coordinated administration was a bigger issue. While some ‘bad guys’ were identified in the distant State Health Department, the true problem was the lack of a shared goal:

*Oh, I think the system is a disaster. It’s got a public service mentality. … The Department of Health is basically completely alienated from the local people. Therefore, the structures they set up and the demands they make on the local administration are often unrealistic and bound to fail. The local administrators … [there are not] a lot of them, and they work quite hard to try to do the right thing, and the people in the hospitals work reasonably hard … It’s like having a football team, where nobody knows exactly who is in the team and what they’re supposed to do. You can work hard every week, and get beaten 80–0 every week.*

**Rheumatologist**

The fact that bureaucrats do not know what good care looks like is compounded by the doctors’ inability to clearly determine and influence those responsible for hospital processes (and to direct or performance-manage staff):

*You have a problem with responsibility and lines of responsibility and that is counter-productive because you can’t change anything quickly. And if somebody says to do something, it takes so many people to convince before it happens.*

**Rheumatologist**

*In private practice where you control who you have working for you … everybody’s got an incentive to work hard. Then you come and work in a system where you’ve got people who don’t regard you as their boss and have a different agenda for their speed of work or whatever. So you get through half the number of patients and the patients don’t necessarily get treated as well as you would like.*

**Dermatologist**

Recently, the views of Swiss doctors and nurses on how to achieve quality health care were sought. Personal and professional qualities of practitioners were considered central, namely technical competency (aided by continuous self-reflection and evaluation), personal motivation and willingness to collaborate (Hudelson et al. 2008). Both administrators and the system were seen as barriers to quality care. Their opinions paralleled those of the Australian interviewees. As the authors of the Swiss study noted, this is at variance with the model developed by quality experts, which has at its heart a systemic-process-oriented vision. Systems thinking has not come easily to clinicians (Henriksen and Dayton 2006). For a variety of reasons, most doctors simply did not see themselves as part of the system. The negative and distancing views that doctors hold on hospitals set a limit on healthcare improvement and are a problem for their own psychological health. One said:

*My energy and missionary zeal and vision are diminished. … Building things to maintain that rage over 25 years is not an easy task.*

**Emergency physician**

Doctors should not need to produce rage to deal with the system in which they work.
Can you think of a couple of big-picture things that would really improve the health system of NSW?

The safety and quality movement has been criticized for creating a broad definition of the health system that includes the political context, funding mechanisms and institutional structures, yet confining work to a narrow suite of problems and focussing on errors in small systems (Jensen 2007). Despite their general negativity and personal impotence with regard to the ‘little’ system of their own hospital work, many interviewees understood the bigger system and had ideas for its improvement in areas far outside their own practices. Most responses suggested removal of inequities and inefficiencies, particularly those associated with State–Federal overlaps. The following list of issues nominated by the interviewees illustrates a marked social conscience:

- reducing the use of legal drugs
- improving population health literacy
- better funding of nursing homes
- improving community services and indigenous health
- better training of nurses
- revaluing general practitioners
- getting specialists and general practitioners to service areas of need
- improving trauma management
- managing public expectations of health care.

The last was an interesting point:

*The average patient comes in saying, ‘I pay my taxes … This is what I am told to expect’. And they’re not getting that expectation and I think that’s a big problem and they need to either match the reality to the rhetoric or they need to come up with a different reality.*

**Paediatric surgeon**

Waste in the delivery of patient care was identified.

*[We need a] universal medical record number. The cost would be retrieved within a year from radiology and pathology costs and would avoid so many unnecessary problems in terms of continuity of care.*

**Haematologist**

*If the politicians just knew how much funding we misuse … although we’re all crying out for funding. There is no justification for how much any doctor can spend. That frustrates me hugely. If you get a consultation from a rheumatologist or an immunologist … they want three things that cost probably about $1,000 in tests before they even look at the patient. That sort of stuff drives me crazy. I think there should be some sort of way of having tighter control on expenditure, particularly investigations.*

**Emergency physician**
Waste in the administration of health care was also identified. Federal funding of hospitals was advocated by nearly half the subjects:

*The cost that's in administration and duplication of services, we could really make big savings there and put that into services ... right down to the level of improving patient treatment in the home.* **Infectious diseases physician**

There is an enormous amount of wastage in the multi-tiered system. It’s Federally funded and State-run and the organization of the Area Health services is flawed and ineffective ... On a smaller level, the organization of the hospitals is ineffective because of the way the health systems tell them to function. Hospitals need to be Federally funded and Federally run and they need to go back to a hospital-based administration that understands each hospital and which is answerable to a person or an organization of just one tier. **Colorectal surgeon**

The NSW Department of Health received major criticism:

*I think that, having worked quite a bit with the administration at ... [the State Department of Health], the best thing to do with that, as it can't be changed, is it just to make it redundant.* **Rheumatologist**

*NSW Health pours money into the top and hopes it trickles out at the bottom.* **Gynaecologist**

It was felt that hospital administration needed improvement and many thought greater involvement of medical staff would effect this. The interviewees were keen for ‘other’ doctors, at least to hold such dual roles:

*If the medical specialists were engaged more in the running of this hospital and ... they said 'Here's the money. Now you have to prove to us that you're using the health dollar efficiently and we'll throw more at you because you're an efficient user of that ...', then we’d get people interested. I mean, clearly clinicians in this hospital would like to have large departments that are well run and well staffed and are more inclined to work towards that if they had more direct responsibility ... At the moment, there is a tendency to ... turn up and do your bit and go home and not invest yourself in it too much because, at the end of the day, you don't have any control over it.* **Anaesthetist**

*I'd say that they should make it [medical administration] more attractive to people with a medical degree to do ... [S]ay to people, 'Look you can come and do a medical admin thing ... free of charge and then take up a role in admin for five years, and ...[then] go back to your clinical duties.'* **Gynaecologist**

Better knowledge management and a greater focus on outcomes were advocated:

*I would like to see more communication of things that have been achieved ... Something similar might have been in place for two years or ten years at another hospital and you just don't hear about it.* **Anaesthetist**
I think the only way you can improve things with the big picture is actually look at outcomes.

**Obstetrician and gynaecologist**

The UK-based policy group, The Kings Fund, conducted focus groups with more than 400 doctors and commented in 2008 that:

*First, the skills of management need to be properly appreciated and respected whether or not they are carried out by doctors. It is becoming increasingly clear that doctors cannot fully exercise their professionalism unless they understand what managers do … Second, medical professionals will almost always need to undertake some aspects of management as part of their own work and there is no reason to see this as an area for amateurs.* (Levenson et al. 2008: 36)

While it was agreed that both undergraduate and postgraduate management training was needed, interviewees were unsure what should be included in this training. They were also unsure how the integration of clinical and management responsibilities should be carried out. There was concern that individual doctors who become managers could merely ‘find themselves as part of a management culture that continued to fail to relate to fellow clinicians’ (Levenson et al. 2008: 33) However, if such training were provided, doctors might understand more about competing priorities.

A few interviewees suggested radical re-thinking about the organization of medical work:

*The closed shop mentality [needs to go]. [For instance] in orthopaedics I find a monopoly, you can’t get them to do things that are sensible to the rest of us or have an impact on their personal income … They come up with a fee and there is nothing we can do about it … [We need to] have the ability to not be dictated to by the craft group, but by what the patients require.*

**Emergency physician**

A lot of the things we do are really, really strange. Why would it not be that at night time in the hospital there was a consultant anaesthetist, consultant surgeon, consultant obstetrician, consultant cardiologist all in the hospital working? It makes no sense to me that at the time when things are most difficult we put the most junior people there. But with medicine you’re talking about huge long training times and huge long careers and dedication to location … [There is an] incredible amount of inertia.

**Anaesthetist**

Political Pressure and Media Scrutiny

Doctors in Australia are the subject of intense media coverage. The press had amplified allegations of poor clinical care at the outer metropolitan hospitals of Camden and Campbelltown hospitals in outer Sydney. Those allegations had been the subject of no fewer than six investigations and considerable local publicity in the year preceding the interviews (Pain and Lord 2006). The media ascribed poor-quality care to the lack of adequate medical and nursing staffing and inadequate specialist expertise. The allegations and the media hype came to nothing. In all cases referred on to the Medical Registration Board, the doctors were exonerated. The adverse event
rate eventually proved similar to that of comparable Australian hospitals (Pain and Lord 2006).

Apart from the media, some interviewees identified the political drivers at play, and these Sydney-based doctors were appalled by the practices of the State government:

Part of the problem is that the Government gets elected every four years and Health Minister changes every two years and I don’t see much foresight … I don’t see anyone with a master plan for where this whole system is going to be in twenty years. I think there is a master plan for how much we’re going to lie about, how we can bandaid the figures up to for the next election … All of a sudden, six weeks before the [election] they were bussing people up from the Illawarra to clear waiting lists. I find this morally reprehensible. Plastic surgeon

The health system should not be managed according to marginal seats. Renal physician

In the UK, it has been suggested that constant politically driven National Health Service (NHS) reforms have produced not just disengagement of the medical workforce but ‘learned helplessness’ (Smith 2005). Leaders expect traditional medical virtues from doctors such as self-sacrifice, compassion and integrity but, at the same time, these leaders show bias in the allocation of resources and focus on their own professional interests and promotion. They show hard-heartedness toward staff problems and a lack of integrity in manipulating financial and performance data. They spawn a corrupt moral culture in health (Chervenak and McCullough 2001).

The situation in NSW degraded further following these interviews. September 2009 marked the appointment of the fifth health minister in five years. Some suggested that the public needed to be better educated, to be more realistic about the limitations of medical care and the hospital system. Unfortunately, the interaction between the Department of Health and sensationalizing media is such as to encourage concealment rather than openness:

It gets frustrating for people who are in the health service … because so often we get patients who will tell me … ‘This has been a great hospital and things have gone really well’. I tell them to write a letter or ring the hospital … [to tell them] you’ve had a good experience because that doesn’t get reflected in the media. Rheumatologist

When patient issues are identified it is very difficult for them to be discussed in a public forum in an open even-handed way because they’re either muzzled by the hospital or the Health Department and so it … sneak[s] out the back door and into the press and then gets sensationalized or it’s not brought up at all … There needs to be a better way of dealing with that. Paediatric surgeon

Media clamour adds to the anxiety suffered by all doctors as they understand the considerable uncertainty associated with medical care. Justice is a pervasive concern in workplaces, and people care about both fair outcomes and fair process (Weiner et al. 2008). For instance, clinicians will not report incidents to incident-reporting systems without fair treatment (Weiner et al. 2008), which has implications for the success or otherwise of the new registration requirements to report dangerous colleagues.
The media treatment of patient safety issues is frequently unfair, as are the political responses. The increasing intervention of ministers in operational details of public service is a problem in Australia at all government levels. The politicization of health in Australia means that deaths from meningitis now require a minister to respond, with politicians providing their own clinical commentaries:

The death of eight-year-old Israelu Pele has thrown the embattled NSW public hospital system into the spotlight, with doctors admitting he was not tested for the disease that killed him.

Israelu was sent home last Sunday by doctors at Bankstown Hospital who told his parents to give him painkillers and lemonade. The hospital recorded his symptoms, included vomiting, fever and headache. Up to four senior clinicians reviewed his condition over nine hours at Westmead Children’s Hospital the following day, but he was again discharged. Israelu died the following day, having never been tested for meningitis.

Less than one week after the release of findings from a parliamentary inquiry into standards at Sydney’s Royal North Shore Hospital, Health Minister Reba Meagher was again in the firing line. Promising a full coronal inquiry, Meagher described the death as a ‘tragedy’ …

Westmead Hospital chief executive Tony Penna today defended his staff … ‘If every child showing such symptoms were given a lumbar puncture, which is the only way to test for meningitis, staff would be taking spinal fluid “every other hour”,’ Dr Penna said. ‘This illness can progress quite rapidly and they can present early on with non-specific signs’ …

Opposition Leader Barry O’Farrell said it was another ‘unwelcome insight’ into the state’s underfunded public hospitals … ‘This is every parent’s nightmare: a serious but treatable illness affecting a young child … They are turned away (from hospital) and the child dies.’

Opposition health spokeswoman Jillian Skinner said the death underscored the potentially fatal consequences of underfunding of the health system. ‘If [the hospital] had enough resources, this child would have been kept there for observation, and then when things really took a turn for the worse he would have been right on the spot for treatment,’ Skinner said. (AAP 2007)

Bad news sells papers and destabilizes government, and so it is hard to imagine change to a different, more open and less adversarial approach in public debate about health issues.

In contrast, the Minister for Health stated, in relation to criticism of hospitals’ failures to meet triage benchmarks, ‘In NSW, there are almost 200,000 unnecessary hospital admissions each year’ (Wallace 2009). 2 The Minister has found a new scapegoat – unnecessary hospital admissions. It is a cold and retrospective view that declares many admissions ‘unnecessary’ when distressed patients arrive at hospitals and clinicians are uncertain of diagnoses (as in the case of Israelu). There is a point, in such a climate of unfairness, where the doctor might be considered foolish to choose a leadership role in health care.

The doctors felt their hospitals to be unfair and disrespectful in treatment of both themselves and their patients. Employees’ shared perceptions of safety policies and

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2 It is stressed that the Minister did not make this statement in response to the Israelu Pele story.
procedures influence their level of participation in patient safety improvement (Weiner et al. 2008). Many of the interviewees expressed very negative attitudes about hospital organization but had been or were currently engaged in management and improvement activities. (And if you remember, a large number were prepared to participate in writing treatment guidelines without pay.) However, if the question was asked whether there is a medical interest in ensuring better care, then the answer is clearly ‘yes’. Without changes in training and attitude, the system will clearly continue to alienate Australian doctors. They are aware that their individual efforts cannot ensure a safe outcome for their patients, yet they are not central to the organization and management of care.

Another way of thinking about both organizational citizenship behaviour and the relationship between doctor and hospital may be to consider the fact that we live in a world where both social and market norms prevail (Ariely 2008). Some things we do for free – for instance, help a neighbour move a sofa – but some things we expect payment for. Introducing market norms inactivates social norms. For example, if you offer a small amount of money to a passer-by to help with the sofa, the individual who would have done it for nothing declines (Ariely 2008). Social norms can provide cheaper and more effective ways to motivate people than offering money. Once social norms are replaced by market norms it is very hard to turn things back (Ariely 2008).

Gifts are a symbolic gesture that allow an acceptable merger of social and market norms (Ariely 2008). Gifts are part of a relationship, hence the gift-giving tale that begins Chapter 8. This explains why the absence of gifts was mentioned by one doctor:

You never get any recognition. ... All of us, always at the end of the term try to say thank you to the residents ... [but] never once does the hospital say ‘Thank you for your teaching and here is a bottle of Bollinger’ or something like that. They only phone up to whinge about some aimless lot who wants to make a complaint ... They have no time for the staff [for instance they won’t] create a reasonable facility like a meeting place. **Endocrinologist**

The interviewees’ comments suggested a deep understanding of the communicative and affective nature of institutional health care. There is a loss of known people and places – ‘Fred’s door’, senior expert nurses, the plastic surgery ward. It was once an environment where:

*Everybody knew everybody in the hospital and all pulled together ... There was a time when if somebody stuffed up [made a serious error] everybody in the hospital would know about it and maybe feel partly responsible. **Neurosurgeon***

This loss is of relationships between doctors and the hospital. Without these relationships doctors are alienated from the hospital system and cannot and will not work to improve health care.

It is conventional wisdom in organizational psychology that the longer an individual continues with an organization the stronger his or her commitment becomes. However, many of the most alienated doctors are the most senior in age and length of service. They complain of a lack of both organizational appreciation and support. There is little trust in their relationship with the hospital.
Organizational identification and cooperative behaviour are fostered by formal and informal communication such as newsletters, team meetings, social events and hallway conversations (Apker et al. 2003). In hospitals the opportunities for communication are diminishing. Reasons volunteered included work intensity, lack of meeting places, rotating hospital administrators and the use of group email. The failure to provide offices, research and secretarial staff were also viewed by doctors as indicators that they were not valued by the institution in which they worked. Their isolation within the institution was heartfelt. This is exemplified by the following exchange, the last line of which is particularly poignant:

**Physician:** You can walk around and the nursing staff don’t know who you are, the admission staff don’t know who you are, and you go up to Casualty and nobody knows who you are and I don’t know who they are either because there is nowhere you can meet and those sort of occasions don’t exist. So …

**Interviewer:** So, you wouldn’t have seen me in a long time.

**Physician:** That’s true.

**Interviewer:** And I’ve been working here for 10 years. And see, that’s a symptom of it, isn’t it?

**Physician:** At Sydney Hospital there was about 500 beds and you sort of ran into everybody and you couldn’t avoid anybody. This place, because [of its size and especially because of ] the Private Hospital … it’s all over the place, and there is no place really to meet. I don’t want to necessarily come to Friday afternoon drinks but occasionally if I passed you at lunchtime if there was somewhere …

**Interviewer:** If there was a nice place to eat lunch, people might all lunch together.

**Physician:** There was quite an amazing part of Sydney Hospital … [which was a doctors’ common room/cafeteria]. … There has never been anything like that.

**Interviewer:** Never been anything like that.

**Physician:** Somebody [some doctor] could die in this place and none of us would know.

The doctor’s world is all-absorbing: physically, with incredible hours worked; intellectually, with the vast amount of knowledge to be manipulated; and emotionally, with their daily work with uncertainty and the close relationships they maintain with patients.

Change is avoided and doctors turn their attention to a life within the confines of their profession. Despite the atmosphere of crisis created by the safety and quality movement, doctors are beset by doubts and feel rejected by the system where they should be leaders. Political intervention and media clamour only accelerates their feelings of rejection and disinclination to act.

*Is this alienation between doctors and the health system that has been described a minor matter, or does it require urgent care?  What treatment is possible?*
Case Summary

The challenge presented by the safety and quality movement remains unmet. The apparent contradiction between doctors’ care for patients and their lack of involvement in patient safety and quality issues was amply confirmed by the research. For their ‘own’ patients the doctors were prepared to make every possible effort, while acknowledging the detrimental effect this had on the quality of their own lives and those of their families. Although doctors cared deeply about their patients, their actions to increase safety in the health system were limited.

Responses to the scenarios revealed that speaking or acting to control the behaviour of a colleague was extremely difficult. Some would try, many would not. Even evidence of the risk of infection to patients counted for little if it could involve risk to the collegiate bonds among doctors. Keeping other doctors as friendly colleagues was considered absolutely essential for patient care. Colleagues were crucial for both emotional support and for practical aspects of patient care. That the retention of trust and easy communication is critical for quality patient care in a world of subspecialists has rarely, if ever, been previously discussed or considered. The doctors were insecure – anxious about their own competence and seeking confirmation of this from colleagues. They even sought it from the colleague interviewing them, as shown when a plastic surgeon said ‘You know I like to do things properly’. The delicate self-esteem of doctors appears rooted in the uncertain nature of their work. The study that stimulated the writing of this book verified in a contemporary Australian context the centrality of uncertainty to medical practice.

The doctors did not rail against the difficulties created by uncertainty because in general they were totally committed to the nature of their work – the intimate relationship with patients and their responsibility and ability to help. Relationship bonds with patients are central to doctors’ satisfaction and pleasure in their work, but limit their ability to face up to error. The doctors who were the subjects of this study lamented a loss of colleagueship and organizational engagement.

Doctors who see their roles as being to ‘flog a derelict system to get the last breath of workability out of it for their patients’ are not working to improve the system. Changes in work patterns and physical circumstances in hospitals have made doctors lonely. There is a loss of ability to know how to mentor younger doctors. Doctors are unable to describe or imagine the correct ways to act and feel in the future. The linkage of one’s internal stories with the stories of others – now, in the past and (hopefully) in the future – is part of the creation of the collective identity narrative (Currie and Brown 2003). Without
self-identity there is the risk of professional disintegration or personal meaninglessness. While the conclusions drawn are based on data from fewer than 100 specialist doctors in two public teaching hospitals in one city in Australia, I believe there is ample evidence in medical sociology (Becker et al. 1963, Fox 1957, Bosk 2003, Rosenthal 1995, Rosenthal 1997) for those conclusions to be generalized beyond hospital, State and nation.

A Critical Situation

It has been suggested that one of the features of modernity itself is that risk is central to how we view the world (Giddens 1991: 3). A study of Australian newspaper coverage and government statements on pandemic influenza concluded:

We encounter a vision of public health which hinges less on the health of the population and more on the nation’s capacity to continuously anticipate and successfully respond (or rehearse responding) to disasters. Seen through the lens of newspaper coverage, it seems that health is currently being securitized in a new fashion with little in the way of comment. (Stephenson and Jamieson 2009)

Details of healthcare disasters are widely promulgated by the media. Some give the news media credit for shaming the medical profession and making patient safety a priority (Millenson 2002b). However, recent commentary on patient safety notes that ‘despite five years of focussed attention, people do not seem to feel safer’ (Altman et al. 2004). Indeed, many are dissatisfied and feel unsafe. It could be hypothesized that the result of the five years of focussed attention and attendant publicity has only been an increase in public anxiety!

The confidence of the Australian public in the health system is generally low, with only 24 per cent believing that the health system works well, 55 per cent suggesting the need for fundamental changes and 18 per cent advocating a complete rebuild (Schoen et al. 2007, Schoen et al. 2008). Despite doctors personally maintaining a relatively high degree of public trust (Hardie and Critchley 2008, Calnan and Rowe 2004, Calnan and Sanford 2004) – compared with hospitals, insurers and the system in general – they are alarmed by changing patient views (Clever 2002). Subjects described this:

There has been a change in the public … over the last ten years where they are now very critical of anything that goes wrong. Plastic surgeon

The misconception [is that doctors are] making millions of dollars, drive Porsches, live fantastic lives. And the facts … [are that we] stick our fingers in peoples’ bottoms, have no breaks, drive average cars … come home stinking … I think that 10 to 15 years ago there was a little more understanding or a little bit more respect whereas … we’ve been torn apart and shredded by the system, so we’re just another government employee who’s not doing a good job and getting overpaid for it. That’s a lot of public perception of what a doctor is today. Emergency physician

The demands on health care in Australia are rising. The ageing population, with its associated financial and service delivery pressures (Productivity Commission 2005a), and advances in medical technology (Productivity Commission 2005b) are already impacting
on the types of care and carers required (Nancarrow and Borthwick 2005). The changes that will be required in health care in response to increased demand and complexity will be profound and fundamental (Armstrong et al. 2007).

The opinion of doctors to the following question was sought:

**INTERVIEW QUESTION**

If I give you three statements, which do you think is most true?
– The best time to be a doctor is now.
– The best time to be a doctor was 10 years ago.
– The best time to be a doctor will be in 10 years’ time.

Why did you choose this answer?

Forty per cent felt the best time was the past, 50 per cent chose now or were equivocal and only 10 per cent selected the future. For those who chose now or the future, altruism was evident, refuting claims that doctors have an inevitably self-serving approach to tradition and the status quo (Askanasy et al. 2004: 285). The existence of scientific advances that helped patients was considered to outweigh deterioration in personal working conditions:

*What we can now do is very exciting in terms of the tools we’ve got in our tool box. Twenty to thirty years ago they didn’t have the same tools so it was a lot harder.* Plastic surgeon

*Technology has improved. It’s just amazing and fantastic the sort of things that have happened in my field and the basic science research that has led to amazing discoveries … You’d hope it would continue.* Infectious diseases physician

*A lot of things have changed that have made doctors’ life much more unpleasant, so probably I suppose you could say it would be better 10 or 15 years ago. The thing is we know so much more now and there are a lot of new avenues opening up. I wouldn’t want to go back.* Gynaecologist

Those who were equivocal considered there was an enduring satisfaction associated with being a doctor that countered the new stresses:

*I now reject a lot of the pessimism about medicine. The problems will change and vary, but the actual medicine will be pretty much the same and that the majority of people in specialist medicine will be happy in it in 10 years’ time just as they are now, and just as they were previously. You know you adapt to problems, like we’ve adapted to the deterioration of the public health system which I find quite distressing sometimes, but often I’m just as happy in a day-to-day basis working within it.* Colorectal surgeon

*Frankly, I think any time is a good time to be a doctor even if there are the terrible distractions and challenges we have at the moment. There are always people in need: there will always be satisfying things to do no matter how difficult it is to achieve those outcomes.* General surgeon
Many doctors were nostalgic:

*I have enormous overheads in my practice and you can’t afford not to see patients because if you stop seeing them, you don’t get paid and you go broke … The pay you get compared with our predecessors is really very much lower, so most of us are working too hard, seeing too many patients just to meet demands of running a practice … My practice costs me $300,000 a year to run … I’m always running around like a blue-arsed fly working long hours … You need the time off but you can’t afford to take the time off. So, I’ve been working here for 20 years and in 20 years I’ve had a single six-week holiday. The rest of the time has been one week here and one week there. Because you’ve got to make sure the patients get looked after. The system doesn’t allow you to have a proper break.* **Oncologist**

The golden era of medicine was when we passed the dangerous part of anaesthesia and surgery … We had the multi-blood analysers: we knew about pretty much every hormone that had an important physiological function. The only thing is we didn’t have was EBM, but all the major diseases and syndromes were defined. Open-heart surgery was happening and there were plenty of beds. You could put a patient in the hospital for a fortnight if you wanted. Nobody would be complaining … [and so] there was good teaching for students. You had the best and the brightest coming in as students. You had a fantastic nursing profession. We didn’t have the problems of the ageing demographic … It was certainly a time when people thought that medicine was going to go up and up and up. I think it’s sort of reached a bit of a wall at the moment. Bit like the space programme, isn’t it? **General surgeon**

Practitioners are anxious and see the current system ‘falling down and falling apart’ under pressure:

*It’s going to be very, very difficult to practise largely because there is going to be an increase in elderly population and decreasing support services. You won’t have the nursing staff.* **Gynaecologist**

*I feel that each year we are getting closer and closer to collapse.* **Physician**

*The workloads and the demand for us as a profession are going to get higher. The remuneration is probably going to get less and I just can’t see any of the practical issues getting any better.* **Haematologist**

The doctors tended to be angry, dissatisfied and non-cooperative with institutional management. Both managers and management are viewed with hostility:

*We lost the old days when you had a medical director who was a doctor … You have to find somebody that everybody respects and also who has a handle on what’s going on … It’s become much more of a bureaucracy run by managers rather than people.* **Focus group member**

From the above it seems the manager belongs to a separate species – perhaps subhuman! The doctors speak of ‘working to rule’, omitting voluntary addenda, and taking legal recourse:
I will do things for free for patients but I’m increasingly hacked off being asked to do things free for the system. **Focus group member**

The progress over the last ten years towards improving the safety and quality of health care has been disappointing and doctors’ engagement in these efforts unsatisfactory (Iedema et al. 2006c, Jorm and Kam 2004, Wachter 2004, Leape et al. 2009). While doctors may not wish to see themselves as part of ‘the system’, they are undeniably part of the system, and their dedication, perfectionism and drive to achieve the best possible outcomes for their patients make them crucial for creating good safe health care. Alienation of this group and their increasing loss of shared identity (and its associated values and behaviours) will add dangers to patient care that cannot be replaced by surveillance, rules and regulations.

**Treatment**

Is reconstruction possible? My research initially led me towards a negative conclusion. I concluded that central features of medical identity were incompatible with organizational engagement. However, I now believe that the two major limitations on medical engagement are external to doctors and are remediable. The first limitation is that some of the measures intended to promote quality and safety do not serve to develop the highest standards in health care. This will be discussed shortly.

The second is the low standard of organizational management in health care. This is discussed in more detail later in this chapter when solutions are proposed. In part, the quality of healthcare management does not match the size and complexity of the task. However, there is a fundamental failure when management structures are unable to direct the intellect, energy and passion of doctors towards improving the quality and safety of care.

The modern hospital lacks clear lines of responsibility and limits the authority of medical staff. A study of patients with gastrointestinal bleeding showed that there is a problem when ownership (as perceived by doctors) and responsibility for the patients become decoupled (Hewett et al. 2009). A range of specialists can be involved with these patients, in particular emergency medicine, general medicine, gastroenterology and intensive care. The result of this decoupling was that there were sometimes considerable delays in these patients receiving an endoscopy and definitive treatment. Specialist emergency doctors interviewed in my own study felt they were held responsible for decisions made by other medical staff and they were frustrated at being forced to participate in non-evidence-based care ordered by other specialists. Other doctors I interviewed missed ‘my ward’ and ‘my clinic’.

The implications of these conflicts and tensions for patient safety are significant. Doctors do not see themselves as accountable for implementation of policy, including safety and quality strategies (Shekelle 2002). The result of the current fractured communication and muddled accountability is that ‘You can work hard every week, and get beaten 80–0 every week’ (Rheumatologist).

Solutions for improving care are not universally accepted or proven. Donald Berwick, a US safety and quality leader and motivational speaker, puts it eloquently:
My friends, the world that you are living in as you are trying to help health care get better is a world of true complexity – strong social influences, tight dependencies on local contexts. It's a world far less of proof than of navigation; far less of final conclusions than continual learning. (Berwick 2009b)

Recently I worked in an organization responsible for aspects of national policy for safety and quality. Interaction with leaders across Australia stimulated my thinking along new lines on such issues. What follows is a personal and admittedly idealistic vision of what changes might be needed to achieve safer, better health care and to re-engage doctors with the hospital system.

Flaws in the Current Approaches to Safety and Quality

Deficiencies in health care have been readily and regularly identified so that the safety and quality movement does not have to justify its role. Its importance and value is now assumed. However, the movement has tended not to examine its own initiatives, successes and failures: it has been peculiarly non-reflective. Three major problems deserve consideration.

TOO MUCH CRISIS TALK AND AN ANTI-RESEARCH ETHOS

In Chapter 2, the origins of, and the energy sustaining, the safety and quality movement were outlined. The negative effects of media sensationalism were discussed further in Chapter 9. We need to take a cooler appraisal of the issues of patient safety. Crisis talk tends to result in political solutions – the hasty quest for a bandaid. The solutions proffered may remain unevaluated so that ‘successes’ can be always reported. Yet striving for reliably good care requires organizational trade-offs (Schulman 2002). For instance, avoiding errors of omission increases the likelihood of errors of commission. There never will be a perfect (or error-free) system, yet the constant talk of disasters, of the absurdly titled ‘never events’ (Centers for Medicare and Medicaid 2006), creates drama that obscures and prevents solid steady work towards improvement.

The number of safety interventions with evidence is very small (de Vries et al. 2009). Charles Vincent is blunt on this issue:

The careful attention to epidemiology and monitoring which would be a first priority for cancer or heart disease has been completely neglected when dealing with the safety and quality of care. (Vincent et al. 2008)

Crisis talk implies an urgency which is antithetical to research (Jorm and White 2009). The authors of the IOM reports started the trend by making ‘calls to action’ and seeking to accelerate the pace of change. Sober analyses such as that below have had little currency:

[The report To Err is Human] demands action without considering realities; it uses data without careful analysis; it promotes models without evidence; it sets unrealistic deadlines; it fails to mention the resources needed ... it suggests use of technology whose reliability is untested. Most worrisome, it minimizes the organizational and cultural barriers to change.
Reconstructing Medical Practice

Overnight change or success is usually short-lived. Developing methods of understanding complex interventions needs to be a research priority. Rigorous analysis is needed both of outcomes and the context for improvement, including the beliefs and values of staff (Wakefield et al. 2010).

There has also been a startling failure to consider the cost-effectiveness of both improvement initiatives and new safety research (Warburton 2005). Despite the huge sums spent, two recent reviews were only able to find a handful of studies which substantiated the financial benefit of safety and quality interventions (Øvretveit 2009, Jackson 2009). Healthcare-associated injury consumes at least one dollar in seven of money spent on hospital care, but we do not know where to invest to reduce this burden.

LACK OF PATIENT-CENTREDNESS AND LACK OF SOPHISTICATED ATTENTION TO ETHICAL ISSUES

There has been little work, bordering on tokenism, on the most productive ways in which patients themselves can be involved in the planning and development of health care (Crawford et al. 2002, Jorm et al. 2009). Currently, systematic methods of engagement with patients and consumers for the purpose of priority setting are rarely undertaken. Patient priorities may not be the same as those favoured by safety and quality advocates. For instance, access, speed and efficiency are highly valued by patients. It is crucial that the healthcare system understands and responds to the actual priorities of patients rather than those presumed or assigned by experts.

Information technology means patients now have access to vast amounts of medical information, much of which is of dubious quality and accuracy. Even doctors themselves struggle to make sense of competing advice and scientific findings. Doctors are still an elite highly educated group. An imbalance of power that can be multidimensional exists between doctors and patients. Often, this imbalance of power itself can be multidimensional—intelligent/less intelligent, educated/less educated, richer/poorer, knowledgeable/less knowledgeable, well/sick, procedurally skilled/unskilled. It is not likely that knowledge or power can be truly shared, despite efforts to increase the perceived value of unique patient knowledge of their body and disease experience. This power imbalance though, especially that of the well/sick, provides a source for doctors’ altruism and action and is the foundation of ‘caring’—the thing patients value above all else.¹

Berwick recently made a disturbing argument for patient-centredness (Berwick 2009a, Berwick 2009b). The emotional call in the excerpt below is patent. It is a classic motivational speech as it appeals to universal self-concerns and is designed to inspire:

1 Interestingly, a study of the experience of doctors who themselves are ill showed their strong, and sometimes unmet, desire for someone else to take control (McKevitt and Morgan 1997).
Or to eat what I do not wish to eat
Or to be named what I do not wish to be named
Or to be told when I wish to be asked
Or to be woken when I wish to sleep

You can call it patient centredness if you choose, but I suggest to you that this is the core, it is that property of care that welcomes me to assert my humanity and my individuality and uniqueness. And if we be healers then I suggest to you that it is not a root to the point. It is the point.

He argues that patient-centred care simply means giving patients what they need and want. From the world view of wealthy, educated Americans, it ignores resource constraints in favour of absolute patient autonomy. Yet health care is expensive and costs are borne by society. There are always other patients and other societal needs outside health care. The claim it is wrong ‘to be made to sit when I wish to stand, to eat what I do not wish to eat … to be awoken when I wish to sleep’ ignores practical realities. Processes are standardized to reduce costs and improve efficiency. A short-order kitchen in each ward would be ideal – but unaffordable. He suggests that if, over time, patients are choosing scientifically wise or unsubstantiated choices we simply need to improve our messages through education and dialogue with patients. Yet, as discussed, true partnership is impossible.

Berwick advocates that the doctor should not act as a steward for healthcare resources but ‘social choices be made where they mostly belong: at the level of public policy’ (Berwick 2009a). His suggestion is to encourage government and bureaucrats to establish blunt methods of gate keeping. While ethicist Richard Ashcroft suggests ‘Teasing out the difference between a late capitalist boutique medicine and medicine that is respectful of the autonomy and personal suffering of patients is remarkably difficult’ (Ashcroft 2002), not many doctors would support the level of abdication proposed by Berwick. The final result is immoral as it allows practitioners to shift all risk and responsibility away from themselves. This emphasis will be mostly placed on to their patients, who will be given what they ask for, even if unwise and wasteful. To be patient-centred but only in the manner described is for clinicians to deny their own humanity, not to reclaim it. Help means giving something that is useful, not necessarily that which is requested.

This argument for patient-centredness is just one example of the unsophisticated approach taken to the ethical issues inherent in acknowledging that there is a gap between the quality of current health care and its potential. It does not help that safety and quality issues are largely ignored in most scholarly considerations of medical ethics.

I believe that doctors are neither fundamentally self-interested nor fundamentally virtuous, but their current mode of interaction with poorly performing and sometimes flawed systems needs to be changed. In the teaching of medical ethics there should be included the doctor’s need to engage with medical organizations, with ‘the system’. For instance, the following could be considered:

*The operating theatres are poorly scheduled and not as productive as they could be, patients are waiting long periods for necessary surgery. What do you do? What could you do? What if a long-term staff member responsible is inadequate? How do you respond if you are requested*
I would suggest that these kinds of questions force confrontation with the fact that patient care involves a health system. To turn away from the system is to turn away from patients.

AN EMPHASIS ON ERROR THAT HAS CONFUSED CLINICIANS

In the transportation, building and manufacturing industries safety refers to workplace safety. You or your workmates may be killed or injured. In these industries accident rates are easily measured and major safety incentives provided by firms and insurers. Conversely, clinical staff are rarely killed at work: rather it is the patients who die when error occurs. But patients also die from their medical conditions and usually error, disease and treatment are intermeshed.

Patient safety has focussed narrowly on the work of doctors, typically on areas such as hours of work (Caldicott and Holsapple 2008). However, improving care for the chronically ill may require macro system redesign and patient safety experts do not always see this as in their remit (Emanuel et al. 2008). The sources of many errors lie in the broader system and this may include the design, engineering and manufacturing of equipment and drugs, the selection and training of staff, the organization and regulation of health care at the state and national level (especially funding models), and even the political system (Jensen 2007).

The importation of safety models from industry has resulted in an over-emphasis on identification and analysis of individual errors. Root cause analysis (RCA) is a time-consuming investigative process imported into health care from industry. It is mandated in all Australian States and represents a significant resource burden, yet there are still no studies on its effectiveness in reducing risk or improving safety in health care (Wu et al. 2008). Retrospective analysis of individual incidents and subsequent remedial actions can even lead to new opportunities for error (Kalra 2004) and represent a poor allocation of scarce healthcare resources.

Charles Bosk argued some years ago that for success in reducing error, it is necessary to understand how clinicians define and feel about error (Bosk 2003: xxiii). A study of surgeons has suggested that:

*If doctors view lapses in practice as inevitable then they are unlikely to attempt to manage these risks. In fact they may not perceive them as risks at all, but instead as occupational hazards.*

(McDonald et al. 2005a: 405)

This is clearly a problem for patient safety experts who may be unable to engage doctors in their endeavours. The doctors do not see a problem or, rather, they do not see a problem that can be solved.

Studies of incident reporting and the work of RCA teams have revealed uncertainty, emotional tensions and differing understandings of the nature of healthcare error (Iedema et al. 2006c, Iedema et al. 2006b, Iedema et al. 2006a). It appears that the social construct of ‘patient safety’ is simply not accepted by many doctors, for whom variability and uncertainty are part of everyday work. Clinicians are thus confused about what their
emotional responses and their practical responses to error should be. Nicholas Christakis points most doctors do feel personally responsible for error, just as they take credit for good outcomes and:

*The problem with industrial solutions to the healthcare quality crisis is that they answer patient complaints and worries ... by saying that no-one – no person, no doctor – is or can be responsible. These solutions wrongly situate the issue in an amoral, almost mechanistic, domain. (Christakis 2008)*

A subject who was a neurosurgeon gave this reflection:

*If you're paranoid about error you're not going to be vigilant. If you're caning yourself every time you make a mistake you're probably being over-sensitive ... It's trying to develop the culture that you have to do your best, but things do go wrong. We're not dealing with a Ford Falcon with the mechanic's manual next to us. We're dealing with very individual people, very individual circumstances ... And you've got to develop the culture where people feel that if they make a mistake – not even making a mistake – if there is a problem – because you know, patients have complications ... you have the courage to keep looking into that to improve things. And you're teaching the people you're training how to look out for problems and how to correct errors and manage things if something does go wrong. It's going to happen. If you stop worrying about errors then you should stop being a clinician.* [Emphasis added.]

This speaker displays his understanding of both biological variability among patients and the uncertainty involved in medical decision making. His attempts to describe an ideal or appropriate emotional response to error were confused. On the one hand, oversensitivity and paranoia were to be avoided but, on the other hand, worry and care about patients was placed at the heart of doctoring. Yet such care also results in shame and denial, and the courage to admit to errors and to accept the necessity of investigations into them may be rare. If doctors’ attempts to strive for error-free practice are a cause of their defensive attitude toward error (Wiener 2000: 205) and cause them suffering (Christensen et al. 1992), should that effort be reduced? The notion of reducing this effort has not been entertained. However, the effort seems generally to be in the interests of their patients and a contributor to safety. Effort is still admired:

*The professional has to get the job done no matter what. No matter what the circumstances are, no matter how tired you are, how distracted you are by family, no matter how uncooperative the patient is or whatever you get the job done, no matter what.* **Paediatrician**

**Moving Forward**

Moving forward is a challenge. As Michael Ward, the Queensland Healthcare Quality Complaints Commissioner, put it: ‘We’ve got to build the plane while flying it’. Our plane is the system delivering health care. The pressures and demands of delivering health care will not stop. The doctors, a major part of the enterprise, have shown themselves to be increasingly disengaged.
We need to study the effects of our changes. This means doing novel kinds of research and publishing that research. The biomedical sciences receive the vast majority of current medical research funding and yet it could be argued that this is an impediment to improving health care. Even if we stopped making discoveries or advances, years of work would be required to determine how to apply the knowledge we already have. More attention needs to be given to relatively mundane and unglamorous research on implementation rather than on the search for more medical ‘miracles’.

It is not easy to measure safety. Observational studies allow details of work to be described and explored. While very few mistakes result in adverse outcomes, only observational data addresses the process surrounding an event and enables information to be collected about ‘errors of omission’. Professor of Organizational Communication Rick Iedema has pioneered a technique he calls video-reflexive ethnography. This combines ethnography (the observation and analysis of practice) with the use of videos and review of edited footage by the clinicians who have been filmed. Seeing themselves on-screen allows staff to gain new perspectives on their work practices. To date, this technique has produced improvements in clinical team work (Iedema et al. 2006d), clinical handover (Iedema et al. 2009b) and infection control practice (Iedema and Rhodes 2010).

In addition to implementation and observational research, there are two other areas that I will draw attention to later in this chapter – using narratives and study of the social or relational aspects of health care (not merely those between the doctor and patient).

There is sometimes a hubris or arrogance about doctors. The fundamental uncertainty of their actual work means they solve complex problems alone every day. This may be one reason they are reluctant to accept assistance and insight from academic disciplines outside medicine (Wears et al. 2005). It is easy to criticize doctors for their dismissal of other fields of study.

Physicians tend to be cynical about subjective approaches to understanding their world. Medicine’s sceptical attitude towards the ‘softer’ sciences – psychology, sociology, cultural anthropology and so forth – is part and parcel of the mindset that erects barriers between physicians and the people they treat (Woods 2007: 46). However, such criticism also ignores their lack of knowledge of these ‘softer sciences’. Until recently, most Australian doctors entered medicine as undergraduates and had a highly technical training bereft of a liberal education. Presently, many entering medical schools are postgraduates with science degrees. However, this does not mean that they necessarily have any background in the safety sciences such as cognitive psychology or the engineering concepts applicable to systems thinking and human factors (Leape et al. 2009).

**Strategies for Rebuilding the Critical Relationship between Doctors and the System**

The following seven recommendations will be discussed in detail in the rest of this chapter. They are:

1. Developing and sharing a more sophisticated understanding of how safety and good care is created.
2. Improving the measurement of harm, error and safety.
3. Redefining the job of the doctor and selecting and training doctors for that newly defined work.
5. Increasing individual learning.
7. Valuing dissonance and confronting emotion.

1. STUDY HOW SAFETY IN HEALTH CARE IS CREATED

Patient safety is poorly understood. Consider an example from outside health. My nephew crosses the road and is listening to his iPod while sending a text message. The car he did not see, driven by a newly licensed driver, did not hit him. Although he reached his destination unharmed, his journey was not safe. However, viewing this through a human factors perspective, the system may have allowed sufficient safety margin for his heedless road crossing not to result in harm. For instance, the street may have been well lit, the driver well trained and tested according to rigorous standards. The car had good brakes and tyres and was travelling at a slow speed. However, if he had been paying attention, my nephew would still have been likely to be safe if a drunken driver in a deregistered car without headlights had careered down the street.

From traffic safety research we have fragments of information about appropriate safety measures. The interaction of all the safety measures may in fact only be able to be measured by adverse events, such as pedestrians hit by vehicles. Is there a normal, reasonable or unavoidable number of pedestrians hit while crossing roads? Most doctors believe that there is a comparable approach to adverse medical events. Why? There is complexity and variability in the human body itself, its illnesses and response to treatment. To this is added patient preferences and the many interventions and interactions required between a cast of clinicians and managers over time. By comparison, pedestrian safety is simple.

It is much harder to learn from mistakes in health care (Katz-Navon et al. 2007). Industries such as transportation and manufacturing have been able to increase their standardization to the point of substantial automation. While there is clearly a place for the standardization of some aspects of care, the complexity and variety of healthcare situations means a vast number of detailed procedures would be required and to create and maintain them would necessitate unaffordable investment. Even where procedures are standardized, there is a risk that they may inhibit clinicians’ discretion in situations where on-the-spot decision making is required.

Inappropriate standardization (Nemeth et al. 2007) can make systems unable to change in response to circumstances: this has been termed ‘brittleness’ (Nemeth et al. 2008). It is necessary to determine the uncertainty of processes before determining what must be made explicit and regulated and what should remain in the domain of the tacit knowledge of empowered individuals (Lillrank and Liukko 2004). Without this determination, a vicious circle can develop of investigations leading to the production of unnecessary new rules that in turn produce new complexities leading to the occurrence of new failures and errors (Kalra 2004).

‘Resilience engineering’ is a term used to identify and value behaviours and resources that contribute to a system’s ability to respond to the unexpected. Eliminating resources, such as reducing staff numbers, is an example of a cost saving that may reduce resilience and produce increased cost in the end. All doctors can recall instances of ‘cost saving’
leading to patient-harm events or necessitating expensive staff recruitment measures when the over-worked remaining staff resign.

New views on human error give the humans in any system far more ‘agency’ in creating safety or providing system resilience (Gherardi and Nicolini 2000, Gherardi and Nicolini 2002, Dekker 2006). Psychologist Charles Vincent says, ‘Procedures are not enough – people create safety’, and we need to ‘leave some space for people to create safety’ (Vincent 2008).

The new safety models describe zones of safety (Amalberti et al. 2006, Nemeth et al. 2008). In the model devised by French safety researcher René Amalberti (and colleagues) there is a central zone of accepted safe action defined by laws and professional standards. However, staff desire for convenience and/or pressure for performance push the point at which the system operates into what is called a ‘normal–illegal’ area of operations. These changes in practice or ‘borderline tolerated conditions of use’ have a number of features. They are first seen as benefits, not risks, in that they enhance system performance, are socially sanctioned, tolerated (or requested) by management, and are associated with a variety of informal safety measures. With time, these practices seem normal until a more reckless violation by an individual causes patient harm.

The degree to which standards can be violated error-free is usually unknown because risk is inherent to specific clinical situations. Further, often doctors ‘identify no direct link between the rules and the risk for the patient, with the result that compliance with many rules is eroded’ (Amalberti et al. 2009a). Charles Vincent explains:

_There are too many procedures – too many for compliance to be achievable in a system under pressure – and the mix of ‘need to follow’ and ‘good to follow’ is dangerous. Compliance with ‘good to follow’ erodes first and infects compliance with others [procedures in the ‘need to follow’ category that are truly vital]. _(Vincent 2008)_

The health workplace is an intensively communicative environment. Psychologists Karl Weick and Karlene Roberts in their study of safety on aircraft carriers (a very high-risk environment) developed the concept of the organizational or group ‘collective mind’ (Weick and Roberts 1993). The most important characteristic of the collective mind is heedful interaction. ‘Heed’ refers to close and thoughtful attention and is developed by training, experience and feeling. When interrelating is heedful, attention is focussed on the joint situation, not just local or individual events, and on the implications of unfolding events. It is developed and preserved in narratives or stories and by ensuring that experienced staff are central to socialization. When people work closely together, being careful is a social rather than a solitary act (Gherardi and Nicolini 2002). The young anaesthetists mentioned earlier in this book learned by telling stories and in their stories the quality of team communication frequently precipitated or averted disasters.

The disengagement of doctors from the hospital and their confusion about professional values (or identity) may be providing a new and powerful force toward brittleness. If we consider the concepts of altruism, self-sacrifice, empathy, sympathy, even paternalism, how much safety behaviour do these values, emotions and attitudes drive? The informal networks and communicative practices of doctors may be critical for averting error and harm. It may be that much of medicine is practised in the normal–illegal zone where informal safety measures are critical. These measures include redundant communication, organizational citizenship behaviour (OCB) and when professionalism – ‘doing the job
properly’ – is being valued by colleagues and management. Informal safety measures are more likely when there are affective bonds to place, to people and where there are workplace structures and practices that promote and develop these bonds. This is a hypothesis that needs urgent study in health care.

Study of the creation and maintenance of safety in health care can be made a priority for research funding. This work needs to be prioritized ahead of experimental organizational interventions, as the groundwork for the design of successful interventions in health care has been lacking. A plastic surgeon stated in regard to the quality of care given by the system that ‘we are losing ground’ and ‘we need to go back up the slippery dip a bit’. His metaphor conveys both speed and the intrinsic difficulty of such a reversal. So much is changing in health care, structurally and culturally, that there is a real possibility of more frequent harm affecting many more patients.

2. IMPROVE MEASUREMENT OF HARM, ERROR AND SAFETY

The general failure to provide data to clinicians gives them little confidence that good care is important to the managers and organizers of the health system. In addition, clinical staff often do not believe (or choose to believe) problems exist in their own departments. This poses a barrier to delivering reliably good care. Systematic collection of local data that is relevant to the work of clinicians is a necessary foundation for engagement between doctors and the healthcare system (Vincent et al. 2008). One of the common factors found in an analysis of high-performing healthcare systems across the world has been the widespread use of standardized information in electronic form (Baker et al. 2008).

The focus on retrospective evaluation of errors has been unproductive and makes it extremely hard to assess improvement. Charles Vincent is correct when he states, ‘At the policy level we need a large shift of emphasis and resources away from unsystematic voluntary reporting towards systematic measurement’ (Vincent et al. 2008).

If we are to make the best from incident-reporting systems their weaknesses need to be appreciated and they need to be combined with other forms of measurement. Queensland Patient Safety Director John Wakefield has proposed a balanced measurement framework for safety (Wakefield and Jorm 2009). There are five domains, each listed below, with an explicit reminder of its limitations:

- safety learning – why incidents occur – obtained from incident analysis (this cannot determine safety performance)
- safety action – whether an action is being performed – measured by compliance audits on protocols (this cannot determine if the action has actually improved safety)
- safety performance – rate of harm – from coded medical record data (however, merely knowing the rate does not contribute to safety)
- patient experience – includes whether patients feel safe and trust the staff and the system and patient reported harm (but feeling safe is not necessarily correlated with low rates of harm)
- staff attitudes and behaviour – includes safety beliefs or culture (this does not measure performance).

French researchers have recently argued for patient safety to re-focus on the frequent kinds of errors experienced by patients and steer away from the dramatic (Amalberti
et al. 2009b). They argue that highly publicized errors concern few people. In essence this is a population health approach brought to bear on patient safety. Similarly, health economist Terri Jackson’s work focusses on outcomes, not errors. She has defined important categories of such events in routinely coded medical record data. The comprehensive list of categories includes ‘little harms’ such as constipation and urinary tract infections that affect many patients (and cost the health system a large amount of money because they unnecessarily prolong hospital stays) (Jackson et al. 2009).

The patient perspective on adverse events is different again and the categorization of events used by clinicians and researchers is largely irrelevant to patients (Jorm et al. 2009, Mazor et al. 2009). In a Swiss study, nearly half the patients reported an ‘undesirable event’ during their hospitalization (Agoritsas et al. 2005) and in a US group 38 per cent experienced at least one ‘error-related concern’ (Burroughs et al. 2005). The types of adverse events reported by patients differ from those typically reported by staff and include missing notes and X-rays and unacceptable delays in obtaining analgesia (Agoritsas et al. 2005, Friedman et al. 2008). One of the goals of patient safety is for patients to feel safe and trust staff and the healthcare system (Wakefield and Jorm 2009). Measuring this necessitates a broad study of patient experience including patient-reported adverse events and patient outcome measures. Recently, patient-reported outcome studies have suggest that a considerable number of hernia and varicose vein operations and hip and knee replacements do not improve patients’ symptoms and lives (Bream and Black 2009).

While safety is sometimes defined within quality (Lee 2002), René Amalberti has expanded the definition of adverse events to encompass quality issues (Amalberti et al. 2009a). Chronic diseases account for 70–80 per cent of preventable deaths or avoidable hospital stays (Amalberti et al. 2009a). Therefore in order to achieve patient safety on a systemic scale, adverse events linked to patient diseases, such as peri-operative stroke, and complex adverse events, such as early death from diabetes (amenable mortality), need to receive much greater attention. In support, a US medical record study found that many people received insufficient medical care, especially those with chronic diseases (Hayward et al. 2005). The result was preventable disease-related adverse events.

Overuse of resources and unnecessary or inappropriate treatment are not currently recorded as adverse events. Treatment is inappropriate when expected benefits outweigh expected harm. It has been estimated that 25 per cent of hospital days and X-rays are inappropriate, and up to 40 per cent of medications unnecessary (Øvretveit 2009). Unnecessary treatment creates both risk and waste. Remember the ‘200,000 unnecessary hospital admissions each year’ touted by the NSW Minister for Health? This was not just ‘spin’.

It is time for action on measurement. There is no reason to delay, the technology is available (Jackson and Johnson 2008). A large amount of data is collected in our healthcare system. Much is not returned to clinicians, not relevant to clinicians (and to be frank, therefore, often not relevant at all to quality patient care), and not collated in a timely manner. Data that is several years old cannot support practice improvement. We need the development of systems that provide timely information to clinicians so that they can track the progress of patients and the success of both their own actions and of the broader and longer-term care processes. Policy makers need to acquire (and share with clinicians and the public) an even broader population health view of preventable harms and poor care. Finally, the patients’ experience and priorities need to be sought and be made central to measurement practice (Wakefield and Jorm 2009, Jorm et al. 2009). This
action can and should take place at unit level, hospital level and Health Department level without delay.

3. REDEFINE THE JOB OF THE DOCTOR

The functions required of doctors (the ‘job’, as some interviewees called it) needs to be better defined. Clarity about what the job entails is the only way to enable the right kind of doctors (correctly selected and trained) to deliver safer, more appropriate care. The doctors did not want to ‘hurt’ their patients or to feel personally responsible for patient harm. Their response to patient safety was personal and emotional. They criticized ‘the system’ for letting their patients down, and tried to protect ‘their’ patients but refused to engage with the system (Jorm et al. 2006). The subjects in this study, in general, did not consider that ‘doing the job properly’ might necessitate organizational engagement.

One reason given was that the doctor’s duty was to the individual patient and involvement in resource decisions was in conflict with that duty. Another justification given was that doctors were unable to influence institutional change. Yet the medical profession still holds substantial power and the members are of high intelligence and ability. How does this sense of helplessness arise? Many doctors appear not to know how to go beyond one-on-one verbal confrontation. They do not know how to plan a campaign or build group support. They do not have the patience for ‘pointless’ meetings. Should the job description for all hospital appointments require clinical work, management (and research and teaching)? If so, individuals should be assessed on their performance in all these roles. If this were to be the case, doctors would need some training as currently they (with few exceptions) are untrained in organizational work including managing human resources and budgets.

Some doctors identified the need for this knowledge:

\[\text{I was never at all prepared for the other side of medicine … It is as important or even more important … [to know] how to deal with the administrative side of actually seeing patients, working out how the system works, that type of thing … It’s been a lot more frustrating in some ways than I’ve expected. Neurologist}\]

Some identified the moral imperative for such action:

\[\text{I think you’re still not giving good care if you don’t try to address the system problems that result in the total care not being good. And I find that a really hard conflict … I can’t, I can’t do anything. I can’t stand by the patient’s bed until they leave the hospital. I have to leave and I have to give responsibility to other people … But you have to reduce seeing those other things not working well. I think you’ve got to start to try to work towards them. Anaesthetist}\]

However, some may not be enthusiastic; consider the extract below:

\[\text{I’m a proceduralist … and I think I have a particular gift … I am perhaps better at doing it than a lot of other people, and I’m prepared to take on complex cases and basically do a [good] job most of the time so that I think that’s what keeps me going. I think if I couldn’t do [the specific procedural work] I probably wouldn’t even be a doctor. The second thing is I do enjoy having people come back to the office, the … human interaction … I am not really a researcher … I}\]
don’t mind teaching the students. In fact I quite like teaching the students. Problem though is finding the time. I have certainly hated management and bureaucracy and meetings and all that sort of stuff. Clinical meetings are fine but administrative meetings, I just hate it. Sydney specialist

Most interview subjects showed commitment to their work, were even absorbed by it, and were unable to imagine doing anything else. They are engrossed in the communicative and emotional aspects of care for patients (and their supportive collegial interactions). It may be less a matter of organizational work being incompatible with medical professionalism than such work being unfamiliar, uncomfortable and an area of unsatisfying inept performance for most practitioners. However, I do not believe organizational work can or should remain optional for doctors.

Organizational theorist Henry Mintzberg recommends improving professional accountability by ‘changing the professionals – changing who can enter the profession, what they learn in its professional schools (norms as well as skills and knowledge)’ (Mintzberg 1983: 213) and requiring an ongoing willingness to upgrade skills. Entry into medicine is not necessarily the best test point for professional qualities.

The US findings of an association between medical school misbehaviour and subsequent medical board concern about the quality of professional practice are important (Papadakis et al. 2005). This association needs to be monitored in Australia and used to derive selection and remediation (and exclusion) processes for the students. Townsville psychologists have screened medical students for ‘dysfunctional tendencies’ (Knights and Kennedy 2006). These included aggressive self-promoting behaviour and ‘excessive diligence’ (picky, critical, stubborn and unwilling to delegate due to perfectionist tendencies). As yet only the relationship of these characteristics with medical school performance has been studied (Knights and Kennedy 2007). Far more important is what sort of doctors these students will make, as assessed later by co-workers (medical and non-medical) and patients.

Assessment of professionalism should be continued throughout undergraduate and postgraduate training. The even harder job of better assessing and remediating poorly performing qualified practitioners should follow (Sullivan and Arnold 2009). Appropriate patterns of interaction with patients and other staff can be taught, and it can be as simple as communication training aided by mnemonics. The basics of good medical care in terms of such things as record keeping and patient follow-up can be specified and taught. A focus on intangible inner virtue is distracting: doctors are not members of a religious order. It is surprising to me to see the following question still being asked in 2009:

Do we want physicians who are professional, or will we settle for physicians who can act in a professional manner? … To what extent can inner virtues and outer conduct be allowed to differ? (van Mook et al. 2009a)

We need to be focussing on the observable (and therefore also measurable) behaviours; that is, patient outcomes and performance as assessed by a range of clinical co-workers and patients.

A form of peer review may be a way to assess professionalism throughout a career. Until very recently medicine appears to have seen itself as too unique to make use of
the common performance development mechanisms used in other occupations and industries, such as ‘360-degree feedback’. This is a threatening process for some doctors but obviously the subject below would be comfortable with this and receptive to results:

I think, by and large, our relationship as doctors with other [non-doctor] health colleagues is much, much better and much more realistic and not so … white-coat-orientated.

Gynaecologist

The fact that the practice of medicine is not homogenous also needs to be faced. Current features of medical identity often include autonomy, scepticism, risk taking and rule breaking. Attempts to mandate doctors to behave in ways that are alien to their personalities seem unlikely to succeed. Psychometric testing may help achieve better role fit (Firth-Cozens et al. 2003). For those areas of patient care where meticulous adherence to rules and protocols is required, there is a need for health workers (not necessarily doctors) with the personal qualities to do this consistently.

An individual’s confidence in his or her ability to control risk has been shown to result in more risk-taking behaviour (Weyman et al. 2003). Some areas of medicine, but not all, require confident risk taking (Hall et al. 2003, Hays et al. 2002). Surgery is a good example.

Patients also often come to doctors ‘as puzzles in search of an interpretation that will make sense of their signs and symptoms’ (Montgomery 2009). Diagnostic work is detective work and, just like detectives, doctors describe their work as involving ‘cases’ with a fundamental chronological narrative flow. Diagnosis is generally not routine work.

Public expectations now seem to necessitate a new and more explicit embrace of uncertainty by both patients and doctors. However, doctors must be the expert navigators through the conflicting ‘evidence’. To do this they need to learn how to make odds explicit and help patients make decisions. Such expertise may produce a more emotionally manageable, less conflicted practice. But it will require increased communication with patients and families. Every consultation may need to be a long consultation. One interview subject saw this as a journey under way:

We do communicate better definitely than we did 10 years ago ... You’d hope that communication will improve further and that things will settle down with patients less angry with doctors. Infectious diseases physician

We must select the right people to do all these kinds of medical work – risk-taking, rule-based, detective and communicative – so that they will have satisfying careers and satisfied patients and will deliver safe care. This will require sophisticated psychological testing and then training that develops insight and the cognitive skills needed for particular kinds of medical work. The latter is briefly discussed in the sections on learning in this chapter. There is a logic for redefining the job of the doctor that must not be forgotten:

The job needs to be defined in terms of the patient’s needs, not in terms of the professional’s needs or the hospital’s needs. Paediatrician
4. MANAGE BETTER AND MANAGE FOR TRUST

Specialist doctors are long-term hospital employees, yet the disengagement and bitterness they revealed during interviews was remarkable. They considered that the system ‘let them down’ and they did not trust local managers, management processes, government health departments and the political system. Doctors claim there is too much money wasted by bureaucracy and administration and that they need more frontline staff instead. Opposition politicians propose the same at election time. But are these claims correct?

My husband, an obstetrician and gynaecologist, recently came home from a perinatal M&M meeting where four cases could not be presented because the clinical notes were not available. It transpired that two of the patients who had had stillbirths were seen for follow-up in the clinic by a consultant on the day before the meeting. This consultant also did not have the notes available and had to attempt to counsel the bereaved couples while taking a history and searching for results.

Medical records departments tend to be desolate places, usually located in a soon-to-be-condemned part of the hospital premises where daunting piles of records sit, tended by a small band of harassed staff. The work is low in status and is poorly paid. It is work that is part of the ‘wasted’ dollars of administration but, in reality, crucial for patient care.

I suspect that hospitals are actually under-administered. Comparable professional organizations might be schools and universities, but their clients can be treated in batches – 30 to 300 during working hours. However, hospitals run 24 hours per day and receive and manage a vast number of different types of patients and provide myriad care pathways.

The interviewees’ complaints were really about poor administration – in particular the lack of longer-term planning and agreed strategy. Short-term government imperatives devalue the work of the long-term staff. Why should they rush around doing extra operating lists before an election, when their theatre time had been whittled away by closures for budget reasons earlier in the year?

Local hospital administration is demonstrably primitive and the lack of discretion or flexibility at this level results in the frequent waste of large amounts of money (in wages) in an attempt to control small cash expenditures:

Decades of archaic systems that … doctors have to practise [with] in place, all the forms that they have to sign, millions of people they have to ring just to get an X-ray done and on and on we go. And these are the reasons … not dollars and cents, that we can’t get [patients] into a hospital. Renal physician

Remember the petty cash story where staff wages were used to attempt to save a few dollars while at the same time antagonizing staff and reducing their willingness to do other ‘stuff for free’. In a social exchange, if there is a relationship, people believe that if something goes awry the other party will help them (Ariely 2008: 82). These beliefs are not spelled out in a contract – and organizations cannot have it both ways. If hospital managers want clinical staff to engage fully with the organization (display organizational citizenship behaviour) they need to support these staff in other matters.

The hospital will abandon you as soon as something medico-legal comes and I think they won’t look after you at all. So I don’t think they’ve got any loyalty. I think that goes for all
Governments have responded to healthcare scandals by attempting to increase rational elements of trust (or public confidence) with governance and management practices focussing on regulation and accountability. Behind these changes lies ‘a faith in the efficacy of surveillance as a directive force in human affairs’ (Salter 2007). Agreed codes of ethics, monitoring, licensing and disciplinary procedures are all grounds for rational trust in the unknown individuals who are part of a system.

As well as producing political pressure, low levels of public trust in the system result in reduced care-seeking behaviour, which can allow people to carry or acquire preventable illness burdens (Mohseni and Lindstrom 2007). Unfortunately, the quest for accountability in health care may not always improve patient satisfaction. Instead it can add suspicion and lead to unrealistic expectations on the part of patients (Wiener 2000: 5). In the UK, many NHS reforms have resulted in service improvement, yet have been accompanied by declining public trust (Taylor-Gooby 2006). In Chapter 9 that trust was characterized as having a cognitive element (based on rational judgements) and an affective element (based on relationships, interaction, empathy) (Calnan and Rowe 2006). The declining public trust seen in the UK may be due to a decreased space for affective trust (such as rostering practices that reduce fatigue but also reduce the patient’s experiences of continuity of care) or due to distortions in practice that can result from performance targets (Checkland et al. 2004).

The complex and expert nature of medical work makes regulation difficult and expensive. Measures to reduce harm by increasing accountability sometimes cause conflict for practitioners – even moral distress. To whom are doctors accountable? The list includes patients, their advocates, employers, professional regulatory bodies, the courts, elected politicians and the wider general public. And the aims and desires of these groups may not be compatible (Checkland et al. 2004). They probably rarely are.

In addition, there are at least four mechanisms by which regulation may reduce safety. First, in teams, relationships and performance are positively related to cooperative behaviours and negatively to monitoring and measurement (Gilson 2003, Bijlsma-Frankema and Costa 2005, Langfred 2004, Landy and Conte 2004: 415–416). Mintzberg suggests regulation may ‘dampen professional conscientiousness’ and the incentive to perfect, and even to innovate (Mintzberg 1992: 212). There is a positive spirit associated with autonomy that is dampened by scrutiny.

Second, policy makers’ desire to control care (to systematize and regulate) may hamper the ability of practitioners to respond to the inevitable unpredictability of health care (Pinder et al. 2005). Doctors are experts at improvisation and bricolage – creating what is needed at the moment out of whatever materials are at hand (McDaniel et al. 2003). These skills are crucial for research advances, but also for ensuring or creating patient safety in a complex evolving clinical situation.

Third, excessive rules may increase the ‘normalization of deviance’ and result in work moving out of the zone of safety discussed earlier in this chapter. Rules should be kept to a minimum with a logic that is understood by those who should follow them.
Finally, regulation of clinical care may also reduce the time available to communicate with the patient. Some even suggest that the inevitable outcome of bureaucratic accountability is neglect of the patient (Brown 2008).

Clearly, regulation does not provide a simple solution, but the following story by John Øvretveit may be illuminating:

*Some managers were chatting during the break in a very frustrating hospital meeting, attempting to seek agreement for change. One said to the other: ‘Dealing with doctors, it’s like herding cats, isn’t it?’ The other replied: ‘No, I think of them like elephants: they think very, very fast, they move very, very slowly and they never forget’. (Øvretveit 2005)*

What is never forgotten are the previous managers now departed and undelivered promises, systems and plans. Doctors also remembered times when they felt a sense of belonging, where they could find ‘Fred’s door’. There is a significant difference in the duration of tenure between doctors and administrators. Specialists spend twenty or more years in a single role in an institution while managers (such as hospital chief executive, director of medical services) change every two to three years and health ministers even more frequently.

*The last time the CEO at the private hospital changed, not this time, the last time, he rang me personally and said ‘I am the new CEO and I would like to meet you’. I thought, wow, that’s really cool. When the CEO changed here nothing happens. And you might say ‘Well, the CEO can’t meet everybody’ but the CEO could invite the hospital to an employees’ meeting so that they become a face that we attach them to and say ‘I’m new and this is what I think and/or this is our plan, this is what we’re trying to achieve over the next few years’. There is nothing like that. Anaesthetist*

Corporate knowledge is a valuable asset: in hospitals, the senior doctors are a reservoir, which is rarely utilized and respected as it could be. Dedicated senior medical staff can lead the creation of a safe healthcare unit. (In a rare longitudinal organizational study of a paediatric intensive care unit (Roberts et al. 2005), loss of these individuals resulted in a rapid deterioration in the quality and safety of care.)

Modern psychological theories of work motivation show success is produced by individuals accepting goals that are specific and achievable and followed by positive feedback. Improvement efforts on the larger scale required for patient safety and quality need to provide satisfaction for individual participants if they are to succeed. Measurement is critical for this, as are long-term trust relationships between the doctors and hospitals. Trust relationships facilitate cooperation in organizations and the coordination of complex activities under conditions of uncertainty (Taylor-Gooby 2006). High-trust management processes are participatory, fair, and encourage employees to share the goals of the organization (Gilson 2003). Many subjects called for a renewal of the relationship between doctors and hospitals. A strengthened relationship would provide the framework for the improvement–feedback process.

This requires increasing organizational trust by improving the quality and tenure of hospital managers and the replacement of short-term politically driven directives with truly strategic planning. A recent international study of high-performing health systems revealed that charismatic long-staying leaders and chief executives were the norm (Baker
et al. 2008). Salary helps, but particularly if it includes such features as retention bonuses for senior executives with good track records. However, the other reason that executives stay in such roles is career satisfaction. This derives from many things but particularly the ability to make changes and be respected. The micromanagement of hospitals by State Health Departments limits the ability of hospital managers to make change, as does the current generic contempt of doctors for managers.

Anchoring many management processes to the roles and jobs of senior doctors may be the best way in the Australian system to provide better continuity in hospital management. In addition to their expertise being utilized, the clinical roles of senior medical staff will minimize the risk of improvement being paralysed by what has been described as the ‘happy principle’ (or ‘managing up’):

**Nothing will Happen while Happy Principle Rules**

*I am not surprised the medical profession has little faith in reforms in the NSW Department of Health … The department has a ‘good news’ system of management. Each level of management is expected to transmit good news to those above. The immediate superior is able to pass on the good news and avoid criticism from those further up the chain. In this way, key performance indicators and budget strategies are achieved, and there is some hope of promotion. To send bad news (also known as the truth) to a superior is a significant career-limiting move … Data is sanitised, fudged or selectively reported, complaints are ignored and whistleblowers are victimised. The result of this chain of happy reports is that the people at the top of the pile get what they want – a glow of self-satisfaction at a job well done and praise from the minister, who has a distorted view of the whole system. The ‘good news’ system means very few reforms will be needed. The process is perhaps perpetuated by the tolerance of the workers, who struggle with inadequate resources and staff numbers. It is they who get the blame when something goes wrong. I think it is time we all heard the truth.*

*(Dr Christopher Dunn, Wollongong, in the *Sydney Morning Herald*, 20 November 2009)*

Doctors will need significant allocations of time, training and support staff to engage in both improvement processes and management. Others have made these recommendations (Olsen and Neale 2005, Dowton 2004, Braithwaite 2004). Salaried medical staff were also a feature of high-performing health systems (Baker et al. 2008). A salaried doctor is both more committed to the institution, which is his/her sole (or major) workplace, and more able to be ‘managed’ (by both performance incentives and sanctions).

The respect of their colleagues is an essential part of professional satisfaction for doctors and may be increased by the development of a greater academic infrastructure in organizational work. Social rewards and reputation strongly motivate organizational behaviour (Ariely 2008). The words below are from a rare doctor who received high-quality (evangelical-style) training in clinical practice improvement:
Oncologist: Stop concentrating on all the paperwork involved with quality assurance ... or rather get rid of the quality assurance department and give us extra nursing staff and extra doctors who do their job properly in the first place, instead of making up all of these bullshit committees and stuff. Blow up the Department of Health, get rid of the quality branch ... I did the quality assurance programme ... and they asked us to do a quality project, and I was from [a regional area] and there was no one to help me do my quality project and I didn't end up graduating. My quality project was to set up a [specialty] unit [in a rural area] which I did with no money ...

I think they've lost the plot, the quality assurance. All they ever do is talk about pilots and aeroplanes. I said to Bruce Barraclough [an Australian safety and quality leader and chair of the previous national organization, the Australian Council on Safety and Quality in Health Care] when I see him at meetings, I said to him, 'Bruce, if you had a tired pilot, with a broken plane, they wouldn't take off'. Planes don't take off unless they have a full crew, the pilot being rested and the plane fixed. Here we haven't got a full crew, everybody is tired and the machine is breaking down. They use the airline industry as a comparison but they don't use it properly ... Let's make sure that if someone comes into the hospital that we have the required number of nurses, the doctors have their required holidays, they work the right number of hours and the right number turn up for each shift. I can remember when I was an intern here at this bloody place ... Every second weekend ... I used to run the Casualty by myself ... 16 hours a day, nobody came to help. The system doesn't back you up.

Interviewer: Are they all quality issues?

Oncologist: Yes, of course they are. But no one does anything about it. I've never seen one quality assurance item get fixed. I said one day, 'The hospital needs a paint'. They said, 'That's not quality assurance'. I said, 'Yes it is'. I said that 'The environment that people get treated in influences how they feel, and if you're going to leave this place with paint hanging off the wall and looking like crap, how do you think the people are going to feel?' Nobody wants to listen to that. If you come up with a quality issue saying 'We need more staff', they will ignore it. Anything that comes up saying they need something, gets ignored. I have no faith in quality assurance, I'm sorry. It might be a big concept but it doesn't work in the health industry.

This doctor's vehemence about his beliefs and experiences is striking. He would be a handful in a meeting, but can the system afford to lose such passion and creative thought? He has his own views on learning from airlines and his point about the paint is well made. The high intelligence and strong decisive personalities of most doctors make them challenging to manage and people to be avoided by mediocre middle managers. Hospital and State Health Department managers are not highly enough remunerated to attract and retain individuals of uniformly high ability in these positions.

We are in a time of change. We know that current care is not as good as it could be and this forms a focus for public dissatisfaction, and thus the dissatisfaction of elected representatives. The current regulatory turn is not surprising. However, inappropriate regulation may make things worse by destroying trust and crippling innovation in care and safety. Instead we need to improve managers and management and mobilize the senior hospital doctors.
5. INCREASE INDIVIDUAL LEARNING

What is an expert? They have been described as having a high degree of accomplishment relevant to others. They notice patterns and anomalies, they see the big picture (have situation awareness), they grasp opportunities, they are able to improvise and they understand their own limitations (reflexivity) (Klein 1998). Their apparent foresight and ability to anticipate problems is due to their ability to run simulations unconsciously, that is, to generate counterfactuals. Senior medical practitioners are experts – the complexity of medicine means that it takes quite some time to become an expert:

_I am a better doctor now than I was when I was a junior consultant only because I’ve seen 3,500 cases of [a condition]. It’s an experience bank that’s hard to beat._ Sydney specialist

Journals periodically make much of the crisis due to the extraordinary expansion of the medical literature in the last two decades. Doctors can no longer memorize the enormous amounts of scientific knowledge that are relevant to their clinical practice (Nicolini et al. 2007), yet the interview subjects did not complain about this. This may be because, in reality, explicit evidence is rarely accessed or used, but tacit guidelines – internalized and collectively reinforced – structure most practice.

_You make your decision, the diagnosis within the first five minutes, and the rest is kind of padding to kind of sort it all out._ Rheumatologist

Tacit knowledge refers to intuitive understandings; that is, personal knowledge based on aggregated information (Eraut 2004). We often cannot recall its provenance and sometimes are unable to even describe this knowledge. This knowledge is uncontrolled in its acquisition and may be biased, but it is used in medicine for generating hypotheses which are then tested. Canadian Emergency doctor Pat Croskerry calls this the ‘Casablanca strategy’ – rounding up the usual suspects (Croskerry 2005).

It has been found that at least 25 per cent of doctors are not accurate judges of their past or likely future performance or current learning needs and competence (Davis 2009). Doctors who perform in a less than optimal fashion often judge themselves to be above average. However, doctors can understand and develop their own thinking processes. This means considering how decisions are made, understanding risks and biases (Groopman 2008) and learning more about cognitive psychology. The new Australian Good Medical Practice Code of Conduct includes self-awareness and self-reflection in its list of the required professional values and qualities of doctors (Working Party of the Australian Medical Council 2009). Doctors need to reconsider the false assumption that they are engaged in a science that encourages an unattainable perfection and precision. Thus cognitive error becomes a moral failing rather than the ineradicable and rational possibility it really is (Montgomery 2009).

There are individual ‘best practices’ associated with learning from mistakes. They include habits of enquiry, self-reflection, personal forgiveness, sharing experiences, empathy toward others, systems thinking and expectations of fallibility (Hoff et al. 2005). Individual doctors are good at some of these some of the time (and systems thinking very rarely). Frequently, an emotional response to error rooted in perfectionism or uncertainty and the doctor’s care about the patient impedes this individual process. It can also be
easy to rationalize errors, particularly those of omission (Hoff et al. 2005). Croskerry states that the typical medical response to error is severe guilt and this is ‘unpropitious and maladaptive in those for whom a major goal is lifelong learning’ (Croskerry 2005). His alternative is the performance of ‘cognitive and affective autopsy’. The adoption of these recommendations will help doctors become expert sooner and then become ‘better’ experts delivering more reliably safe care.

6. SUPPORT INSTITUTIONALIZED LEARNING

The metaphor of ‘falling between the cracks’ is often applied to analyses of patient safety failures. Perhaps this is an attribution of the problem to the dark and shadowed interstices in staff conceptualization of ‘the system’. These cracks are areas where responsibility is unclear or disowned. Clinicians see the system as a behemoth that cannot be understood or easily altered and improved and where learning does not happen. Yet it is possible to establish organizational processes that can allow for translation of personal and group reflection into sustainable organizational learning (Nicolini et al. 2007).

For example, let us consider a teamwork issue. Teamwork is not an automatic consequence of co-location and depends on willingness to cooperate for the sake of a shared goal (Amalberti et al. 2005). Health care has difficulties in setting and determining shared goals. Doctors and nurses frequently have different goals. Nursing focus is often on the series of tasks that deliver care, while doctors’ focus may be on diagnosis. It is sometimes possible to make the goal both better shared and defined. Intensivist Peter Pronovost was able to halve patient length of stay in an Intensive Care Unit at Johns Hopkins Hospital by introducing a patient goals checklist initialled by all care providers three times a day (Pronovost et al. 2003). The first question asked was the most important: ‘What needs to be done for the patient to be discharged from the ICU?’

We learn all the time and much of our learning is implicit and unconscious. The introduction of group ‘best practices’ for learning from mistakes can support the individual learning process. Such practices include feedback, collaborative enquiry, real time briefings and tolerance for creative tension (Hoff et al. 2005). (I will return to this last point later in this chapter.)

Learning researcher Michael Eraut considers we learn best in the workplace working alongside others, as this provides support and means tacit knowledge is made explicit (Eraut 2004). Information is sought by asking colleagues and information circulates best when there is ‘operational proximity’ and ‘value sharing’ (Nicolini et al. 2007). These were features of the ‘golden era’ the nostalgic clinicians harked back to, when the work environment enabled doctors to work closely with colleagues and to access their knowledge and experience (Nicolini et al. 2007). This was a period when the exercise of professional skill was combined with new scientific knowledge and the pace of work was more civilized – and allowed for learning:

_It’s no longer fun to be a doctor. When I was a student it was enjoyable, it was entertaining and I don’t think it was because I was a student either ... We were a team. That just doesn’t happen anymore. That dedication to teaching, you don’t see that attitude anymore._ Cardiac surgeon
If safety is socially mediated, as agreed by both sociologists (Gherardi et al. 1998, Gherardi and Nicolini 2002) and organizational psychologists (Weick and Roberts 1993, Weick 2002), then the ability of an organization to provide processes that allow staff to interact and make sense of events determines safety (Gherardi et al. 1998).

Eraut delineates three categories of informal learning: implicit, reactive and deliberative (Eraut 2004). Implicit learning occurs when an experience enters episodic memory and produces unconscious expectations. Reactive learning varies from brief spontaneous reflection on past events to asking questions and observing effects of actions on current events. An organization can maximize this learning by allowing adequate time for reflection, maximizing continuity of patient care and allowing teams time to discuss cases and question plans.

A hospital can increase deliberative organizational learning by instituting and supporting ‘gutsy’ review meetings, encouraging storytelling, ensuring maximum engagement of staff (including juniors and non-doctors) in decision making, conducting observational audits and research, and by the use of simulations.

The quality of existing review forums is rarely analysed. A US study suggests that morbidity and mortality meetings (M&Ms) are not sufficiently used to drive staff learning (Schwappach and Boluarte 2008). The factors that make for a productive meeting include the presence of all relevant staff, including senior experts, and time allowed for adequate preparation of case material. Measurement of harm, error and safety is also key as regular collection and presentation of useful data are required to support institutional learning. Outcomes and indicators to support the work of a unit are required to ensure a meeting can deal in numbers and facts as well as anecdote.

There is another more controversial issue. Review meetings cannot exist in a Maxwell Smart-like ‘cone of silence’. They need to be designed to produce conclusions and link to mechanisms where action (such as work redesign) can occur. The ability both to monitor performance and to alter the work environment appears to be a requirement for individual engagement in safety (Gherardi et al. 1998). Without the ability to influence major change, doctors merely accommodate to the unsafe system (Waring 2007).

American philosopher and educationalist John Dewey conceptualized education as simply ‘experience that is arranged to be both motivating in the moment and consequential for capabilities in the long run’ (Cohen 2009: 451). Stories do this and review meetings are places where stories are told. In contrast, the compressed and superficial information collected by incident monitoring systems is inadequate for sense-making about error, and discourages staff engagement in safety (Waring 2009). Teaching using narrative is fundamental to the acquisition and retention of most medical knowledge, yet its value and importance for life-long learning is not always recognized.

With colleagues, I conducted a piece of research collecting the teaching tales told by young anaesthetists. (One is retold at the start of Chapter 7.) Retelling of horrific events increases their salience (Henriksen and Dayton 2006) and the emotional content of the stories makes them memorable (Croskerry 2005). Despite both the interest and safety significance of the analyses, we were not able to have this research published in any anaesthetic journal. (One paper was published in Social Science and Medicine (Iedema et al. 2009a) – not a journal read by many anaesthetists!)

Another way to help institutionalize learning is to formalize continuing links with universities. Currently the alumni are primarily approached for donations. Yet all could be engaged in organizational and clinical practice research throughout their professional
careers. Employment in a medical school is associated with career satisfaction for US doctors possibly because it provides intellectual stimulation and creative expression (Leigh et al. 2009). This formalization of an on-going university link could be a solution for some of the bored and burnt-out doctors. At the moment, relatively few doctors ‘do’ research, and accolades, income and status are directed only to this small group who do. It is hard for ‘ordinary’ doctors to recognize the importance of a role outside their one-to-one doctor–patient relationships. Any work they do to systematize the delivery of good clinical care is not valued. This work easily could be reframed from ‘management’ to ‘organizational research’ to increase its attractiveness and interest and so add to the knowledge of the organization of health care.

7. VALUE DISSONANCE AND CONFRONT EMOTION

Institutionalized learning will only occur if doctors are engaged in change. Organizational engagement to date has been a rough road for doctors, yet creative tension and dissent create maximal organizational learning (Hoff et al. 2005, Edmondson 2004, Coutu 2009). In short, the ‘happy principle’ does health care a disservice:

*It is time for managers to value providers who present evidence contrary to the view that things are alright, who create cognitive dissonance that serves as an impetus for change, and who step out of their accustomed roles to help solve the problem-behind-the-problem. And foremost, it is time for managers and their leaders to value these same qualities among themselves.* (Henriksen and Dayton 2006: 1550)

It has been suggested that:

*The basic tenets of professionalism are attractors to the human spirit unless the institutional ecology disables, frustrates, and renders unachievable, respectful behaviours and relationships.* (Leach 2009: 96)

An organization that cannot learn or support learning is inhospitable. Quaker ethicist Palmer Parker discusses a case where a patient died under the care of a single overwhelmed junior doctor (Parker 2007). His analysis of the reasons why the resident did not call for help could be disputed. The latter may have been unsure how sick the patient was and therefore whether help was really needed, or whether she was merely feeling inadequate (the medical student dilemma). However, Parker makes a number of thoughtful claims for educational change:

*We must help our students uncover, examine and debunk the myth that institutions are external to and constrain us, as if they possessed powers that render us helpless – an assumption that is largely unconscious and wholly untrue … [T]he shadows that institutions cast over our ethical lives are external expressions of our own inner shadows, individual and collective. If institutions are rigid, it is because we fear change … [I]f institutions are heedless of human need, it is because something in us is also heedless.* (Parker 2007)

His remedies include teaching students to ‘explore their feelings about themselves, the work they do, the people with whom they work, the institutional settings in which
they work, the world in which they live’. Doctors have been trained to view their own emotions with suspicion and suppress them. Researchers coding student narratives were stunned at the absence of language that conveyed the students’ emotional responses to the significant events they recorded (Karnieli-Miller et al. 2010). In the interviewees’ definitions of professionalism, cool reserve was lauded although some forgave themselves and each other for not always achieving this. (Writing and reflecting on narratives in fact may be an effective way of teaching professionalism – a method by which both students and faculty can learn – see Quaintance et al. 2010, Karnieli-Miller et al. 2010.)

Instead of being suppressed, some of these emotions need to be turned toward organizational action. Croskerry, too, suggests that M&M meetings should include an analysis of the doctor’s cognitive style and affective state (Croskerry 2005), as decision making is affected by mood (Croskerry et al. 2008). For doctors to understand more about the care they give, the experiences patients have and their own emotional responses to the work they do requires ‘metaprocessing’ – ‘thinking about thinking’ and ‘feeling about feelings’ (Epstein 1999).

Fundamental to building effective new healthcare communities will be an understanding of doctors’ social support networks and social identity so that reform is possible. All the doctors interviewed longed for a sense of belonging. A perceptive subject placed this as central to the work of health care:

*You know, you can run a hospital from any kind of building or tent … It’s not so much the facilities as the staff morale and people working together and feeling valued.* Plastic surgeon

Belonging was associated with safety:

*Patient safety has declined … because what we’re doing is more complex. It takes greater team work to do the complex things we do and the chain can break in any one of a dozen places … Hospitals have become much more fragmented … Terrible things happened when I was a junior resident and a registrar because you just didn’t know any better. But everybody knew everybody in the hospital and all pulled together: you didn’t see the administrators as the enemy … A lot of people here now do a job, go home again. They have no real sense of anybody else in the place: they don’t have any real sense of corporate allegiance and responsibility and … cooperation and being part of the place … They say ‘It’s not my problem’, and go home. There was a time when, if somebody stuffed up [made a serious error], everybody in the hospital would know about it and maybe feel partly responsible. Now you’re just bloody glad it was somebody else not you.* Gastroenterologist

Rebuilding a hospitable ecology in hospitals – a sociable environment where responsibility, cooperation and support are norms – requires confronting the emotions that attend hospital work and admitting their importance. Discussion of emotions and relationships must be explicitly included when adverse events are reviewed. The current education on dealing with the doctor–patient relationship needs to be complemented by undergraduate and particularly workplace education on managing workplace relationships – managing conflict and building teams. Managing conflict includes seeking constructive conflict – the disagreement that attends group creative processes. Team building is really relationship building and, as these relationships appear to be critical to patient safety, both skills and the responsibility to use them need to be taught.
If Doctors Learn to See and Influence the System, Things can Change

Doctors only ‘see’ a fraction of the care they give. As has been discussed, sometimes this is literally so but there is a broader system, not so easily video-taped, where doctors’ action and inaction, particularly their disengagement from system improvement and management, results in patients suffering poor care and adverse events. Human factors experts talk of ‘socio-technical systems’; that is, the interaction of technology, task, complexity, work processes, environment, human skills and cognitive limitations with the organizational culture and social systems. If doctors learned to see this broader system, they have the potential, as the most powerful and influential healthcare providers, to forge it into better shape, to make change others cannot.

Unfortunately, many doctors are not able to value or understand much of the information they need to do their jobs – medical sociology, organizational psychology, human factors engineering and business processes. This knowledge can be gained as doctors are eager and able learners, but they will gain it only if they respect these disciplines and if the knowledge is useful and they are allowed to use it. More research is needed to define the work of doctors and the processes of healthcare delivery and this needs to be done before bringing in a further pastiche of solutions from other industries. No other industry has patients or the complex communicative and emotional engagement between staff and patients and among staff.

We need to explore and open for scrutiny the space between the individual and the organization, and between knowledge and structure and will and affect. ‘Command and control’ is a military term that refers to the exercise of authority and direction to achieve strategic or tactical direction objectives. ‘Control’ is defined by the Australian Defence Force (ADF) as ‘those structures and processes devised by command to enable it to manage risk’ (Burnett and Durant-Law 2008). We have a plethora of control structures in healthcare to attempt to ensure that safe high-quality care is delivered by managing risk. The ADF definition of ‘command’ is apposite: ‘the creative expression of human will necessary to accomplish the mission’ (Burnett and Durant-Law 2008).

How could we provide an environment that encourages healthcare staff to engage in ‘the creative expression of human will’ to accomplish a mission of safer health care? The mission in health is not always an agreed one, and practitioners’ inability to see or understand long-term goals for patients and society is a problem. To ‘see’ we need measurement of broad patient outcomes and experiences and opportunity for organizational learning and reflection.

Doctors also lack the ability to influence the system in which they work. The clinicians interviewed had plenty of passion and anger but they had neither the tools nor the time for change processes, nor clear structures through which to work as part of the system. We need creativity to move away from the deadening weight of protocol, policy and procedure that are produced but do not change practice or improve care.

‘Will’ is a powerful word as it brings with it both determination and affect. In the military the exercise of will would include action towards the safety and survival of the group. For doctors, this would be centred on caring about patients and caring about excellence. Remove the bonds to patients and consistently obstruct clinicians’ attempts to be excellent, and they may retire defeated.
Doctors have a long tradition of using will and determination to solve complex problems. If doctors could be encouraged to see ‘the system’ in the same way they see a patient, success in healing the healthcare system would seem ensured.

Patient safety advocates with industrially derived paradigms need to listen to the practitioners who, instead of aviation safety tips, call for an expanded sense of place and relationships. This requires allowing doctors more control over the organization of their work and the rebuilding of the relationship between the doctor and the hospital. By understanding and valuing communicative and interpersonal interactions, it is possible to create safety and satisfaction and reconstruct medical practice.


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