Factors that encourage or discourage doctors from acting in accordance with good practice

Final report

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Preface

This research was commissioned by the General Medical Council (GMC) in order to better understand the factors that affect doctors' behaviour and decision making. Clinicians must apply their knowledge, developed during their years of education and training, to wide-ranging situations and circumstances. They have support in this process in the form of official guidance from GMC and others. This allows them to reduce uncertainties and make a decision based on their best judgement.

However, we know that at times good standards of medical care are not met. Investigations of serious service failures have provided useful data on where the vulnerabilities of the system lie and where the biggest challenges are to be faced. However, they do not inform us about why doctors do or do not adhere to good practice.

This study is intended to begin to fill this gap in understanding, by harnessing a broad range of existing literature and through discussions with UK experts in the field.

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Introduction

In November 2011, the General Medical Council (GMC) commissioned RAND Europe to undertake research to investigate the nature of influences on doctors' behaviour and specifically to explore factors that encourage or discourage doctors from acting in accordance with good practice. The ultimate aim of the research is to inform policy development to support doctors in the course of their work. The main focus of the assignment was to review lessons from existing evidence in this area, rather than to undertake new primary data collection.

The GMC

As the independent regulator for doctors in the UK, the GMC is responsible for protecting, promoting and maintaining the health and safety of the public by upholding standards in the practice of medicine.

Purpose of this study

The question of why doctors adhere or do not adhere to good practice is the focus of this study, in order to improve understanding of the factors that may contribute to the failures in service provision that lead to poor standards of care. Investigations of recent service failures have shown that poor practice can arise at all levels – individual doctors making a poor decision, inadequate local systems and processes for managing aspects of health care or at a strategic level where the effects of policy decisions (such as the development of performance targets) can create an unintended negative impact. The overall purpose of the study is to develop an improved understanding of the critical enablers and barriers to embedding the principles and standards of good practice in doctors' everyday decision making. This will enable the GMC to inform the development of policy and a programme of work aimed at supporting doctors to adhere to good practice in the care and management of patients.

Methodology

The approach used for this work included a literature review in the form of a Rapid Evidence Assessment (REA), key informant interviews and a benchmarking review.

The REA enabled a detailed and critical assessment of the scope and quality of available evidence. This is replicable since the parameters of the approach are agreed in advance, which sets some limits on the span of the inclusion criteria and sets clear exclusion criteria. The approach involved searches of the literature within these criteria.

Interviews were undertaken with 10 individuals with specific insights into the field due to their role or experiences. These discussions were intended to provide an additional source of data for the core questions of the study. Specifically, they explored individual experiences, views on motivational factors and perceived difficulties related to good practice.

The benchmarking study was intended to facilitate comparison with experiences of another sector and to provide pertinent insights into adherence to good practice.

Key findings

In reflecting on the data presented in this report, it is possible to make a number of observations on the factors that influence the behaviour of doctors in relation to acting in accordance with good practice.

Goals and incentives of doctors are sometimes misaligned with the goals of patients

The goals of doctors when they treat their patients may differ from the goals of their patients. Assumptions are sometimes made about what patients want and need. Patient-centred approaches do not seem to have countered this risk. If behaviour change by doctors is needed, multifaceted combined approaches that involve patients and that work at several levels of influence appear to be most effective. Reward and incentives for doctors appear to work best if they use a broad definition of reward that goes beyond financial incentives and includes areas such as recognition for achievement.

Habits and patterns of behaviour can impede adherence to good practice guidelines

If a new guideline or good practice recommendation requires a change to previous patterns of behaviour or habits among doctors, it becomes harder to implement. Less specific or more vague recommendation also have less take-up. If doctors have a strong belief that they can and will be able to perform particular actions, they are more likely to engage in that behaviour. In addition, the intrinsic value of the action to be taken encourages increased manifestation of that behaviour.

Reconciling personal judgement with guidelines involves assessing the available evidence

Doctors increasingly decide to adhere to guidelines when they better understand the evidence of their effectiveness. This is because it reduces the uncertainty within the span of decision making that they are dealing with. When reaching a decision, together with a patient, doctors will weigh up the evidence that they have and decide what is the most reliable – often this can be the 'informal' information rather than official data or statistics. Guidelines may potentially pose a barrier to creative problem-solving and reaching a balance between personal judgement and the use of guidelines can be challenging for some medical staff.

Team working and human factors influence good practice behaviours

Personal characteristics, such as a belief in having control over life events and personality dispositions, can have an impact on the decisions and behaviour of doctors. Preconceptions and values can also affect their interactions with and decisions reached about some patients, for example in the case of older patients. Effective team working can be challenging for some doctors who may see themselves as being the natural leaders of the team or as being 'above' the team. When teamwork within a healthcare environment is not working well there can be negative impacts for both patients and team members. Research points to a connection between teamwork and patient safety. One of the strategies identified in the literature as helpful for improving team working was inter-professional education.

Morale, workload and resources need to be effectively managed to enable doctors to make good decisions

The morale and prevalent attitude of medical staff has been linked to their ability to communicate with patients. Perceived behavioural control over their circumstances seems to positively affect performance. Information overload and heavy workloads have been documented to affect the ability of doctors to adjust their behaviour and make good decisions. The need to find strategies to deal with this seems to be an important area to affect change, where it is needed. Potential solutions to some of the individual and team-based challenges proposed in the literature include simple measures (such as colour-coding) and more complex, technology solutions. Some aspects of the wider system and policy environment may affect the ability of doctors to provide a good standard of medical care, such as increasing role substitution affecting continuity of care.

Organisational culture may obstruct ongoing improvement and negatively affect standards of care

Education of doctors throughout their training and ongoing career development was seen as critical to effective practice. In particular, ongoing opportunity to develop reflective capability in alignment with and in support of technical capability was identified as important for the effective provision of care. Early stages of medical training were observed to be critically important in the development of good practice among doctors. Tight management and monitoring of these important stages of learning, as well as ongoing continuing professional development were seen in the literature as important factors. Ensuring clarity about and creating a shared understanding of accountability structures and processes was seen as an important aspect of improved communication. In particular, the range of values and meanings applied to accountability mechanisms mean that doctors may be working towards varied priorities - for example they may focus on managerial standards or may be working towards social responsibilities and norms (or some combination of these). A culture of support of patients by doctors can potentially make it difficult to offer advice that might not be well-received and can result in doctors not providing the advice that they need to in relation to, for example, smoking cessation or obesity management. There has been, in some medical environments, a culture of acceptability of non-disclosure of errors or concerns for care quality. Tacking these challenges requires supporting staff and ensuring that they are not fearful of the consequences of their actions.

Within each of these thematic areas we recognise that the data relate to a complex set of influences that exist at various levels– individual (micro), organisational or local (meso), and wider policy level (macro) of influence. In each thematic area, one of these levels of influence may be more significant than the other two. However, they are ultimately linked together within the wider policy context.

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CHAPTER 1   **Introduction**

1.1   **Introduction**

In November 2011, the General Medical Council (GMC) commissioned RAND Europe to undertake research to investigate the nature of influences on doctors' behaviour and specifically to explore factors that encourage or discourage doctors from acting in accordance with good practice. This document is the final report for this work.

The ultimate aim of the research is to inform policy development relating to supporting doctors in the course of their work. The main focus of the assignment was to review lessons from existing evidence in this area, rather than undertaking new primary data collection.

1.2   **Background and context to the role of the GMC**

As the independent regulator for doctors in the UK, established under the Medical Act of 1858, the GMC is responsible for protecting, promoting and maintaining the health and safety of the public through its work upholding standards in the practice of medicine. In the course of this work, the GMC is responsible for undergraduate and postgraduate medical education.

Under the Medical Act 1983, the GMC has four main functions:

- Keeping up to date registers of qualified doctors;
- Fostering good medical practice;
- Promoting high standards of medical education; and
- Dealing firmly and fairly with doctors whose fitness to practice is in doubt.

The GMC is a registered charity in England, Wales and Scotland. It is primarily funded by doctors' registration fees. Their governing body, the Council, has 24 members of which 12 are doctors and 12 are lay members, all appointed by the Appointments Commission[1].

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[1] Description of role, function and context of GMC as set out in GMC, Invitation to Tender 2011.

The Council has power to 'provide in such a manner as the Council thinks fit, advice for members of the medical profession on standards of professional conduct; standards of professional performance; or medical ethics[2]'.

To fulfil this role, the Council publishes guidance which sets out the ethical principles that underpin good practice. *Good Medical Practice*[3] (GMP, 2006) is the core guidance to the profession which sets out the standards of conduct and care which society and the profession expect of all doctors throughout their careers. The guidance applies to all registered doctors across the UK, whether or not they hold a license to practise and regardless of their specialty, grade or area of work (i.e. National Health Service (NHS) or independent practice).

GMP is supported by a range of more detailed guidance booklets on areas such as confidentiality and raising concerns. The GMC use a number of approaches to raise the profile of their guidance and learning materials amongst doctors and other key groups. These approaches include media campaigns around new guidance, a variety of talks and workshops, and collaborative projects with partner organisations.

1.3 Purpose of this research

It is a part of doctors' professional responsibility to be familiar with and follow GMC guidance. Doctors are expected to use their judgement to apply the principles and standards in guidance to the various situations they face in their day to day practice. The guidance is not mandatory, but serious or persistent failure to follow it will put a doctor's registration at risk. Doctors must be prepared to explain and justify their decisions and actions against the principles and standards contained in the guidance.

Therefore, doctors must apply their technical knowledge, in combination with their own judgement on the appropriate decision to make and simultaneously ensure that this is in line with principles and standards of good practice and care. This involves a potentially complex interaction of influences upon an individual doctor. Data from investigations into situations where there have been serious service failures[4] of various kinds provide some insight into the challenges that arise when things go wrong. These investigations do not provide a detailed understanding of why doctors do or do not meet their obligations to provide a good standard of care and to act to protect patients from harm (as set out in good medical practice). However, they do shed light upon the type and nature of failure that can occur and some of the explanations offered by the practitioners and managers involved.

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[2] Under *section 35* of the *Medical Act 1983* (as amended).

[3] *Good Medical Practice* (2006) is available on the GMC website along with the other supporting guidance documents on the 'Guidance on good practice' pages: http://www.gmc-uk.org/guidance/index.asp

[4] Previous Bristol Royal Infirmary Inquiry – 2001; Investigation into Mid Yorkshire Hospitals NHS Trust – 2004; Investigation into outbreaks of Clostridium difficile at Maidstone and Tunbridge Wells NHS Trust – October 2007; Investigation into 10 maternal deaths at, or following delivery at, Northwick Park Hospital, North West London Hospitals NHS Trust, between April 2002 and April 2005; Healthcare Commission: Learning from Investigations – 2008.

Specifically, within the investigations of serious service failures, there were trends in the types of problems which arose across some of the particular situations, settings and contexts. Because of these patterns, it was observed that some of these may, in fact, be more widespread problems, rather than simply one-off problems. For example, leadership issues were observed to be prevalent in these cases. Most notably, there were situations where the focus on clinical quality was compromised, there was a discontinuity between leaders due to staff turnover problems and a lack of team work was evidenced between managers, clinicians and clinical groups. In addition, problems were identified in relation to the use of targets compromising patient safety, inability to learn from experience due to autocratic management style, poor governance arrangements and use of information, inadequate understanding of adult protection procedures and poor care on general wards (Commission for Healthcare Audit and Inspection, 2008). Recommendations for change following from these investigations also provide useful insights for this study. These focused on cultural shifts to change behavioural patterns towards more openness and listening to staff and patient concerns, focusing board responsibilities, improved governance models and creating enough time and space in the system to ensure that the needs of vulnerable patients are considered.

The question of why doctors adhere or do not adhere to good practice is the focus of this study, in order to better understand the factors that empower or act as disincentives on doctors (or other professionals) to do so. We know from the service failure investigations (detailed above) that these problems can arise at all levels – individual doctors making a poor decision, at a local level, inadequate systems and processes for managing aspects of effective care and at a strategic level, where the effects of policy decisions (such as the development of performance targets) can create an unintended negative impact. The issues and challenges arising at each of these levels are, of course, interwoven with related challenges at other levels. The complexity of this area has driven a need to understand it better, and to utilise fully and draw from the existing literature in this area. Therefore, the project was designed to rapidly identify and assimilate existing knowledge on factors that encourage or discourage doctors from acting in accordance with good practice.

The overall purpose of the study is to develop an improved understanding of the enablers and barriers to embedding principles of good medical practice. This will ultimately inform the GMC about where and how best to invest their resources, work with partner organisations and deliver an ongoing programme of work.

1.4 Definitions of 'good practice'

The concept of 'good practice' was defined broadly for this study. It refers to key standards in good medical practice for treating patients with dignity and providing care that is of high-quality, safe and patient-centred. The use of clinical guidelines (from the National Institute for Clinical Excellence (NICE) and others) is obviously part of good practice within this broad definition.

1.5   This approach

The approach used for this work included a literature review in the form of a Rapid Evidence Assessment (REA), key informant interviews and a benchmarking review.

The REA enabled a detailed and critical assessment of the scope and quality of available evidence. REAs follow the same structure and are as replicable and transparent as systematic literature reviews, but are less resource intensive. They are replicable since the parameters of the approach are agreed in advance, which sets clear exclusion criteria and sets some limits on the span of inclusion criteria. The approach involved searches of the literature within these criteria. Other approaches to sourcing potentially relevant documentation, such as citation searching, are not undertaken as part of the REA approach.

The key informant interviews were undertaken with 10 individuals with specific insights into the field due to their role or experiences. These discussions were intended to provide an additional source of data for the core questions of the study. Specifically, these explored individual experiences, views on motivational factors and perceived difficulties related to good practice. Thirdly, the benchmarking study was intended to facilitate comparison with experiences of another sector and to provide pertinent insights into adherence to good practice.

1.6   Aims and objectives of the research

The study aimed to gather evidence about what influences doctors' decision-making and behaviour in the environments in which they practice. In particular, the research aimed to address the following questions:

* What are the factors or influences that may actively empower or act as disincentives on doctors to behave in ways that are consistent with established standards of good practice?

* What are the factors or influences that may actively empower or discourage doctors from acting in ways that are consistent with guidelines about raising concerns in circumstances where patient care or safety may be compromised or at risk?

The objectives of the work were to better understand the nature of the influences on doctors' practice and to identify any potential opportunities or levers for raising awareness among clinicians of good practice and increase their willingness to act to protect patients in challenging situations.

1.7   Structure of this report

This report sets out the main findings of the study. Chapter 2 presents a short review of the methodology used in the research. Chapter 3 describe the six main themes emerging from the research. Chapter 4 presents the conclusions of the study. The bibliography sets out all of the literature gathered and reviewed for the assignment. The appendices present the specific research tools used (protocols etc) for each of the three strands of the research methods.

Methodology

The methodology used for this work included a literature review in the form of a REA, key informant interviews and a benchmarking review. Each is briefly described below and more detailed information is included in the appendices.

2.1 Rapid Evidence Assessment

The primary question the REA aimed to answer was what influences doctors' adherence to 'good practice'. The evidence included in this review was focused on the qualitative nature of the influences on behaviour, as opposed to measuring the discrepancy between behaviour as prescribed by standards of good practice and actual behaviour. In terms of scope and inclusion criteria, we limited our review of the evidence to that already appraised by existing systematic reviews in the first instance. We anticipated a high number of returns due to high interest in research of physician behaviour, in quality of care studies in particular. We focused initially on reviews appraising evidence from randomised controlled studies and high quality non-experimental observational studies, and aimed to include reviews that follow standard practice according to Cochrane, Evidence-Based Medicine quality criteria. One limitation of systematic reviews is that they typically do not include the most recent evidence. Thus, we aimed to complement the evidence extracted from systematic reviews with single Randomised Controlled Trials (RCTs) and controlled studies not yet considered by existing reviews. These were identified through hand searches, referrals from interviewees and discussions with the GMC.

We used search terms that represent the principles and values set out in both the GMC's GMP booklet[5] and the NHS Constitution[6], together with terms reflecting potential influences on physician behaviour. We used free-text as well as Medical Subject Headings (MeSH) to maximise capture of related results. Given the GMC's interest in the 'human-related' aspects of good practice, the search was focused accordingly. Searches were done through three search strands derived from the theme of 'Good Practice': Patient-Centred Care; Clinical Ethics; and Team work.

Applying this approach, we found that, although systematic reviews and controlled studies that analyse specifically physician adherence to 'good practice' (as defined by the GMC)

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[5] Good Medical Practice. London: General Medical Council, 2006.

[6] http://www.nhs.us/Constitutions-and-Governance/NHS-Constitution

are relatively rare, many studies include secondary findings on these topics. Much more common are studies that examine adherence to clinical guidelines or evidence-based practice, but make reference to behavioural aspects of decision making. There are also a number of systematic reviews that refer to or draw conclusions from physician adherence to elements of good practice as defined by the GMC, despite focusing on a broader or unrelated concept. Points drawn from these works are all included here.

Because of limited research focusing on our specific topic of interest, we expanded the search method and inclusion criteria to include other reviews and papers, not formally classified as systematic reviews, found through hand searches of reference lists, as well as observational studies of particular relevance. **Combined, searches resulted in 35 papers selected for review: seven of which focused on elements of 'good practice' relating to clinical ethics; 21 related to patient-centredness and seven related to inter-professional team work.** However, a few touched on issues or behaviours associated with more than one of the themes, as defined for search purposes.

A second round of searching was subsequently carried out using a combination of previous search terms with a loosened inclusion criteria (allowing for the inclusion of less rigorous studies). The intention was to re-review a subset of results and reference lists for potentially relevant studies not captured in the first round. Reviews (of any degree of rigour), and comparative, evaluative and intervention studies were all acceptable for inclusion. Additionally, we reviewed articles suggested by the GMC. **After review of abstracts, 12 additional papers were added for full text review.**

Reasons for exclusion were as follows:

- Article was an editorial or personal commentary of the author;
- Focus was on patient instead of physician behaviour (e.g. patient adherence/compliance with prescribed treatment);
- Focus was on medical education or clinical research rather than practice;
- Focus was on evidence-based clinical practice rather than human-focused factors;
- Focus was on clinicians other than physicians (although articles focusing on nursing were included in a few cases where directly aligned with the key questions of this study).

Regarding clinical ethics, exclusions were made where the paper did not refer to an element of good practice but rather the ethics surrounding a particular concept in society (e.g. organ donation, euthanasia, or pharmaceutical philanthropy). All full texts of selected articles were then reviewed for application to the GMC good practice behaviours, and the relevant findings were recorded and written up by good practice theme.

2.2 Review of grey literature

As set out in the REA protocol, we used the results of the peer-reviewed literature review to define the main search strands for the grey literature. Using the same categories as for the academic review, we carried out searches around the three 'Good Practice' themes: Patient-

centred Care, Clinical Ethics, and Team work. In order to adapt the search to the internet, we also ran a 'General search' (very broad) and an 'Adherence search' (very specific).

In order to ensure we retrieved the widest set of relevant papers, we also ran variations of the search terms replacing 'physician' with 'GP' (General Practitioner) and 'doctor'. Each search was conducted for websites of the following organisations which were agreed with GMC to be most relevant to medical practice regulation and health care standards in the UK:

- The Royal College of General Practitioners, www.rcgp.org.uk
- The Royal College of Surgeons, www.rcseng.ac.uk
- The Royal College of Physicians, www.rcplondon.ac.uk
- The Health Foundation, www.health.org.uk
- The Council for Healthcare Regulatory Excellence (CHRE), www.chre.org.uk
- The King's Fund, www.kingsfund.org.uk
- The Nuffield Trust, www.nuffieldtrust.org.uk
- The Institute for Healthcare Improvement, www.ihi.org

The organisations' publication lists were also browsed manually, as a complement to the automatic search. Additionally, we included one paper suggested by an interviewee. **Combined, searches resulted in 25 documents selected for review**: five of which were retrieved through the general search; three through the Clinical Ethics search; two through the Patient-Centredness search, one through the Team work search, one through the manual search. The Adherence search did not produce any relevant results. Primary reasons for exclusion were:

- Focus was on patient rather than physician behaviour (e.g. patient adherence/compliance with prescribed treatment, patient perspective on the quality of consultation);
- Focus was on medical education rather than practice;
- Focus was on evidence-based clinical practice and clinical guidelines rather than human-focused factors;
- Focus was on care-givers other than physicians;
- Focus was on conceptual frameworks and definitions.

Full texts of selected articles were then reviewed for theme and application to the GMC good practice behaviours.

2.3   Key informant interviews

We undertook 10 key informant interviews to gather experts' views about and experiences of decision making in relation to standards of good practice. Adoption of this qualitative method made it possible to identify potentially different conceptions of good practice and to understand which factors impact on individual behaviour, how standards of good practice are embedded within decision-making, how potential conflicts of interests are perceived and how experts believe that adherence to good practice can be promoted.

Based on the GMC's research specifications, it was planned to interview leading experts working for various key UK-based healthcare organisations. These were identified through early discussions between RAND Europe and the GMC. Some individuals emerged as potentially important to interview through the REA or were suggested by other interviewees. The following people were interviewed for the research:

- Prof. Martin Marshall, The Health Foundation and University College London;

- Prof. Stephen Ramsden, Chair, Patient Safety First;

- Dr. Frances Eliot, Chief Executive, Healthcare Improvement Scotland;

- Dr. Helen Bevan, Chief of Service Transformation, NHS Institute for Innovation and Improvement;

- Dr. Suzette Woodward, Director of Patient Safety, National Patient Safety Agency;

- Graham Ixer, Head of Social Work Education, General Social Care Council;

- Prof. David Haslam, CBE, National Clinical Advisor, Care Quality Commission;

- Sir Lewis Ritchie, Director of Public Health, NHS Grampian and member of the Professionalism and Excellence in Scottish Medicine Group;

- Prof. Sean Hilton, Kingston University and Association for Study of Medical Education; and

- Prof. Dr. Dinny de Bakker, Head of Research Department, Netherlands Institute for Health Services Research.

Semi-structured interviews were used for the discussions (the key informant interview topic guide is presented in Appendix B: Key Informant Interview topic guide), in order to provide sufficient flexibility for a comprehensive discussion but also allow interviewees to raise issues as they saw fit. The precise focus of the interviews depended to some extent on the knowledge base and position of the interviewee but some of the main topics included the following areas:

- Conceptions of 'adherence' and 'good practice': what does adherence to good practice mean?
- Reasons for adherence (or not) to good practice: covering psychological, social, economic, institutional and possibly other influences on decision making;
- Embeddedness of codes of practice within individual decision making: how do codes of practice feature in judgement making, including situations of conflicting interests?
- Suggestions as to how to promote good practice.

Interviews were conducted by telephone or in person and were recorded to ensure accuracy of note-taking. They were then systematically analysed and coded.

2.4 Benchmarking

A third aspect of our research was a comparative benchmarking exercise in order to compare our emerging findings with experiences of other sectors and to identify lessons to

be learnt. In this context, different regulatory environments needed to be taken into account when drawing conclusions. However, despite the inevitable differences between sectors, this benchmarking exercise provided potentially pertinent insights into adherence to good practice.

The benchmarking exercise involved four main stages. First, it was necessary to select two benchmarking comparator sectors for the study. An initial 'long-list' of six possible benchmarking comparators was developed based on early discussion and brainstorming. Each of these six areas was briefly reviewed in order to develop a preliminary understanding of its potential as a benchmarking comparator. The six included: the health sector in the Netherlands; the health sector in Australia; the food standards sector; the adoption/childcare sector; the financial services sector; and the welfare/benefit system. In each of these cases, the available literature, the relevance of the substantive area and the relevance of the policy context to the central questions of this study were considered. Each was then ranked. From this process, the health sector in the Netherlands and the adoption/childcare sectors were selected. The latter was subsequently refined and focused on the area of child protection.

The selected benchmarking sectors were judged to have relevance to this context in different ways. The health sector in the Netherlands operates within a similar regulatory environment and therefore offers a relevant and useful comparison. The area of child protection is relevant due to the necessity of making regular decisions within an uncertain environment. All of the facts are generally not available and therefore staff in this field must make important decisions based on the information that they do have, in combination with their professional judgement.

The second stage of the benchmarking work involved the design of a benchmarking template for the desired information in each of the two selected sectors. This was reviewed, discussed and agreed with the GMC. The template is presented in Appendix C: Template for benchmarking analysis.

Third, data were collected to populate the benchmarking template in each of the selected cases. This was accessed through online searches and document reviews. Where data was not available, supplementary information was collected through interviews. Once all data was collected, this was then reviewed and analysed in order to extract key information for this study.

2.5 Structure of key findings

In the next chapter, we discuss each of the influential factors that emerged through the data collection process. These are organised thematically and structured within these themes into sub-areas. Our approach has been presented this way in order to facilitate examination of where an intervention to change behaviour may best be focused. In this way, the policy implications may be more effectively identified.

Factors that influence doctors to act in accordance with good practice

3.1 Introduction

This chapter draws together the data collected for this study and synthesises and organises them under themes relating to factors that encourage or discourage doctors from acting in accordance with good practice. We present the overall themes that emerged from the various sources and methodological approaches in the study (i.e. from REA, grey literature review, interviews and benchmarking).

The six overall primary themes that emerged from the study were as follows:

1. Goals and incentives of doctors;
2. The role of habits and self-belief;
3. Reconciling personal judgement with guidelines;
4. Team working and human factors;
5. Morale, workload and resources; and
6. Organisational culture.

Within each of these thematic areas we recognise that the data may relate to one of three spheres of influence, as relevant for that context – individual (micro), organisational or local (meso), and wider policy level (macro) of influence. In each thematic area, one of these levels of influence may be more significant than the other two. However, they are ultimately linked together within this context.

3.1.1 Goals and incentives of doctors

Literature on the goals and incentives of doctors, identified within the parameters of the REA, tended to focus on three main aspects of doctors' decision making. First, the goals of doctors when they treat their patients (and how these goals may differ from the goals of their patients) were researched. Studies in this area were conducted between 2007 and 2011 and included a range of different types of research papers and reports. These included observational studies, one systematic review and one qualitative study. Second, the various ways of incentivising doctors to change their behaviour (if needed) in the provision of care to their patients was researched. Although some of this work is relatively old (from 1986 to 2006), some detailed and relevant research was done, including five systematic reviews over that period and an observational study in 2002. Third, the issue of reward and incentives for doctors was researched primarily within the grey literature area, with two recent relevant studies included. Each of these areas will be considered in turn.

Looking first at the goals of doctors when they treat their patients and how these goals may differ from the goals of their patients, our search identified a number of relevant studies. Johnston et al. (2007) undertook a qualitative study of 61 patients to explore specifically how the different goals of patients and doctors might influence treatment options, uptake and adherence in relation to depression management. They found that the goals that patients and doctors brought with them differed in terms of the definition of the patient's condition. In particular, they found that GPs tended to frame conditions mainly as requiring a medical treatment while patients emphasised self-management. The key point here was that physicians may benefit from greater awareness of the extent to which their goals for the management of depression were perceived by their patients to be relevant and/or achievable. Another study the following year by Young et al. (2008) which examined the use of patient-centred approaches and shared decision-making behaviours by physicians with depressed patients supports this finding. They found that primary care physicians performed few shared decision making behaviors in new patient visits for depressive symptoms. In addition, the overall practice-setting (or local context) and patient-initiated request for medication influenced these shared decision making behaviours. Therefore, both of these studies show that the goals of doctors can be different from the goals of patients and that this can affect the extent to which shared decision making takes place or how the condition is managed.

On the same theme and reinforcing this finding, Rosewilliam et al (2011) conducted a systematic review of previous research on the nature, extent and effects of application of patient-centred goal-setting in stroke rehabilitation practice. This was a comprehensive review and included quantitative and qualitative studies from 1980 to 2010. The review found that patient-centred goal-setting has actually only been adopted on a small scale in goal-setting practice due to various barriers. These barriers include potential perceptions by clinicians that some patients may be unable to participate effectively in shared decision making or goal-setting due to limitations in cognition, communication ability and/or education. Therefore, this study points to a potential for mis-alignment between the goals of patients and doctors, which may ultimately result in less than optimal quality of patient care.

One further study was included in this review on the effects of wider policies or contexts on the goal-setting between doctors and patients. An interesting point, related to patient-centred goal setting, was made in an earlier study in 2009, that the ability of physicians to provide patient-centred care was potentially negatively impacted by wider NHS policies such as enabling patient choice of provider. This is because it may make it harder for physicians to have continuity in the doctor-patient relationship, which is often seen as significant for patient-centred care (Keith, 2009).

Turning next to look at studies that considered **ways of incentivising doctors to change their behaviour,** six papers were included on this topic. Five of these are systematic reviews of the area and the other an observational study.

The first of these was a literature review on the influences on GP behaviour by Horder, Bosanquet and Stocking (1986). They found evidence that the most effective way to bring about changing patterns of behaviour among doctors was through mechanisms involving personal contact with other people. This was effective through contact with other people

within teams and also individually. It was noted in contact between doctors, nurses and other colleagues/professionals, as well as other forms of personal and peer group contact. The latter includes contact with patients. One study cited in the report presents evidence that the use of patient participation groups can lead to changes in practice organisation and communication. Contrary to preconceptions about what brings about behaviour change, the authors found little evidence to support the efficacy of financial incentives. They provided a number of examples to support this view. According to the authors, no causal connection between financial incentives and increased involvement of GPs in family planning during the 1970s could be established, due to other factors such as increased patient demand for the services. Financial incentives were also seen as only one of a number of possible factors (for example changes in patient demand and medical attitudes) influencing an increase in cervical cancer examinations by GPs from 9% (1966) to 43% (1980).

Building upon this early review, Oxman et al., (1995) conducted a systematic review of the effectiveness of different types of interventions aimed at improving the performance of doctors' performance. They considered the effect of a wide range of strategies such as outreach visits, audit/feedback and reminder systems. Areas of potential behavioural change included general patient management; prescribing practices; and diagnostic services. The authors found dissemination-only strategies, such as holding conferences or direct mailing of unsolicited materials, triggered very little change in behaviour when used in isolation of other strategies. More complex strategies (such as those involving outreach visits or the use of local opinion leaders) were more effective, resulting in improvements of up to 30% in some cases. Multifaceted strategies linking for example, audit and feedback, reminders, outreach visits and opinion leaders, demonstrated improvements in performance and (to some extent, though less consistently) health outcomes. When this involved the patient, this also had an effect on performance. One example of this is shown through enhanced effects in the improvement of management of diabetes through patient education when combined with physician education. This was corroborated by later systematic reviews with similar conclusions by Grol (2001), Grol and Grimshaw (2003) and Wensing et al. (2006).

A further study by Grol (2002) looked at different approaches to changing physicians' behaviour, with a particular focus on educational activities. This study highlighted the benefits of applying combined interventions, as well as linking educational activities to other approaches, such as best research evidence, guidelines/protocols and internal/external performance monitoring. This focused not only on the individual but also on the team level, the organisation and even the wider political/economic context. An example provided was the Institute for Healthcare Improvement 'Breakthrough Collaborative'. In this case, several hospitals/practices cooperate for rapid change within an integrated approach, combining exchanges on best practices, collecting data on performance targets, feedback mechanisms and plans for change that will be developed, tested and monitored on site. According to Grol (2002) different stages of this change process need to be addressed by different strategies, which is why it is helpful to consider change at a number of levels (individual, organisational and policy levels). These stages include early orientation stages through to acceptance and maintenance of the change.

This issue was also raised in discussions with **key informants**. They were asked what action could potentially be taken to motivate doctors to change their behaviour (if a change was needed) so that they would increasingly adhere with good practice standards and guidelines. In response, three of those interviewed pointed to aspects of the education of doctors. They highlighted the need for education to be ongoing throughout medical careers, as well as the need for a specific focus on good practice within teaching. One of this group specifically felt that doctors '*start out very enthusiastic and end up burned out in their 30s*' and that more educational focus could help prevent this. A further four interview participants believed that improved monitoring of doctors' performance may help to improve or change behaviour, if change was needed – though all of these were cautious that any such approach needed to be very carefully designed and implemented in order not be cumbersome or monitor for the wrong things. In addition, four interviewees pointed to softer motivators that could potentially encourage behaviour change. These included the '*need to create meaning and conviction around values*' at difficult times, such as when clinicians are managing end-stages of disease. Suggestions also included finding ways to enable doctors to manage relationships better – '*relationships are the greatest area of weakness – with colleagues, patients and families*'. Other ways that were mentioned were by making doctors believe that the alternative approach is genuinely better that what they are doing now and by recognising and celebrating more the effort that doctors put into their work.

Third, the issue of the **actual reward and incentives for doctors' work** emerged as an important one in the literature and was researched primarily within the grey literature area. The issue of what is valued and rewarded within the NHS was the subject of a 2010 study by Freeman and Hughes. In particular, this explored the extent to which NHS policies and guidelines, such as the Quality Outcomes Framework (QOF), might potentially reward 'technical' care rather than focusing on human factors. It argued that this was increasingly the case due to the changes to GP contracts (Freeman and Hughes, 2010).

A further study in 2011, considered the question of how best to reward individuals and incentivise practices within the wider context of an increasingly complex patient care landscape. In this report, Improving the quality of care in general practice (King's Fund, 2011), the authors highlight some of the challenges - a changing physician workforce, standards incentivising technical quality and changes in the patient population. As patients increasingly present with more complex conditions, it can become more difficult to recognise and follow best practices. The study also outlined some of the downsides of current incentive/reward schemes in the UK. The authors argued that performance-incentive schemes in the UK have, to some extent, been biased in the past towards financial incentives, neglecting a wide range of other values that may be considered to be core to the professional identity of clinicians which can be strong motivators (such as, for example, recognition by colleagues). Solutions suggested included micro-incentive schemes or locally determined incentives linked to quality metrics e.g. clinical outcomes, rates of referral into specialist care, patient satisfaction ratings and use of generic drugs. In summary, rewards, both financial and non-financial, were generally portrayed within this study as a potential means to develop an environment for quality improvement. They argue that high-performing practices should support weaker practices but should ultimately be given the opportunity to expand or take over failing practices. In this report, the role of pay-for-performance introduced in the 2004 GMS contract under the QOF was

briefly reviewed (King's Fund, 2011). There is a large literature specifically on this area which is outside the scope of the present study.

3.1.2 The role of habits and self-belief

Literature in this area that was identified within the parameters of this REA tended to focus on two main aspects of doctors' behaviour which influence their decision making. First, the issue of the habits and patterns of practice that evolve through doctors' engagement with the local environment and the wider policy context was a notable observation within a 1998 study in the Netherlands. Second, the role of self belief and the belief in the value of specific action or decisions taken was an issue arising from the literature. In particular the potential of these variables to predict the behaviour of doctors was considered. Two research papers were the main sources in this area – one study in 1996 and one systematic review in 2007.

Looking first at the issue of the **habits and patterns of practice,** an observational study by Grol et al. (1998) found habit to be an important barrier to doctors' response to adjustments or new recommendations or guidelines. They also noted that the specificity or vagueness of the recommendations made a difference to how possible it was to change those patterns of behaviour. This study of general clinical practitioners in the Netherlands tried to determine which attributes of practice guidelines influence the use of guidelines in decision making. The authors found that the recommendations that required changes in existing practice routines were followed in 44% of decisions, compared to 66% of decisions when this did not require a change. Therefore, when it was necessary to adjust previous patterns of behaviour or habits, it became more difficult to adopt the new recommendations. In addition, non-specific or more vague recommendations were followed only 36% of the time, as opposed to clear recommendations in 67% of decisions. Similar outcomes were found for controversial and non-controversial recommendations and with regard to research evidence-based recommendations (71% compared to 57%). Overall, on average, recommendations were followed in 61% of the decisions.

The research shows that specific attributes of guidelines determine whether they are used in practice. While evidence-based recommendations are better followed in general, other important attributes, such as whether or not the recommendation is likely to affect existing work or behaviour patterns and the level of specific details included, are also important in whether or not they are followed. Therefore, guidelines are likely to be more effective if these considerations are taken into account when they are set. Ensuring the precision of definitions and testing the feasibility and acceptance among the target group is likely to be important for implementation of and adherence to guidelines.

Second, the role of self-belief and belief in the value of specific action or decision was studied by Millstein (1996) and by Perkins et al (2007). Millstein's study examined the extent to which self-belief was a more significant factor than the expected value of the behaviour in itself, in determining whether or not a particular practice was undertaken. The research examined doctors' practices in educating adolescent patients about the transmission of HIV and other sexually transmitted diseases. It was found that this self-belief accounted for 27% of the variance in intentional behaviour and for 39% of variance in subsequent behaviour (Millstein (1996), p. 401). The study also confirmed that social

norms influence physicians behaviour (with physicians being familiar with beliefs of colleagues and their standards of care having stronger intentions to deliver services and being more able to translate intentions into behaviour). This can have implications for interventions to change behaviour in that such interventions may be more effective if they aim first to ensure physicians feel they have the ability to carry out the activity and that highlighting the social normative nature of services may increase delivery rates.

The importance of this earlier study was reinforced by Perkins et al. (2007), which was a systematic review of research in this area. It looked at the application of psychological theory-driven approaches to understanding clinician behaviour. The authors argued that although many previous studies had focused on understanding patients' behaviours, relatively little had been focused on analysing the behaviour of clinicians. In particular, the research focused on some core variables that influence doctors' behaviour: the expected value of that behaviour, subjective norms and the doctor's perceived self-efficacy or belief that he/she can in reality perform the action. The research argued that the psychological theories that focus on these variables 'can be used to predict intentions and behaviour among different groups of clinicians and for different behaviours and guidelines' (Perkins et al. (2007), p. 342).

3.1.3 Reconciling personal judgement with guidelines

Literature in this area that was identified within the parameters of this REA tended to focus on three main areas. First, the issue of how and why doctors' decide to adhere with guidelines was the focus of a systematic review completed in 2000. Second, the issue of how doctors and patients work together in the context of a patient-centred approach was studied. This was the focus of a 2007 study within the grey literature and a 2009 literature review. Third, the extent to which guidelines can represent a barrier to creativity and the challenges of reaching a balance between personal judgement and the use of guidelines was the subject of a 2008 study.

First, the issue of **how and why doctors decide to adhere to guidelines** was the subject of a systematic review conducted by Garfield and Garfield (2000). This literature review focused on physician decisions to adhere with clinical guidelines. We believe that these findings may also have a wider relevance to other physician decisions, beyond their decision to adhere to guidelines. Based on the studies reviewed within this research, the authors concluded that there is a likelihood of an increased usage of guidelines if research can provide more evidence on their effectiveness to clinicians. They explain this by pointing to the fact that clinicians make decisions under the conditions of uncertainty. They bring with them some cognitive biases which means that they do not always act rationally, coherently or to maximum effect. This also results in a tendency to ignore unspecified possibilities and an inclination to respond with inaction when faced with multiple options. Studies indicate that experienced clinicians sometimes implement guidelines selectively, while others show that clinicians are concerned about the ability of guidelines to address real world problems and complexity. The problem of balancing judgements with guidelines may expand in the future because older patients with more complex diseases may require more specific therapies and sophisticated judgments on the part of clinicians.

This issue of doctors adhering to guidelines was explored in discussion with **key informants.** When asked if guidelines related to good practice were known to the majority of doctors, half of them (four out of eight) thought that the guidelines were known in general and the other half thought that many doctors feel that they implicitly have an understanding of the guidelines (although they may not know every specific word of the guidelines).

Three of those interviewed, although recognising the importance of adherence to clinical guidelines, noted that in certain situations clinicians made an active decision outside of guidance based on the situation that they were dealing with. Examples of this view were:

> *People decide not to follow it sometimes for very genuine reasons. It may be that the guidance was written in such a way that it was unimplementable in that setting, or that they were having to do something for clinical reasons to go outside of the guidance or that they were doing something to support the needs of the patient… There are risks associated with all of those things. (IV 04)*

> *As an individual clinician you might say my patient is different (to the guideline) or their requirements are different or I don't believe the evidence …. all those are legitimate things to say and are justified it seems to me. (IV 02)*

This issue was an important aspect of the **benchmarking study** in the child protection sector and provides some insight into how the balance between judgement and guidelines is also a challenge in other environments. It has been noted within the literature that social work consists of judgemental as well as intellective decisions (Tibrewal, 2000). Available frameworks provide procedural guidance but do not prescribe outcomes. As a comparator to decision making among general practitioners, good practice in the field of child protection is less clearly defined. Social workers cannot make the 'right' decision in any absolute sense – they are often asked to make moral judgements and decisions can only be the 'best' on the available evidence (Munro, 1996, 1998[7]). As a result, good decision making can often only be established retrospectively. This element of social work is well understood within the profession, where training is focused on equipping social workers with the skills to deal with the inherent uncertainty of the judgements they will have to make.

Second, building upon the theme of how personal judgements interact with guidelines, the **issue of how doctors and patients work together and how decisions are reached** is a further area which was addressed within the literature. A qualitative study, conducted by Rosen et al*.,* (2007), researched the relationship between GPs and patients, as well as the information that GPs use in the course of making decisions. The study found that GPs tend to make choices on behalf of patients, unless they explicitly express a preference otherwise. It also found that the availability and quality of formal and informal information was very important in influencing their behaviour. The study focused on GPs' views about supporting patients' choices and a number of influences on their behaviour,

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[7] Munro's articles dealing specifically with the nature of decision making were those published in the 1990s (e.g. Munro 1996; Munro 1998). Where more tangential references to factors influencing decision making were made in her later work, these were also included for reference (see references to Munro 2009; Munro and Hubbard 2011).

including on their referral decisions; early experiences with Choose and Book; and choice at point of referral. They found that GPs balanced informal information about clinical quality with patients' preference or (formal) published data. However, informal information tended to be preferred over (distrusted) formal information while acknowledging that relying on one type of information is insufficient. GPs therefore used a mix of both when making referral decisions. The authors concluded that there are limits to the influence of factual information. They also concluded that GPs' perception of the quality and reliability of published NHS data sets (formal information) influences the extent to which these are incorporated into the decision making process.

Developing this area further, a literature review conducted by Keith (2009) examined consultation processes between doctors and patients. This examined the meaning of 'patient centredness' and 'participation', as well as the wider factors that facilitate or impede communication in consultation. The research found that rigorous attention to guidelines might not fully recognise the 'ability of patients to be experts in their own illness and hence to negotiate their own solutions'. The author identified a number of factors that impede both 'patient centredness' and 'participation', including new information technology, the tension between choice and continuity, the process of medicalisation and limited availability of resources. These were thought to potentially impede patient-centredness by changing the nature of the interaction between doctor and patient. An example of this was provided through the adoption of evidence-based medicine which may encourage more biomedical approaches to diagnosis rather than psychosocial frameworks which may be more appropriate in many consultations. Concerning the role of guidelines, it was noted that highly stringent use of guidelines may sometimes pose a barrier to patient choice and individual patients' best interests. All of these limiting factors, it was argued, make it even more important to have effective communication within the doctor-patient consultation.

Within **discussions with key informants**, the issue of how decisions are reached between doctors and patient was also raised. Two respondents spoke of how doctors' empathy may lead them to act in accordance with patient preferences and that this can lead to acting outside of best practice. The difficulty of striking the correct balance in this context emerged as an important area for doctors to manage in their work. One respondent spoke of an example where doctors had breached a protocol on a medication administration (which necessitated the administering of two medications by different professionals on different days) near a public holiday to avoid the patient having to make a repeat visit to the hospital. This breach resulted in a medical error and the death of the patient. Several participants spoke of the tension between acting in the best interest of a patient and other factors;

> *...the reality of life, you know, things are often difficult. There is always conflict of interest and one patient might want something very different from another patient for the same problem and it may be easier for the doctor to fall in with one patient preference than another. There are always conflicts to be managed and that's really what professionalism is about. Good medical practice is about doing the best you can in difficult circumstances. (IV 08)*

A classic example is the discrepancy between your duty to an individual patient and your duty to the health system and often those two are at odds. They are in conflict and when you see, particularly when you see the sort of grumpy, cynical, disengaged doctor, it is because they can't cope with that tension. (IV 02)

Third, **the extent to which guidelines can represent a barrier to creative thinking** was studied in 2008 by De Casterlé et al. While this study focused on nurses rather than doctors, it has nevertheless some relevance to the current research. The authors found that evidence-based protocols/clinical guidelines can sometimes pose a barrier in this context. The study explored the responses of nurses to ethical dilemmas in their daily practice. Their major finding was that nurses tended to use conventions as guides for decision making rather than pursuing what is best for the patient in terms of needs and well-being. These conformist practices can make it difficult to take appropriate actions because creativity in thinking and critical reflection are not enabled. The authors call for the consideration of new strategies to try to change this. They suggest that education and stimulation through the professional environment should be used to encourage nurses to reflect critically and creatively on their work, in combination with personal and professional empowerment.

This theme of the challenge of identifying creative solutions within the context of guidelines was also one that emerged from the **benchmarking study in the child protection** area. The Munro review was commissioned as part of a national drive to improve the quality of child protection services. The review pointed to some of the unintended consequences of previous reforms that had arisen in the child protection system. It concluded that professionals are, in particular, constrained from keeping a focus on the child by the demands and rigidity created by inspection and regulation. Where excellent practice flourishes, they argued that it is due to "courageous and intelligent efforts to counteract the factors that encourage a defensive, compliance-driven service" (Munro, 2011:94). The key point here is not that guidelines, regulations and inspections are not needed but rather that there is a fundamental and inevitable tension between the use of professional judgement and guidelines.

3.1.4 Team working and human factors

Literature in this area that was identified within the parameters of this REA tended to focus on three main areas. First, the issue of personal characteristics and the impact of these on the behaviour and decisions of doctors was a focus of the literature. We included two studies done in this area – one was a longitudinal study done in 2007 and one study done in 2008. Second, the issue of how doctors interact with certain patients groups was researched in two studies (2004 and 2008). Third, the area of team working was the focus of five studies between 2006 and 2009, of which two were systematic reviews.

First, the issue of **personal characteristics and the impact of these on the behaviour** and decisions of doctors was studied by Libert et al., in 2007. This longitudinal study found that physicians who believed that they had personal control over life events and circumstances (internal 'locus of control'), benefited more from training in patient-centred communication than did physicians who believed strongly that they had less control ('external locus of control'). Libert et al., concluded that psychological characteristics such

as sense of internal or external control may influence doctors' ability to acquire communication skills due to physicians' belief in their ability to control communication with patients.

The area of personal characteristics was also considered in a study of 46 primary care providers by Chapman et al. (2008). They found that physician personality disposition was related to patient-centred communication with depressed patients. In the process of doing this work, they explored whether factors other than patients' presenting symptoms influenced patient-centred communication and focussed on personality dispositions of primary care providers. They observed a trend that physicians who were more aware and accepting of emotion in themselves and others (i.e. with higher 'emotional acuity') tended to engage more in communication with the patient to find out about patient experiences and effects of the depressive experience on function. Meanwhile, physicians who reflected conscientious adherence to perceived standards and responsibilities (i.e. were more 'dutiful') engaged in communication patterns that were more likely to focus on treatment planning, as well as gathering psychosocial information about the patient's family, social life, job, and hobbies. However, they were also less likely to find common ground and reveal patient preferences in the context of treatment planning. This is particularly interesting because although 'dutiful' physicians are more likely to cover relevant ground, their sense of obligation and responsibility might ultimately result in a more directive rather than consultative approach to treatment guidelines.

They also found that physicians with tendencies toward 'worry, insecurity, and self-doubt' were less likely to engage in communication patterns that elicited patient participation in treatment decisions. The implication for medical education and good medical practice is that if varying personality dispositions of trainees were identified this would make possible individual training to improve future communication with patients. Doctors with higher anxiety may also benefit from additional training to manage worries about patient involvement in treatment planning, as well as training focussing on perspective taking and empathy skills for some physicians.

In **interviews with key informants**, the pre-existing sets of values that doctors bring with them to their work was mentioned by a majority of those interviewed. One participant felt that doctors built upon their own views and values in order to ultimately adapt and develop their own code of practice which they used in the course of their work;

> *I suspect that people develop their own codes of practice based on their own values. These blend in with the GMC ones. (IV 06)*

It was further argued by one interviewee that tapping into the personal and group values of doctors was the key to raising standards of care overall. Their view was that '*we can best communicate guidelines through emotions and appealing to values – connecting to a higher purpose*' (IV 07).

A further point made by over half of the interview participants was that some personality characteristics were very common and led almost inevitably to some behaviours, such as pushing boundaries and taking shortcuts. One participant likened breaches in good practice to breaking the speed limit;

I think at its most benign form it's the usual transgressions we are all guilty of like when we are driving. I don't know if you do, but I certainly don't stick to 70 mph when I am driving on a motorway. We sort of nudge it don't we, we think it's safe and so we drive at 80mph. But we are actually breaking the law ... In the main we think that is ok, I think that will be what governs doctors when they take short cuts because they are under pressure, they are busy, they have something else on their mind. (IV 01)

Therefore, this points to the fact that some personality characteristics that doctors bring with them to their work may help and some may hinder their performance. It may be possible to develop bespoke training to assist with improvement in some specific areas and to plan for more common behaviours such as boundary pushing.

In the Netherlands **benchmarking review**, adherence to guidelines was also been found to be more dependent upon the nature and characteristics of the individual practitioner than the organisation. In a cross-sectional cohort study involving 62 general practitioners from 21 practises, Smolders et al, (2010) found that rates of adherence to guidelines on depressive and anxiety disorders were not associated with practice characteristics, but to some extent with physician characteristics. More specifically, GPs with strong confidence in their abilities to identify depression, as well as GPs who collaborated with professionals and institutions that specialized in mental health care, were found to treat their patients more often in accordance with the guidelines than GPs who had difficulties with distinguishing depression from unhappiness and those who did not collaborate with mental health specialists, respectively. In addition, older GPs and GPs who perceived more barriers for guideline implementation were less likely to adhere to depression and anxiety guidelines, compared with their younger colleagues and those who perceived fewer barriers to guideline implementation. Another study included in the Netherlands benchmarking review by Cabana et al (2000) reported on three focus groups conducted to try to understand better some of the barriers to the use of recommendations within the National Heart, Lung, and Blood Institute (NHLBI) asthma guidelines.[8] They found the type of recommendation and physician year of graduation from medical school were related to perceived barriers to adherence. Senior physicians mentioned lack of agreement or lack of training, whereas younger physicians described lack of confidence in dosing or recognizing contraindications. Only senior physicians described the inertia of previous practice as a barrier, and all groups cited time limitations.

Second, **the issue of how doctors interact with certain patient groups** was the focus of research in two papers. The first of these was an international comparative study conducted by Wetzels et al. in 2004. The work analysed the barriers to involvement of older patients in decisions in a general practice context by conducting qualitative interviews with GPs in 11 European countries. They found that GPs believed that older patients were especially likely to be accepting of physician authority and to lack familiarity with involvement as a concept (or not to desire it). GPs, from their own perspective, believed that lack of time was regarded as the main barrier to the involvement of older patients.

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[8] These were prescription of inhaled corticosteroids, recommendation of daily peak flowmeter use, smoking cessation screening and counselling, and allergen exposure counselling.

A further study in the area was done in 2008 by Gold et al. This was a survey with 321 participants (102 patients and 219 staff) which explored the expectations of patients, their carers and physicians regarding the communication of clinical information to carers. The main finding of the study was that there can be quite different expectations between doctors and patients about what information should be communicated to their carers. They argue that physicians need to be aware that their own expectations and those of patients and carers regarding information communication may not be in alignment. In terms of implications for good practice, they argue that patients and carers should be made aware of physicians' constraints and be encouraged to discuss preferences for information sharing. This could eventually be supported by a prompt sheet to assist the clinical encounter.

Third, the area of **team working** was the focus of five studies between 2006 and 2009, of which two were systematic reviews. A study by Levenson, Dewar and Shepherd in 2008 involved ten consultation events with 800 people (including 406 doctors). This research indicated that team work behaviours can be impeded by the fact that GPs may see themselves as the only possible leader of the team, or as being 'above' the team. These views on team work were earlier acknowledged in a series of essays, *Partnership and Prejudice* (1986). This work identified barriers to 'good practice' in communication between doctors and those in the other caring professions, including nurses, admin staff and social workers. Documented mainly by the experience of the writers, it nevertheless provides useful insight. One of them comments: 'So often teams are formed and doctors then think of themselves as the 'Leader', without being able to use the contributions of others'.

A systematic review undertaken in 2008 by Manser (which included 277 studies and a detailed review of 101 studies) examined research literature on team work within health care environments. They found that negative perceptions of team work and leadership qualities were associated with employee emotional exhaustion, burnout, negative job satisfaction, and lower organisational commitment. The research provided evidence for the connection between team work and patient safety, drawing on a range of studies. In particular, the review highlighted how the functioning of teams can be an important factor for adverse events. Examples of this included failure in communication leading to clear consequences (delay, tensions, procedural error) during surgical procedures; evidence on increased surgical errors due to team work and communication problems; and effective team work being associated with fewer minor problems per operation. The authors pointed to shared mental models of team work as key to effective team performance and they cite a study that found better team work to be associated with 'improved quality of care, reduced post-operative pain, improved post-operative function, and decreased lengths of hospital stays' (Manser, 2008: 146). The author concluded that a future research agenda could be targeted at integrating existing evidence into planning and management practices and to identify a set of behaviours related to effective team work. They also argued that there is a need to identify a set of generic skills/behaviours that increase team performance across settings, teams and situations (routine vs. emergency) in health care.

In terms of strategies for improving team work, a 2008 Cochrane systematic review, by Reeves et al. reviewed research on inter-professional education and found that various forms of this type of education produced benefits for team working. These included

improvement of the working culture in an emergency department; decreased errors in an emergency department; improvement in the management of care delivered to patients experiencing domestic violence; and improvement in the knowledge and skills of mixed professionals caring for mental health patients. However, the authors caution that, due to the small sample size of some of the studies included in the review, extrapolation was limited to some extent. They pointed to the need for a more comprehensive study on this area.

In relation to the link with the wider environment, a 2009 study by the Economic and Social Research Council suggested that there are links between biopsychosocial risk factors and levels of performance among doctors. The objective of the study, which included 30 doctors, was to identify potential biopsychosocial indicators associated with students and doctors who were referred to the Individual Support Programme at Cardiff University (Cohen et al., 2009). Overall, 13 factors were identified in the original study that were biological (such as anxiety, depression, feeling de-motivated); psychological (such as work behaviour, personal qualities, responsibility, motivation; or social (such as life events, isolation, academic performance, post-graduate education and training, cultural difference, language, communication, or organisational factors). In addition the factor 'physical wellbeing' was included for completeness. This study recognises that the risk factors do not all reside within the individual themselves but rather the overall combination of the individual and the system or local environment that they work within (Cohen et al., 2009).

In **interviews with key informants**, the support and guidance provided as part of a team was seen by a majority as important in helping doctors to act in accordance with good practice – '*we need to rely on a team rather than just one doctor who can get it wrong*' (IV 01). Participants also noted that lone practitioners or those working in a dysfunctional team structure may be vulnerable to acting outside of good practice. Team working was seen by one respondent to have become even more important due to the increasing complexity in the way care is delivered, which requires a greater reliance on team working, for example the care of elderly patients by a number of disciplines.

3.1.5   Morale, workload and resources

Literature in this area that was identified within the parameters of this REA tended to focus on four main areas. First, the issue of the morale of medical staff was a theme of two studies conducted in 1992 and 2004. Second, the area of information overload and heavy workloads was the subject of five studies between 2002 and 2010, four of which were from the grey literature. Third, aspects of the wider system and policy environment that may affect the ability of doctors to provide a good standard of medical care was a focus of three studies in 1996, 2008 and 2010. Fourth, suggestions for potential solutions to some of the challenges were discussed in two relatively recent pieces of research (2010), including a systematic review and a grey literature study.

Turning first, to the issue of the **morale and the prevalent attitudes of doctors** and the affect that these can have on the standards of medical care, two studies were done in this area. An experimental study by Ridsdale et al., (1992) suggested that available time is less the obstacle in the provision of good quality care than the prevalent behaviour pattern of the physician. They found that GPs who would generally tend to use certain patient-

centred communication techniques during consultation used it more often when given more time with patients. However, GPs who tended to use the techniques less frequently tended not to increase use even when more time was available. Within two experimental studies the authors analysed doctors' use of different verbal interventions when dealing with patients that were given shorter or longer appointments. Ridsdale et al. suggest that there is a differential response to changes in time available, with increased time being a necessary but not sufficient condition to increase the usage of communication techniques among doctors who use them less frequently.

A study by Tabak and Ozon in 2004 on 109 nurses in six hospital wards explored the impact of personal morale and attitudes on work. A positive correlation was found between nurses' performance and their perceived behavioural control over their situation. Facilitators of the perceived behavioural control included: feelings of having enough time and not being overworked (nurses working part-time as opposed to full-time were more likely to work to maintain privacy) and perceived autonomy and control over their own behaviour (also found amongst medical students a lack of authority was found to act as a barrier against behaviours associated with 'professionalism'). More advanced education had an impact on nurses' attitudes, making them more positive.

Building on this theme, in discussions with key informants, three mentioned the importance of engaging doctors in a dialogue about good practice and ensuring that morale was not damaged in the effort to improve the standards of care. Participants noted the need to get doctors on board and engage with them on issues rather than alienating them through punitive actions or compulsory attendance at meetings;

> *Taking the example of hand hygiene, I remember when someone said we should make it a disciplinary offence if people do not comply with hand hygiene and I remember looking at the recent audit on compliance with hand hygiene within the hospital and it was 40%. So I said are you really going to discipline 60% of the doctors because they are not complying... Instead we used persuasion, champions, publicity then when you have 90% compliance you can use disciplinary action to get everyone else on board. If you discipline everyone you lose the relationship with the clinical body. (IV 01)*

It was further noted by two interviewees that it was important to work with doctors to understand what barriers there were to implementation of good practice guidelines and standards of care and understand better if there was something that could be done to make implementation easier.

Second, the area of **information overload and heavy workload** appeared relatively frequently in the literature and five studies were included here. A study by Grimshaw and colleagues in 2002 described one of the main barriers to physician practice change as being 'information overload'. They argued that this stems from simultaneous organisational, peer group, individual and patient-created incentives to act. Dissemination of research findings through peer-reviewed publications was thought to be the main approach to close the gap between best clinical practice and implementation by doctors in the past. However, given that professionals have less than one hour per week to read and given the identified 'information overload', new ways to improve physician's information management are needed.

In two reports in 2007 and 2008, the information overload problem was highlighted as a factor in explaining physicians' poor understanding of the needs of certain patient groups. This is described extensively in the Mencap report of a qualitative study Death by Indifference (2007) and in Sir Jonathan Michael's report on access to care for people with learning disabilities (2008). Both studies found that physicians were too often unaware of the legislation (about consent and treatment, among others) related to learning disabilities. The reasons for this included the low priority assigned to people with learning disabilities, the lack of individual knowledge about learning disabilities, appropriate consulting strategies and the law around capacity and consent to treatment, as well as time-consuming and ineffectual NHS complaint mechanisms. The Health Care for All report (2008) detected similar findings and reasons for this lack of treatment. These problems resulted in a variety of recommendations to try to improve the way information was accessed to make it more structured and accessible. The recommendations also aimed to monitor the use and management of information in a more efficient way. The measures suggested included: revision of legal frameworks and competences, introduction of new standards and monitoring of implementation/performance, increased adjustment to existing legislation, awareness-raising, as well as training and knowledge dissemination on various levels, for health service staff.

A further two studies focused on the problems that can emerge due to inadequate understanding of information. A study by Slowther et al (2009) for the GMC of UK and non-UK qualified doctors is also relevant in this context. This focused on the extent to which non-UK trained doctors might be familiar with ethical standards and the GMC guidelines. The study identified a notable gap in information and awareness of such guidance prior to registration in the UK combined with variable levels of support in place to fill this gap.

Another study by the Department of Health (DH) in 2010, Responding to violence against women and children - the Role of the NHS, involved a literature review and interviews on this topic. The report stated that poor practice results from the fact that the physician may not be able to identify important information quickly (such as legal and healthcare services) to help those patients that are most vulnerable. As well as improved familiarity with particular competence areas, the study points to a need for well-functioning processes to help doctors to navigate through and deal with very complex issues. Raising awareness, improved education and training of NHS staff on risk factors for violence and abuse when acting with patients was one of the main recommendations followed by clarification of responsibilities, new positions, referral and care pathways, data standards, improved policies, focal points, cross-organizational cooperation etc. as essential steps in managing information needs. However, in this study, and in Slowther et al (2009) described above, the issue of ensuring that doctors and the wider NHS staff are able to navigate through a myriad of information presents a considerable challenge.

Data collected in **interviews** also pointed to the pressure of doctors' work and the environment within which they practice as challenges to acting in accordance with good practice. In particular, pressures of time, resources and fatigue were frequently mentioned. Several respondents felt that such work pressures led doctors to take short cuts which made practice more susceptible to errors;

… There are always decisions to be made, shortcuts to be made of necessity that you take a risk, you stick your neck out, you do something that ideally you wouldn't want to do but you take a view that it's for the best under the current circumstances. (IV 08)

The extent which wider factors, such as financial pressures, may worsen this situation was also explored in these discussions. A minority acknowledged that there were conflicts in terms of finances, where a clinical decision conflicted with a financial one. One participant, who had practiced for a number of years, noted that doctors are now more aware of finances than ever before and warned that this issue could become more pronounced with the changes occurring within the NHS. Two participants felt that finances were sometimes used as an excuse not to act in accordance with good practice. They felt that where trusts could provide improved quality to patients they were obliged to find the finances to enable it to happen. One respondent noted the challenge to the NHS in the current climate was to improve quality whilst reducing costs.

We are in challenging financial times at the moment and there is no doubt that when systems have to make efficiencies and reduce cost that can sometimes rub up against clinical priorities and clinicians can sometimes find that difficult to manage. Prioritisation is always a challenging task in the NHS and so there is absolutely no doubt that that when teams and services are tasked with reducing cost that can get in the way of good clinical practice. (IV 03)

Information overload in relation specifically to the use of good practice guidelines was also discussed in interviews. A key obstacle to doctors following guidelines was seen by half of the group to be the volume of guidelines issued:

I truly don't know how they (clinicians) get to grips with the amount of guidance that is out and I worry constantly about the fact that we actually add to that. (IV 04)

The amount of guidance issued was seen to be a particular challenge to some groups of doctors such as junior doctors who regularly change specialty. Two participants spoke of the need to make guidelines easy to understand and non-burdensome for doctors to follow and one further participant noted the need for managers and clinicians to work together in implementing guidance, rather than clashing over the issues. Another advocated the involvement of doctors in the development of guidelines. Due to the number and complexity of clinical guidelines, some participants advocated embedding guidelines in clinical practice such as within paperwork, care pathways or with use of information technology;

…we have relied on paper based approaches which are not immediately accessible at the point of care. I do think that the new technologies and smart phones that can provide instant access at the point of care for clinicians is something that would really help. (IV 03)

The **benchmarking study in the child protection** area also highlighted the importance of having access to the right information, the appropriate amount of information and avoiding making decisions based on only a part of the available data. Munro (1996) reviewed a sample of all inquiry reports published in Britain between 1973 and 1994, in order to examine the causes of errors in professional reasoning in child protection work. She found that professionals based assessments of risk on a narrow range of evidence,

which was biased towards the information readily available to them and overlooked significant data known to other professionals. The range was also biased towards the more memorable data, and evidence that was 'vivid, concrete, arousing emotion and either the first or last information received' (Munro, 1996: 793). A later study by Munro (1998) confirmed the importance of how a child protection officer originally frames a situation. Social workers were found to be persistently slow in revising their judgements, as misjudgements about clients that may have been unavoidable on the limited knowledge available when they were made continued to be accepted, despite a growing body of evidence against them. Munro argued that social workers therefore often have to recognise that 'their former views were wrong - although reasonable at the time they were made'. In this sense, 'mistakes' are conceived as an inevitable part of practice and recognising them is 'an essential element of good practice' (Munro, 1996: 796).

Third, **aspects of the wider system and policy environment** that may affect the ability of doctors to provide a good standard of medical care was an area of study within the literature. A study by Sibbald (1996) focused on less contact time between doctors and patients. It argued that policy initiatives intended to promote greater team working and/or role substitution among primary care clinicians may, as an unintended impact, reduce possibilities for sustained relationships between individual clinicians and patients - increasing the challenge of achieving some aspects of patient-centred care.

This theme was developed further in a study by Goodrich and Cornwell (2008) in their review of patient-centred care in the UK. This study, which used national patient survey data, identified increasing and diverse pressure on hospitals in the UK that can affect the ability of doctors to provide good standards of care. This leads increasingly to a dehumanisation of relationships (between patient and staff / between staff, e.g. doctors and nurses) due to factors such as increased volumes of activity, the trend towards larger institutions, the pace of organisational life and increased specialisation of medicine and nursing reducing the contact time between staff and patient.

Further evidence for some of the challenges of a changing policy environment in the patient-centred care context, was provided through a study by Freeman and Hughes (2010). This study analysed the provision of continuity of care and patients' experiences with it, by bringing together evidence from research (literature review), with data collected through practice visits and interviews. They define continuity of care as relationship continuity – 'a continuous therapeutic relationship with a clinician' – and management continuity as the 'continuity and consistency of clinical management, including providing and sharing information and care planning, and any necessary co-ordination of care required by the patient' (Freeman and Hughes (2010), p. 4). The study found that continuity of care is endangered by the increasing specialisation and fragmentation of primary care services, changing working patterns and an emphasis on rapid access. The shift towards increasingly more doctors choosing to work part-time or to take temporary positions means they do not have continuous therapeutic relationships with patients as often. Management continuity was also seen as increasingly challenging because clinicians other than GPs sometimes take on the role of co-ordinating care (treatment planning, navigation of services, maintaining patient's engagement with care). The authors found that despite the fact that there is a high degree of awareness among doctors of the

importance of continuity of care, little guidance is offered to them on how to manage these problematic aspects and implementation is poorly monitored and incentivised.

This theme also arose during **interviews with key informants**. Two individuals mentioned that there is now more discontinuity of care than was there previously which can lead to greater likelihood of lower standards of care. Reasons for the increase in disjointed care were identified as due to more part time doctors (especially in GP practices) and the nature of shift work.

> *There may also be a lack of continuity of care – this can be caused by shift-work creating a discontinuity.*

One participant felt that the working time directive prevented doctors acting in accordance with good practice and that a rigid approach to time-keeping and poor hand-off between doctors made this worse.

Fourth, **suggestions for potential solutions to some of the challenges** were discussed in two relatively recent pieces of research. In the first of these, a systematic review of 23 previous studies looking at information exchange mechanisms between primary care and specialist physicians was conducted by Foy et al. (2010). This found that interactive communication tools such as shared software and internet-based portals can have a positive impact on collaboration between primary care physicians and specialist. The study assessed the effects of interactive communication between primary physicians and specialists, together with outcomes for patients with diabetes, cancer or psychiatric conditions. Studies that included interventions targeted at enhancing communication quality were found to have larger effects on patient outcomes.

In the second study, by The Older People's Commissioner for Wales (2010) it was found that in certain settings (hospitals, care homes), some very simple systems have proved efficient in helping to achieve patient-centred behaviours. This research reviewed 16 hospitals in 2010 for which evidence from older people that have spent 5 or more consecutive days in hospital between 2008 and 2010 was collected and good practices identified. Some of the reviewed hospitals already had implemented systems responsive to older peoples' needs, such as traffic lights to regulate access to curtained areas, or the use of coloured trays to identify patients who need assistance to eat, helping health care staff to respect the patients' dignity. Isolated rooms for the physician to deliver medical information to the patient while respecting confidentiality were also identified as making good practice easier.

3.1.6 Organisational culture

Literature in this area that was identified within the parameters of this REA tended to focus on four main areas. First, the issue of how a culture of support of patients by doctors can make it difficult to offer advice that might not be well-received was the subject of two studies (in 2006 and in 2008). Second, the issue of a culture of acceptability around non-disclosure of errors or concerns for care quality was considered in two papers (one of which was a systematic review) between 2006 and 2010. This was also the subject of a number of reviews of Serious Service Failures. Third, aspects of organisational culture and ways of working together were a focus of three studies in 2000, 2006 and 2011. Fourth, the education of doctors and how this can be a focal point for change and improvement in a

prevalent organisational culture was discussed in two relatively recent pieces of research on 2009 and 2010.

Turning first to the issue of **how a culture of support of patients by doctors potentially can make it difficult to offer advice** was a theme that emerged in the literature. In particular, the fear that advice offered may have a negative effect on a relationship between a doctor and a patient was identified as an important factor in terms of whether or not good practice was followed by doctors. A study by McEwen et al. in 2006 found that concerns about this were a significant, independent predictor of whether or not GPs would offer unsolicited smoking cessation advice to patients who were smokers. They assessed whether the use of desktop-reminder software increased the frequency of GP advice. They stated that the use of this software increased provision of cessation advice among the GPs who expressed fears about doctor-patient relationship. Possession of the software did not change the views of doctors on whether intervening would affect doctor-patient relationships but it made it easier for them to provide the advice. This research highlights the point that, when designing health promotion activities, it is necessary consider that GPs' concerns over harming the doctor-patient relationship can prevent them from making an intervention.

This research was corroborated by a further study in 2008 by Guassora et al. This observational study, of 11 patients and 6 GPs, found that fear of negative impact on the doctor-patient relationship was found to be a barrier to care. They found that GPs felt offering smoking cessation advice could be at odds with their desire to show respect and uphold a 'moral acceptance of patients' during consultations.

In the **benchmarking study of the health system in the Netherlands**, research was noted which concluded that doctors have most often explained their departure from guidelines by referring to a potentially detrimental effect on the patient-doctor relationship. In a study by Veldhuis et al, doctors attributed their departure from good practice to 'the wish to be nice' in 42% of deviations, and to 'the wish to prevent a conflict' in 30% of cases (Veldhuis et al., 1998). Compliance has been strengthened where guidelines do not demand too stringent a change to existing routines, and are compatible with existing values (Grol et al, 1998).

Second, the issue of a **culture of acceptability of non-disclosure of errors or concerns** for care quality emerged as an important area of the literature. A large scale systematic review was conducted by Kaldjian et al. in 2006, which examined 475 previous studies published between 1975 and 2004. According to this research, the variety of motivators for and impediments to disclosure indicates that this diversity of factors also needs to be taken into account when planning efforts to encourage disclosure. This review looked for those factors that facilitated or impeded disclosure of errors, as well as objectives for disclosure. They found a total of 41 factors that were believed to impede disclosure. These included fear of professional repercussions, collegial embarrassment, malpractice litigation and negative patient reaction. Personal attributes that hindered disclosure were perfectionism, guilt, and doubt that any good would result. External/environmental barriers cited were a 'medical culture of silence', absence of an institutional forum for disclosure, and uncertainties about cause of error. Personal attributes facilitating disclosure were accountability, honesty, empathy and altruism. In terms of objectives in making the

disclosures, the study found that patient safety, enhancing learning and informing patients were the main goals for disclosure, while in terms of motivation, accountability was most cited along with fear of professional repercussions.

This issue was further discussed in a 2010 Lancet editorial by Martin Marshall and Iona Heath. They suggest two reasons why it seems physicians in recent years have tolerated an inadequate quality of care for their patients (in reference to Shipman, the Bristol heart scandal, Mid-Staffordshire, etc.). They argue that firstly, individual physicians are focused on the individual patient and do not have a wider system perspective, and secondly, the complex realities of daily work necessitate that physicians make tradeoffs regarding which of many problems they see are critical, and which they actually have the personal resources to address. As for inducing behaviour change, Marshall and Heath suggest that physicians need safe and confidential systems to report problems and suggest remedies. This, they claim, should be possible in the same way that patients have access to a complaints system. They also suggest that medical education should aim to teach physicians how to critically assess the wider health system.

Evidence of some acceptance of poor standards of care is provided through a number of reports. One of these is the Care and compassion report (Parliamentary and Health Service Ombudsman, 2011). This is a report on ten investigations into NHS care of older people across NHS Trust across England and 2 GP practices, based on the personal experience of ten people aged 65+. The stories were collected during investigations in 2009/2010 and describe a significant gap between the principles and values of the NHS and the actual reality of care for older people revealing an attitude (personal and institutional) that fails to recognise older peoples' most basic medical and personal needs in a sensitive, compassionate and professional way.

Data on the difficulties that doctors and other medical staff face when dealing with situations such as these and when they are considering raising concerns are provided in the investigations of Serious Service Failures between 2001 and 2008. In the case of the investigation into the Mid-Yorkshire NHS Trust, it was found that junior doctors especially were very concerned about their future careers and potential victimisation, if they articulated their worries (2004). Similarly, in the investigation into outbreaks of Clostridium difficile at Maidstone and Tunbridge Wells in 2007, it was noted that there was an unhelpful culture for dealing with complaints and problems. Most notably, information on any problems arising were never provided in any detail to the board or any relevant sub-committees, clearly indicating that the problems were systemic, as well as based within individual behaviours.

Further insights were gained through **discussions with key informants** of this issue of disclosure of errors and raising concerns. Participants were asked about the factors which might encourage or discourage a doctor from raising concerns if they were alerted to the fact that a colleague was not acting in accordance with good practice.

Half of the interviewees (four out of eight) highlighted the inhibiting effect on doctors of the potential implications of speaking out. They felt that there were concerns about the way people had been treated within the NHS when they had previously raised concerns about poor practice. This may result in people being less likely to report poor practice for fear that their complaint might not be taken seriously or that there may be repercussions

for them in terms of their career progression. A number of interviewees mentioned examples, case studies or high profile media cases (such as Mid-Staffs and Birmingham hospital) where those who had reported poor practice had been treated poorly and noted this was a disincentive for others to do the same:

> *There are too many cultures in the NHS that I have seen where people are afraid of speaking out because of what has happened before when people have spoken out. We need to create a climate where people are safe to raise concerns. (IV 01)*

Three of those interviewed felt that the culture within NHS organisations could inhibit people from speaking out. One participant commented that within the NHS the culture around reporting even minor errors was poor and another that negative feedback was not necessarily welcomed in the NHS. Several participants spoke of the need for NHS structures to enable doctors and others to provide a meaningful culture of feedback, and the need for senior people within the organisation to address this issue and remind staff of their responsibility to inform others if they are concerned about the practice of a colleague. One participant made a distinction between 'whistle blowing policy' and the creation of an environment in which people are able to voice concerns;

> *By the time they have got to be whistle blowing it is way too late, whistle blowing means your organisation has failed to have the right culture to enable people to speak out. So you can have a whistle blowing policy great … but actually if you have too many whistle blowers you have got to ask yourself, to question your organisation. (IV 04)*

> *[we need] a culture of openness so that people can raise concern without feeling like it is a major thing, either they are going to get punished themselves or the person they are talking about is going to get punished. A non-punitive approach is important … (IV 01)*

Although concerned that current policies were not adequate enough, one participant did note caution in relation to how professionals were treated when accusations of poor practice were made against them and warned of the need to be mindful of the damage that malicious accusations could have on doctors.

Four of those interviewed pointed to the challenge of raising concerns if they have a prior relationship with that colleague or if they fear that it may damage that relationship. This was especially the case if they felt it was something which could have happened to them;

> *Doctors tend to be quite forgiving of their professional colleagues, mainly because 'but for the grace of God it could happen to me.'(IV 02)*

In some circumstances colleagues may notice a doctor is transgressing from good practice but the extenuating circumstances they are aware of in the individual case mean they make a decision not to report such behaviour. The reluctance to raise concerns about colleagues was worsened if hierarchical factors were also involved (i.e. implications for junior colleagues of raising concerns about senior staff).

A few participants spoke of doctors not acting in accordance with good practice as they did not wish to do so:

...there are attitudes and behavioural issue. They think they are above doing what everyone else does. These things need to be tackled and there should be penalties if after counselling and discussion about what needs to change things don't change clinicians need to be held responsible for their actions. (IV 03)

This may include doctors whose practice is out of date but who have no inclination to update their knowledge, or doctors who disagree with the behaviour requested of them. Some interviewees felt such attitudes were arrogant;

…doctors might not adhere because they might see a better way of doing it. (IV 05)

Third, **aspects of organisational culture and ways of working together** were a focus of three studies between 2000 and 2011. Research by Degeling (2000) focused on the way accountability is conceptualised and interpreted by various clinicians. This work argued that the way doctors think about accountability is likely to impact which behaviours they associate with being accountable. The frame of reference that is used to understand accountability is underpinned by varying values and meanings that bring about different and sometimes competing views on what constitutes the essence of service provision, priority of tasks, values that should be enacted and criteria for performance assessment. For example, if they feel most accountable to managerial standards they may prioritise organisational or system resources, while those who feel accountability applies most to social responsibility may prioritise upholding the norms and conventions associated with their profession. The author emphasises the importance of finding ways to manage different views on this. For example, to some extent, multiple accountability frameworks can be competing such as `patient centred', `management centred' and `clinician centred'. Degeling (2000) argues that in the absence of doctors understanding this wider context, policy-makers will opt for managerial accountability on their behalf. We have evidence of the significance and relevance of this issue through an investigation of service failures at Maidstone and Tunbridge Wells in 2007. This found that there was confusion and misunderstanding of accountability across the structures within the organisation which contributed to the problems and failures.

The benchmarking review of child protection also flagged up the importance of a shared understanding of priorities and accountability. The shift in UK child protection in recent years has resulted in supervision processes being dominated by managerial concerns, of checking that workers are following procedures and meeting performance indicators, so that time for overall clinical review and reflection can become inadvertently compromised (Munro, 2009). It was noted by Munro and Hubbard (2011) that at the level of the workforce, it is important to consider how individuals interpret their social context, how they understand organisational messages about priorities, and how they feel supported or undermined by managerial scrutiny.

A second study in this area was done on communication between doctors and other medical team members by Reader et al., (2006). They conducted a survey of Intensive Care Units (ICUs) in the UK, with 48 doctors and 136 nurses involved. The work focused on the extent to which there is a shared perception of interdisciplinary communication among doctors and nurse in intensive care units (ICU). Particularly, nurses and trainee doctors reported less openness and transparency while senior doctors had particularly positive perceptions of team communication; however, trainee doctors were more likely

than senior doctors to report that team communication was 'accurate'. The work demonstrated that openness of communication predicted the degree to which doctors and nurses reported understanding of patient care goals. The authors cited factors likely to be associated with different perceptions of communication, such as: role hierarchy, gender differences, differing patient care responsibilities, differing perceptions of required communication standards, and differences in training methods of nurses and doctors.

A study done in 2011 by the Health Foundation was relevant to the development and emergence of a culture of patient-centred care. Definitions of the concept vary in the literature and each stakeholder group (managers, educationalists, professional leaders, patient organisations) defines the concept differently. This can potentially make it a challenging aspect to build into an organisational culture. The Institute of Medicine provides a definition of quality of care consisting of six dimensions which includes patient-centred care. These were safety, effectiveness, patient-centredness, timeliness, efficiency and equity. The Health Foundation is relevant in this context for their work in designing programmes to facilitate GPs' good practice and patient involvement in the decision making (Health Foundation, 2011). The importance of organisational culture to the provision of good quality of care was also reinforced through investigations of service failures in Bristol Royal Infirmary in 2001 and in Northwick Park Hospital (between 2002 and 2005). These pointed to the prevailing culture within the hospitals as directly impacting the care quality being provided to patients. It was hard for staff to raise concerns and there was a discouragement of speaking openly on these issues.

Ways of working together and the effects that this can have on providing good standards of care were also **discussed in interviews**. The hierarchy within NHS organisations was seen by three of those interviewed as a barrier to acting in accordance with good practice. This was particularly the case when more senior members of staff condoned behaviour which was outside of good practice, which then affected and influenced the rest of the group;

> *An example I will give you a simple, simple thing like hand washing. We have a number of junior doctors say to us that the senior clinician in their team will rush them through going from one patient to another patient and they will say 'I am just going to wash my hands' and the senior clinician will go 'you don't need to worry about that you have hardly touched the other patient'. (IV 04)*

One participant mentioned issues of hierarchy as relevant not just within professions but also across professions, for example pharmacists may be reluctant to report problems to a doctor. The issue of hierarchy was also frequently mentioned as a barrier to raising concerns when problems arise.

In terms of suggestions of how working practices and working together could be a focal point for improving standards of care, three participants advocated the use of champions or opinion leaders. These would be in the form of other doctors who had adopted a particular way of practicing and who could be used to inspire and encourage others to do the same. This was felt to be particularly effective where the champion was a respected member of staff. Peer pressure was also mentioned as a technique to ensure doctors acted in accordance with good practice. These interviewees commented that the use of positive champions and role models was far more powerful than examples of bad practice, or 'bad apples' in influencing the behaviour of colleagues. Two participants felt that there should

be more focus on good practice rather than bad, for example through greater praise and reward for good practice.

One participant spoke of how it was not possible to persuade everyone to follow good practice and that there will be people who, no matter what efforts are made will not engage. They advocated spending energy converting early adopters who then persuade the majority to come on board; others are later to get on board and some will always be resistant.

Fourth, the **education of doctors in relation to changing and improving a prevalent organisational culture** was the subject of a study by the Economic and Social Research Council in 2009. The research argued that there are transition points within the medical education of doctors that are critical to developing their thinking. Rather than just being stages of learning within the medical training of doctors, in fact they claim that these stages should be considered as much more important critically intense learning periods. This study explored the transitionary stages of medical training and career progression in particular, because those particular stages were previously identified as especially problematic in terms of patient outcomes. This is because the learning has to be done in a work practice or action-related situation and is done in an intense and limited time span. They conclude that management of these important transitions should be tighter and with closer monitoring and process planning (Roberts, 2009).

This was reinforced by research done by Schostak et al in 2010 for the GMC, which focused on the effectiveness and importance of continuing professional education for doctors; it was considered essential to effective practice and to professional career development. This was because it was fundamentally connected to doing the job well, ensuring that knowledge was kept current and allowing continuous improvement and development. In the context of the prevalent culture, it was noted in the study that continuing professional development provides a way to connect to some of the culturally embedded ways of interacting and thinking and potentially influencing these.

Reinforcing the point above about the timing of education and the significance of this for doctors, the majority of participants in **key informant interviews** noted the importance of undergraduate education as the time when codes of good practice were embedded in the future practice and behaviours of doctors. There were varied views as to how adequately participants felt these values were currently embedded in undergraduate training. Three felt that issues associated with adherence to good practice, such as patient safety, were not successfully integrated in the undergraduate curriculum. One of these three interviewees felt that such issues tended to be focused within one module which students may miss and felt the issues should be more embedded across the curriculum. Another felt that there was a barrier in ensuring that some medical schools included adequate teaching of such issues;

> *Getting them [issues relating to good practice] onto GMC guidelines about what should be taught is one thing, getting them onto medical school curricula is another one. But more importantly getting them then properly taught … is an even bigger thing. (IV 02)*

A further interviewee, reflecting some differences within the group of key informants, felt that over the last ten years undergraduate education had in fact reinforced the importance

of skills other than medical knowledge and the culture of undergraduate education had changed to reflect the importance of such issues;

> *Students are now aware it is not enough to pass their MCQs - they need to reach a certain standard in their professional behaviour. (IV 08)*

There were also varied views on current recruitment practices. One interviewee commented on how the current recruitment process, hiring doctors for undergraduate courses, worked well in selecting the appropriate sorts of people to become doctors. However, another felt that the wrong people were currently recruited, on the basis of academic qualifications rather than vocation. A third interviewee felt that recruitment should take account of the different roles doctors perform since different criteria may be necessary when recruiting a psychiatrist, GP or surgeon.

Half of those interviewed acknowledged the importance of continuing professional development throughout doctors' careers. This was considered to be particularly important due to the differences between learned professionalism as taught in undergraduate courses and the reality of clinical practice;

> *What we talk about and what we teach in the medical school will not correspond directly to what you see in the clinical environment where it's busy and it's pressured. The system may be breaking down and people are under great pressure and you might see bad role models as well as good role models. And the same when you are working in that system there are aspects of it whether it's over-work, lack of resources, political pressure, difficult patients you know those put pressure on you, on the values you are trying to lead through good practice. (IV 08)*

> *Some of it is deficits in people's education and their skills and a lot of that is because practising medicine is a lot more complex than it used to be and we are not trained to deal in that complexity. There are still plenty of doctors out there who believe that it should be off the top of their head, they should be able to practice intuitively. But we know that keeping up to date with all the latest evidence base is impossible for the human brain and most doctors have not been trained to do that. I think and I hope the next generation of doctors will be so much better at this as they will have been trained in this way. (IV 02)*

Several participants stressed the importance of the appraisal processes and the coming revalidation process in ensuring doctors did not become out of date in their practice.

CHAPTER 4   **Conclusions**

This study aimed to gather evidence about what influences doctors' decision making and behaviour in the environments in which they practice. In particular, the research aimed to address the following questions:

- What are the factors or influences that may actively empower or act as disincentives on doctors to behave in ways that are consistent with established standards of good practice?

- What are the factors or influences that may actively empower or discourage doctors from acting in ways that are consistent with guidelines about raising concerns in circumstances where patient care or safety may be compromised or at risk?

The objectives of the work were to better understand the nature of the influences on doctors' practice and to identify any potential opportunities or levers for raising awareness among clinicians of good practice and increase their willingness to act to protect patients in challenging situations.

The journey that an individual doctor makes through their career inevitably shapes their perceptions about themselves, their immediate environment, their patients, their role models, their view of what success looks like and what the ultimate goal is of the work that they do. They bring to this situation all that they had previously internalised from their family socialisation, local context, peers, education, preconceptions and assumptions.

In reflecting on the data presented in this report, it is possible to make a number of concluding observations the factors that influence the behaviour of doctors in relation to acting in accordance with good practice.

4.1.1 Goals and incentives of doctors are sometimes misaligned with the goals of patients

The goals of doctors when they treat their patients may differ from the goals of their patients. Assumptions are sometimes made about what patients want and need. Patient-centred approaches do not seem to have countered this risk. If behaviour change by doctors is needed, multifaceted combined approaches that involve patients and that work at several levels of influence appear to be most effective. Reward and incentives for doctors appear to work best if they use a broad definition of reward that goes beyond financial incentives and includes areas such as recognition for achievement.

4.1.2 Habits and patterns of behaviour can impede adherence to good practice guidelines

If a new guideline or good practice recommendation requires a change to previous patterns of behaviour or habits among doctors, it becomes harder to implement. Less specific or more vague recommendation also have less take-up. If doctors have a strong belief that they can and will be able to perform particular actions, they are more likely to engage in that behaviour. In addition, the intrinsic value of the action to be taken encourages increased manifestation of that behaviour.

4.1.3 Reconciling personal judgement with guidelines involves assessing the available evidence

Doctors increasingly decide to adhere to guidelines when they better understand the evidence of their effectiveness. This is because it reduces the uncertainty within the span of decision making that they are dealing with. When reaching a decision, together with a patient, doctors will weigh up the evidence that they have and decide what is the most reliable – often this can be the 'informal' information rather than official data or statistics. Guidelines may potentially pose a barrier to creative problem solving and reaching a balance between personal judgement and the use of guidelines can be challenging for some medical staff.

4.1.4 Team working and human factors influence good practice behaviours

Personal characteristics, such as a belief in having control over life events and personality dispositions, can have an impact on the decisions and behaviour of doctors. Preconceptions and values can also affect their interactions with and decisions reached about some patients, for example in the case of older patients. Effective team working can be challenging for some doctors who may see themselves as being the natural leaders of the team or as being 'above' the team. When teamwork within a healthcare environment is not working well there can be negative impacts for both patients and team members. Research points to a connection between teamwork and patient safety. One of the strategies identified in the literature as helpful for improving team working was inter-professional education.

4.1.5 Morale, workload and resources need to be effectively managed to enable doctors to make good decisions

The morale and prevalent attitude of medical staff has been linked to their ability to communicate with patients. Perceived behavioural control over their circumstances seems to positively affect performance. Information overload and heavy workloads have been documented to affect the ability of doctors to adjust their behaviour and make good decisions. The need to find strategies to deal with this seems to be an important area to affect change, where it is needed. Potential solutions to some of the individual and team-based challenges proposed in the literature include simple measures (such as colour-coding) and more complex, technology solutions. Some aspects of the wider system and policy environment may affect the ability of doctors to provide a good standard of medical care, such as increasing role substitution affecting continuity of care.

4.1.6 Organisational culture may obstruct ongoing improvement and negatively affect standards of care

Education of doctors throughout their training and ongoing career development was seen as critical to effective practice. In particular, ongoing opportunity to develop reflective

capability in alignment with and in support of technical capability was identified as important for the effective provision of care. Early stages of medical training were observed to be critically important in the development of good practice among doctors. Tight management and monitoring of these important stages of learning, as well as ongoing continuing professional development were seen in the literature as important factors. Ensuring clarity about and creating a shared understanding of accountability structures and processes was seen as an important aspect of improved communication. In particular, the range of values and meanings applied to accountability mechanisms means that doctors may be working towards varied priorities - for example they may focus on managerial standards or may be working towards social responsibilities and norms (or some combination of these). A culture of support of patients by doctors can potentially make it difficult to offer advice that might not be well-received and can result in doctors not providing the advice that they need to in relation to, for example, smoking cessation or obesity management. There has been, in some medical environments, a culture of acceptability of non-disclosure of errors or concerns for care quality. Tacking these challenges requires supporting staff and ensuring that they are not fearful of the consequences of their actions.

Within each of these thematic areas we recognise that the data relate to a complex set of influences that exist at various levels– individual (micro), organisational or local (meso), and wider policy level (macro) of influence. In each thematic area, one of these levels of influence may be more significant than the other two. However, they are ultimately linked together within the wider policy context.

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Appendix A: Rapid Evidence Assessment – detailed methodology

This section sets out RAND Europe's approach to the REA to explore factors that encourage or discourage doctors from acting in accordance with good practice.

Research question and definitions

The primary question the REA aimed to answer was: What influences doctors' adherence to 'good practice'? Following discussion with the GMC at the project inception meeting, the following definitions were agreed:

- Influence – Includes individual level (micro), organisation/local level (meso), and system/strategic level (macro) influences, both external (environmental) and internal (cognitive)
- Doctors – Adherence among primary and secondary/specialty care physicians, practicing both within the NHS and privately
- Adherence – Described as having three components: accumulation of knowledge, internalisation of knowledge (attitudes), and ultimate behaviour
- 'Good practice' – Based on the GMC core standards (with input from NHS Constitution), and emphasis on 'human factors' of practice, particularly whistle blowing, communication

The evidence for this review was focused on the qualitative nature of the influences on behaviour, as opposed to measuring the discrepancy between behaviour as prescribed by standards of good practice and actual behaviour.

Scope and inclusion criteria

We limited our review of the evidence to that already appraised by existing systematic reviews (systematic reviews) in the first instance. We anticipated a high number of returns due to high interest in research of physician behaviour in quality of care studies in particular. We focused on reviews appraising evidence from randomised controlled studies and high quality non-experimental observational studies. We included reviews that follow standard practice according to Cochrane or CRD criteria. One limitation of systematic reviews is that they typically do not include most recent evidence so we complemented evidence extracted from systematic reviews by single RCTs and controlled studies not yet

considered by existing reviews. As needed, the search was expanded to include the next best available research. Other criteria included:

- Language: English language only: Within the scope of the work commissioned we expect limiting included studies to those published in English language;

- Time period for studies to be included: Initially unrestricted;

- Quality restrictions for systematic review inclusion: Cochrane collaboration and CRD systematic review quality criteria;

- For RCTs and studies (if reviewed) Location: UK: This limited the number of returns to review and allowed us to focus in more detail on the influences unique to the doctors the GMC regulates: those working in the UK. However, where necessary and appropriate, e.g. where evidence from the UK is considered as weak, we extended the scope to also include international evidence

The search strategy was initially run as a pilot test to ensure the terms were broad enough to include a range of relevant studies but also narrow enough that number of studies retrieves was feasible to access and screen.

When reviewing titles and abstracts, inclusion/exclusion criteria were applied in three stages. Firstly, criteria were applied on the titles. Those appearing to fit the criteria, or where there was uncertainty, were included. The abstracts of these titles were then read and inclusion criteria applied again. Secondly, those fitting the criteria, or those where there was uncertainty were included. In these first two stages tended to be over-inclusive to avoid excluding potentially relevant studies. Thirdly, reviewers retrieved full reports of studies passing the first round. Full texts were re-screened against the inclusion/exclusion criteria. Each criterion was applied in turn, for each title/abstract/full text.

Search terms

We used search terms that represent the principles and values set out in both the GMC's booklet Good Medical Practice[9] (GMP) and the NHS Constitution, together with terms reflecting potential influences on physician behaviour. We also used non-medical as well as Medical Subject Headings (MeSH) to maximise capture of related results. We noted the GMC's interest in the 'human-related' aspects of good practice and focused the search accordingly. Given this particular interest in elements that impact behaviour, we applied some qualifiers to the searches to ensure relevance of results: for example, including the following: 'barrier/ constraint/ disincentive/ impede' or the reverse 'enable/ facilitate/ incentive/ promote'.

These three search strands were carried out by theme of 'Good Practice': Patient-Centered Care, Clinical Ethics, and Team work. Each of these strands contained blocks of search terms to further qualify results, so that a search can be visualised as follows:

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[9] Good Medical Practice. London: General Medical Council, 2006.

[Action terms relating to good practice theme] AND [Terms relating to attitudes and behaviour] AND [Terms relating to barriers, facilitators, or influence]

More specifically, searches will entail:

Search 1: Patient-Centered Care

("Patient-Centered Care"[Mesh] OR "Physician-Patient Relations"[Mesh] OR "Information Dissemination"[Mesh] OR "Comprehension"[Mesh] OR "Patient Rights"[Mesh] OR "Dignity"[All Fields]))

AND

("Physician's Practice Patterns"[Mesh] OR "Behavior"[Mesh] OR "Attitude"[Mesh] OR "Guideline Adherence"[Mesh] OR "Decision Making"[Majr:NoExp] OR "Compliance with standards"[All Fields] OR "principles of good practice"[All Fields])

AND

("Motivation"[Majr] OR barrier[All Fields] OR constraint[All Fields] OR "disincentive"[All Fields] OR enable[All Fields] OR facilitate[All Fields] OR incentive[All Fields])

* Because we expect this theme to be especially broad, "Physician's Practice Patterns"[Mesh] may be entered as a mandatory inclusion term on its own

Search 2: Clinical Ethics

("Ethics, Clinical"[Mesh] OR "Confidentiality"[Mesh] OR "Social Responsibility"[Majr] OR "Presumed Consent"[Mesh] OR "Informed Consent"[Mesh] OR "Patient Safety"[Mesh] OR "accountability"[All Fields] OR "personal responsibility"[All Fields])

AND

("Physician's Practice Patterns"[Mesh] OR "Behavior"[Mesh] OR "Attitude"[Mesh] OR "Guideline Adherence"[Mesh] OR "Decision Making"[Majr:NoExp] OR "Compliance with standards"[All Fields] OR "principles of good practice"[All Fields])

AND

("Motivation"[Majr] OR barrier[All Fields] OR constraint[All Fields] OR "disincentive"[All Fields] OR enable[All Fields] OR facilitate[All Fields] OR incentive[All Fields])

Search 3: Team work

("Whistleblowing"[Mesh] OR "Communication Barriers"[Mesh] OR "Interprofessional Relations"[Mesh]) OR "Cooperative Behavior"[Mesh] OR "Raising concerns"[All Fields] OR "Flagging of problems"[All Fields])

AND

("Physician's Practice Patterns"[Mesh] OR "Behavior"[Mesh] OR "Attitude"[Mesh] OR "Guideline Adherence"[Mesh] OR "Decision Making"[Majr:NoExp] OR "Compliance with standards"[All Fields] OR "principles of good practice"[All Fields])

AND

("Motivation"[Majr] OR barrier[All Fields] OR constraint[All Fields] OR "disincentive"[All Fields] OR enable[All Fields] OR facilitate[All Fields] OR incentive[All Fields])

Sources

Although the primary literature reviewed to answer our research question was sourced from subscription academic databases, we supplemented findings with review of grey literature (related government and third sector publications) to provide further context to the evidence found.

In addition to the literature quoted in the research specifications of the GMC's ITT, we searched the following to identify relevant work (keeping inclusion criteria of systematic reviews and under expanded criteria, systematic reviews and controlled trials):

- Academic literature:
    - Subscription databases: Searches will be carried out primarily through PubMed (and where texts are unavailable, EBSCOhost[10])
    - For tracking full texts unavailable through subscription, or obtaining other relevant texts:
    - Non-subscription databases and search engines: Google Scholar[11]
    - Individual journals
    - 'Snowballing' (searching bibliographies of relevant papers to identify additional articles);
    - Advice from project advisors on ongoing studies and other potential sources for relevant studies.

- Grey literature:
    - NHS and Department of Health agency web sites
    - Web sites of professional associations such as:
        - Royal Colleges
        - The Health Foundation
        - The Council for Healthcare Regulatory Excellence (CHRE)
        - International organisations with health care improvement aims (eg. Institute of Medicine (IOM), Agency for Healthcare Research and Quality (AHRQ), and the Institute for Healthcare Improvement (IHI) in the United States)

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[10] RAND has an extensive on-line library with access to these and hundreds of other databases, as well as to over one thousand individual peer-review journals. In addition, RAND librarians and researchers have access to a range of print libraries, including those at Cambridge University, Georgetown University and George Washington University in Washington DC.

[11] The Google Scholar search was conducted using Google Advanced Scholar Search.

In order to ensure review of grey literature sources was as systematic as possible and confined to those most relevant, we used the search function available on the web sites of the above listed organisations, in addition to Google searches of the sites using keywords representing the concepts we wished to research further. These keywords were decided ahead of time, following the academic literature review. A sample search, for example, looked like: site:http://www.rcgp.org.uk/ "whistleblowing".

This overall approach enabled a systematic collection of evidence, while allowing for additional contextual factors from current practice and policy discussion to be brought into the analysis.

Information management processes

In order to ensure transparency and reliability ('replicability') throughout the review process, we used information management processes as follows:

- Record studies selected for review of full text;

- Apply and record the application of inclusion criteria to full text;

- Apply and record study characteristics of included studies;

- Apply and record quality appraisal criteria; and

- Organise and analyse included studies for synthesis.

A review template was designed and maintained using Microsoft Excel. EndNote software will be used to record and organise references.

Extracting data and synthesising the evidence

When reviewing and characterising selected papers, researchers independently recorded on a review template information about each selected paper that fits the inclusion criteria. The template included publication type (e.g. peer review journal article, institutional working paper), research question(s), study design, and findings. Within the findings section(s), we highlighted the aspect of 'good practice' under study; any variation in influence/behaviour related to physician characteristics, for example, ethnicity, age, or gender; and any particular intervention or policy noted to impact adherence. Included studies were simultaneously added into EndNote.

Analysis

Evidence on behavioural influences in relation to adherence was reviewed in terms of:

i. Source of influence: internal (i.e. personal/cognitive factors) or external (environmental)

ii. Level of source within system: e.g. individual (micro), organisational (meso), system (macro)

iii. Other themes that emerged

We then examined potential connections between the influences and types of behaviours.

Findings from the REA were subsequently combined with data from the key informant interviews and the benchmarking exercise.

Appendix B: Key Informant Interview topic guide

As you may be aware we are conducting some research, funded by the General Medical Council (GMC), which examines factors that encourage or discourage doctors from acting in accordance with good practice. In the context of this study, by 'good practice' we mean for example accepted minimum standards for treating patients with dignity, quality, patient safety, ethical standards and principles etc.

Anything you say (as an individual) will be treated as <u>confidential</u>. Your organisation may be identified (this may make you identifiable). <u>Is this acceptable to the interviewee?</u> Yes/no

Researcher seeks permission to record the interview.

(Note Italics indicate prompts)

BACKGROUND

1. Can you tell me about your current role?

    Do any aspects of your role relate specifically to doctors acting in accordance with good practice?

ADHERENCE TO GOOD PRACTICE

2. What does adherence to good practice mean to you?

    When you think of doctors acting not in accordance with good practice what sort of behaviours do you think of?
    Are certain areas / issues more likely to be the subject of non-adherence than others?

3. Are guidelines relating to good practice *(referring to standards, principles, values etc as well as more formal guidelines)* known to the majority of doctors in your view?

    How are these communicated to doctors – undergraduate/in practice/written documents/courses?
    Are modifications to good practice guidelines adequately communicated to doctors?

4. Do you perceive there to be a difference between good practice as outlined in guidance and the reality of what happens in practice?
    In what ways/circumstances?

Behavioural drivers

5. Sometimes doctors may act in a manner which is not in accordance with good practice. What do you consider to be the motivations for doctors to comply or not to comply with good practice? (individual, organisational, macro-levels)

   Personal factors which affect behaviour?
   The influence of colleagues in complying, or not complying, with good practice?
   Institutional factors within the organisation the doctor works for?
   Practical factors in their practice e.g. how easy it is to act in accordance with good practice?
   Economic factors?
   Fear of consequences of not complying with good practice?
   Other

6. Where do you perceive the greatest barriers to acting in accordance with good practice to be? *At the individual, organisational or macro levels?*

7. To what extent do you think codes of practice *(referring to standards, principles, values etc as well as more formal codes of practice)* are embedded in individual doctors' decision making processes?
   Are there situations of conflicting interests?

8. Given that doctors work in a variety of environments do you think some specialities or settings make it easier or more difficult for doctors to comply with good practice?
   Which specialities do you feel face particular challenges?
   Differences between primary and secondary care?
   Differences between private and NHS practice?
   Other

Raising concerns when problems arise

9. There may be situations where a doctor is alerted to a colleague who is not acting in accordance with good practice. What do you think are the factors which may encourage or discourage a doctor from raising concerns about such behaviour?

   Concerns over patient safety?
   Concerns of affecting relationships with colleagues?
   Degree of the doctors understanding of the code of good practice?
   Organisational culture (e.g. culture of blame, poor leadership, lack of confidence in the system etc)?
   Other

Changing behaviour

10. How in your view could adherence to good practice be promoted? What actions do you think would motivate doctors to comply with good practice? (individual, organisational, macro-levels)

> *Practical procedures in practice which make it easier to comply with good practice guidance?*
> *More monitoring of doctors practice?*
> *Stricter consequences to not complying with good practice – what would these be?*
> *Changes to organisational culture?*
> *Improvements in dissemination and explanation of guidance?*
> *Other*

OTHER

11. Is there anything we have not spoken about on this topic which you would like to add?

12. Do you have any suggestions for relevant <u>literature</u> that we should look at for this study?

13. Do you have any suggestions for other <u>stakeholders</u> that we should speak to for this study?

Thank you very much for taking the time to talk to us.

Appendix C: Template for benchmarking analysis

Health system NL	*Child protection UK*

Please provide full references for all data collected

Background questions:	
How is this system regulated overall? e.g. legislation, voluntary etc	
Name of regulator and associated agencies	
What do they do?	
How much power do they have?	
Has the cost of the regulatory system ever been monetised?	
Codes of practice in this area:	
Is there a code of professional practice in this area? Is it written down?	
Is the code of practice voluntary or mandatory?	

How do individuals and organisations sign up to it?	
What is the level of support for this code of practice (i.e. to what extent is it used)?	
What happens if people do not sign up to this code of practice?	
<u>Approaches/policies to promote adherence to good practice:</u>	
Are there any specific measures in place in this sector to encourage adherence to good practice? If so, what are these?	
What happens when cases of poor practice come to light? Is there a body that deals with it? How might they deal with it?	
To what extent are a range of factors considered in relation to good practice? If to some extent, how are these dealt with?	
<u>Gaps between behaviour prescribed by standards of good practice and actual behaviour:</u>	
Is this a topic that has been considered or discussed in this sector?	
Is there any understanding in this sector of the factors that influence behaviour (and potentially change it)?	

If so, what are the factors?	
If so, has this resulted in a change in policy direction (to create a behavioural shift)?	
If so, what is the driver behind the shifts? (e.g. did a negative event create the discussion or is there a desire for decreased regulation)?	
Are these gaps monitored or measured in any way? If so, what changes have occurred over time with these gaps?	
<u>**Success and effectiveness of these approaches and policies:**</u>	
Is there any measure of the success of these approaches to regulation and influence over behaviour? If so, what does it tell us? (e.g. change in numbers of explanations of divergence from codes of practice)	
How many complaints were received in the last 3 years?	
Has there been any analysis of the potential impacts of the current approaches to this?	
Has there been any public debate on this issue? If so, what have the different sides of this debate been advocating?	
Other observations	

Appendix D: Benchmarking background data

This chapter presents a summary of data collected on two benchmarking comparators: one in the child protection area and one comparative study of the Netherlands health system. Each of these is presented in turn below.

4.2   Child Protection: Regulatory Structure and Guidelines

Local Children's Safeguarding Boards (LSCBs) are the key body supervising the conduct of child protection officers. LSCBs are inter-agency forums set up by the local authority; they have a statutory footing and ensure the key agencies involved in safeguarding children work effectively together in safeguarding and promoting the welfare of children at the local level. The core functions of LSCBs include reviewing the deaths of all children who work in their areas and undertaking Serious Case Reviews (SCRs). The LSCB has a key role in achieving high standards in safeguarding and promoting welfare, not just through co-ordinating but by evaluation and continuous improvement (DCSF, 2010)

Two frameworks provide assessment guidance for officers working with children. The Common Assessment Framework (CAF) is an attempt to provide a structured template for recording every aspect of a child's life and environment at the pre-assessment stage, although the use of CAF is neither mandatory nor a prerequisite to making a child protection referral. The Framework for the Assessment of Children in Need and their Families is to be used post-referral, for the assessment of all children at the initial assessment stage (the brief assessment carried out by a social worker upon first contact with the client), and core assessment stage (required in cases where families were judged to have problems requiring more comprehensive examination and possibly a more elaborate provision of services or intervention). The latter framework outlines the principles involved in doing the assessments but does not set out step by step procedures.

4.2.1   Complaints and procedures for dealing with bad practice

Complaints against child protection officers are investigated by the local authority designated officer in consultation with the employer (or if reported to the police, in conjunction with the police force liaison officer). Suspension may be considered if the allegation is not clearly untrue and serious enough to merit dismissal. Where the initial evaluation decides that the allegation does not involve a possible criminal offence it will be dealt with by the employer, although where further investigation is required to inform consideration of disciplinary action the employer should discuss who will undertake that

with the local authority designated officer (DCSF, 2010). Cases must be investigated where it is alleged that a person has behaved in a way that has harmed a child, or may have harmed a child; possibly committed a criminal offence against or related to a child; or behaved towards a child or children in a way that indicates s/he is unsuitable to work with children (DCSF, 2010).

The LSCB is required to carry out a serious case review when a child dies or is seriously injured and abuse or neglect are thought to be contributing factors. Any professional or agency may refer a case to the LSCB if they believe that there are important lessons to be learned (DCSF, 2010).

4.2.2 Policy shifts and public debate

Child protection practice in the UK has developed largely in response to the recommendations of public inquiries into the deaths of children already known to child care workers. Although these deaths may be atypical of child abuse generally, clusters of inquiries have been extremely influential in focusing public and professional concern on who was most culpable and lessons that needed to be learned (Kelly and Milner, 1996).

The introduction of both the CAF and the Framework for the Assessment of Children in Need and their Families reflected a shift away from a narrow focus on child protection towards an emphasis on the child's wider welfare (Spratt, 2001). This movement was also expressed in the government publication 'Every child matters', resulting from Lord Laming's inquiry into the death of 8-year-old Victoria Climbié in 2000, which gave rise to the requirement to investigate any case where a child is suspected to be suffering or likely to suffer significant harm. The refocusing trend has been accompanied by a greater emphasis on inter-agency collaboration, and has received support within the social work profession, despite concerns that it could reduce vigilance in relation to child protection (Millar and Corby, 2006).

Although supported by some practitioners, there has been criticism of the Framework for the Assessment of Children in Need and their Families, particularly in terms of the impact of its prescriptive style on practitioner discretion and on the quality of social worker–service user relationships (Millar and Corby, 2006). Social workers have also expressed anxiety about their ability to adequately analyse the information gathered during an assessment (Platt, 2004). A dominant theme in the criticisms of current practice is the skew in priorities that has developed between the demands of the management and inspection processes, and professionals' ability to exercise their professional judgment and act in the best interests of the child. In the view of Eileen Munro, commissioned by the Department of Education to write a review of the child protection system in 2010, this has led to 'an over-standardised system that cannot respond adequately to the varied range of children's needs' (Munro, 2010: 5). Lord Laming's The Protection of Children in England: A Progress Report (March 2009) expressed similar sentiments, reporting that 'Professional practice and judgment, as said by many who contributed evidence to this report, are being compromised by an over-complicated, lengthy and tick-box assessment and recording system. The direct interaction and engagement with children and their

families, which is at the core of social work, is said to be at risk as the needs of a work management tool overtake those of evidence-based assessment, sound analysis and professional judgment about risk of harm.' (Munro, 2010: 6)

Munro has highlighted how repeated public inquiries into child abuse tragedies in Britain have demonstrated the level of public concern about the services designed to protect children (Munro, 1998; Munro and Hubbard, 2011). She asserts the level of public criticism when children die from maltreatment to be one of the most striking features of child protection work in the UK. The level of abuse and blame in the media is said to create an atmosphere of defensiveness and a need for workers to protect themselves as well as children. Defensive practice, however, tends over time to provoke public concern that professionals are intervening too readily in family life, creating a pendulum effect as child protection services swing between prioritising child rescue or family preservation (Munro, 2011).

Munro has further argued that although the public is understandably distressed when a child dies and is right to demand an inquiry into the quality of help provided, a clear distinction is needed between avoidable and unavoidable mistakes in child protection work, as a child's death is not proof that any professional was incompetent (Munro, 1998). High profile public inquiries into child deaths have been so influential in shaping the development of the child protection system that the nature of their recommendations has been scrutinised. In her critique of the findings of these inquiries, which she takes to be symptomatic of the child protection system more broadly, Munro argues that the central problem is too often seen as errant human beings, and so solutions entail strategies for controlling them, which have a detrimental effect. These strategies take the form of psychological pressure to perform to a higher standard; minimizing the scope for individual judgment by automating or formalizing practice as much as possible; and increasing the level of managerial surveillance to ensure workers are complying with the increased set of rules and protocols. In the child protection system, these three strategies have all been implemented. Munro asserts that this psychological pressure has created a high level of anxiety among workers about making a mistake, leading to serious problems in the recruitment and retention of staff, and that increased formalisation through standardised procedures and documentation has radically altered the individual style of practice (Munro, 2009). Partly in response to these perceived failings, the Munro review was commissioned as part of a national drive to improve the quality of child protection services. The review's first report provided an analysis of the unintended consequences of previous reforms that had arisen in the child protection system. It concluded that professionals are, in particular, constrained from keeping a focus on the child by the demands and rigidity created by inspection and regulation. Where excellent practice flourishes, it is due to 'courageous and intelligent efforts to counteract the factors that encourage a defensive, compliance driven service' (Munro, 2011:94).

4.2.3 Key Points from the Literature/ Interviews
It has been noted that social work consists of judgemental as well as intellective decisions (Tibrewal, 2000). The above frameworks provide procedural guidance, but do not prescribe outcomes. As a comparator to decision making among general practitioners, good practice in the field of child protection is thus less clearly defined. Social workers cannot

make the 'right' decision in any absolute sense – they are often asked to make moral judgements and decisions can only be the 'best' on the available evidence (Munro, 1996). As a result, good decision making can often only be established retrospectively. This element of social work is well understood within the profession, where training is focused on equipping social workers with the skills to deal with the inherent uncertainty of the judgements they will have to make.

Munro has outlined that social work has historically been a relationship-based service operating predominantly within a humanist tradition, with a relatively underdeveloped professional knowledge base. Most social workers have operated without any explicit theoretical framework and those using theories have drawn from a vast store, ranging, for example, in psychology from psychoanalytic to strict behavioural approaches. The efforts that have been made to prescribe good practice in the social care sector (dating to the audit and inspection system instigated in the 1980s) are said to have often been founded on misplaced assumptions that were not empirically grounded, including a preference for readily measured aspects of professional behaviour such as time taken to respond to a referral, or how many children had been placed on the child protection register. In so doing, according to Munro's narrative, conceptions of good practise have underplayed the significance of the relationships formed between professionals and family members, or the quality of the thinking in making assessments and decisions. The methodological choice of quantitative over qualitative data has had pervasive repercussions in the way practice has evolved, as aspects of the work that could not be measured in this approach have tended to become less valued.

Munro asserts that in child protection social work, the omission of three aspects in particular is proving problematic: relationship skills, emotions, and critical reasoning. As Munro states, 'no one would deny their importance and, indeed, many agencies strive to encourage them, but there is a strong pressure to give them less time and attention when the official system of rewards and punishments does not include them''(Munro, 2009). Munro has consistently stressed the emotive nature of child protection work, coupled with the importance of relationship skills. Unless the emotional dimension is brought into conscious review, workers are said to be in danger of being unconsciously influenced in ways that damage their judgments and decisions (Munro, 2009). Throughout her recent work, Munro has argued that the task of improving the child protection services should be seen as a systems problem, and has advocated adopting the system-focused approach to investigating errors that has been developed in areas of medicine and engineering where safety is a high priority (Munro, 2005).

Concern about the decision-making abilities of practitioners in child protection has emerged as a strong and recurrent theme in the literature, and notably in child death and serious case reviews (Reder and Duncan, 2004). Decision-making processes have been found to be affected by a myriad of factors including the cognitive structure, the heuristics and schema held by individuals; the individual's attitudes, beliefs, values and knowledge; the agency and legislative context; and the characteristics of the service users (Drury-Hudson, 1999). At the level of the workforce, it is important to consider how individuals interpret their social context, how they understand organisational messages about

priorities, and how they feel supported or undermined by managerial scrutiny (Munro and Hubbard, 2011).

A number of studies have reviewed the recordings of public inquiries in order to gain insight into decision making in this area. Kelly and Milner (1996) applied universal features in the assessment of risk (as identified in psychological literature) to examine decision making processes in child death inquiries. Factors found to influence decision making included ''groupthink'' (characterized by shared rationalizations to support the first adequate suggestion by an influential group member; a belief in unanimity; direct pressure on dissenters; and a high level of confidence in the group's decision). Examples were also found in support of prospect theory and the 'certainty effect'. The critical influence on decisions is stated as the framing of the problem in terms of losses or gains, with individuals exaggerating the distastefulness of losses that are certain relative to those which are less sure. The operation of the 'certainty effect' was illustrated by reference to the Kimberley Carlile case, in which a variety of professionals had identified a number of possible and actual losses to the children. Avoidance of the certain loss of the mother-children relationship determined that the potential losses to the welfare of the individual children became ''subsidiary considerations'' (Kelly and Milner, 1996: 96).

Munro (1996) reviewed a sample of all inquiry reports published in Britain between 1973 and 1994, in order to examine the causes of errors in professional reasoning in child protection work. She found that professionals based assessments of risk on a narrow range of evidence, which was biased towards the information readily available to them and overlooked significant data known to other professionals. The range was also biased towards the more memorable data, and evidence that was ''vivid, concrete, arousing emotion and either the first or last information received'' (Munro, 1996: 793). A later study by Munro (1998) confirmed the importance of how a child protection officer originally frames a situation. Social workers were found to be persistently slow in revising their judgements, as misjudgements about clients that may have been unavoidable on the limited knowledge available when they were made continued to be accepted, despite a growing body of evidence against them. Munro argued that social workers therefore often have to recognize that ''their former views were wrong - although reasonable at the time they were made''. In this sense, 'mistakes' are conceived as an inevitable part of practice and recognizing them is ''an essential element of good practice'' (Munro, 1996: 796). Munro asserts that supervision has traditionally been seen as the forum in which workers are helped to take a more critical look at their reasoning. Research in psychology has demonstrated how hard it is for people to correct their own intuitive errors, so supervision is crucial. However, the shift in UK child protection in recent years has been for supervision to be dominated by managerial concerns, of checking that workers are following procedures and meeting performance indicators, so that time for clinical review is compromised (Munro, 2009).

Literature has also identified a number of 'devices for practical reasoning' that social workers and others use in analysing information. Wattam (1992) suggested that social workers use the structures of motive (motive to offend or to report the allegation), corroboration (the availability of corroborating evidence), specificity (the specific detail of the allegation) and categorisation (the tendency to hear information according to certain

expectable features or cultural categories). Platt (2004) examined the means by which social workers evaluate the information recorded in the new assessment frameworks. Measures of evaluation were found to include specificity (the extent to which the social workers described the information they obtained as clear and specific in its detail); severity and risk; parental accountability; corroboration (this might involve another professional concurring with the worker's opinion, or providing information that backed up information the worker already held); and parental co-operation. Factors that have been said to empower social workers to comply with good practice include having the confidence that they will receive support, where the decision they have taken proves to have been incorrect; having confidence in their own decision making ability; being open to potential interventions; and being provided the opportunity to learn from mistakes.

4.2.4 General Social Care Council

The General Social Care Council (GSCC) is an arms-length government body funded partly by the Department of Health and partly by registration fees, and is the regulator of the social work profession in England. The GSCC launched the first UK-wide codes of practice for social workers and employers in September 2002. They codes arose due to an understanding that social workers needed improved support and supervision, and in response to public concerns that social workers were being employed who were clearly unsuited to the profession. The codes of practice set out ''the standards of professional conduct and practice required by social workers as they go about their daily work''.[12] Although the introduction of the codes initially received opposition from some social workers, data collected from our key informant interview, suggests that the codes are becoming widely supported and perceived to have exerted a positive impact on adherence to good practice. The codes have received praise for their clarity and level of detail. At present, observations about their impact are based only upon the changing patterns of complaint referrals. However, they will be shortly be the subject of a review recently commissioned by the GSCC to ensure the codes remain relevant and up-to-date.

The GSCC receive referrals from members of the public, employers and local authorities, among others. Complaints are also received from co-workers, with an anonymous reporting process in place to facilitate this (there is an element of risk to be assessed by the complainant, as co-workers may be challenged on the evidence they present in making a complaint). On receipt of a referral about a social worker, the GSCC determines whether there is a specific allegation of misconduct against a registered social worker, and if this is established, seeks to ascertain if there is evidence of misconduct that calls into question their suitability to be on the Social Care Register. The GSCC may liaise with the afore-mentioned local authority designated officer, depending on the seriousness of the case. Registered social workers who are found to have breached the codes of practice may be removed from the Social Care Register. An appeals system exists for social workers who wish to challenge the verdict of the GSCC.

The number of complaints received by the GSCC initially increased as the public, employers and professionals became more aware of the codes of good practice. Surges in

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[12] http://www.gscc.org.uk/page/18/What+we+do.html

the number of complaints received have also been correlated with public enquiries that have brought social work to public and media attention. The most prominent cause of complaint has related to transgression of professional boundaries (for example, a social worker forming an inappropriate relationship with a person under their care). Interview data suggests that there is also an inherent risk that social workers may seek to deviate from taking responsibility for their actions, because of the grave consequences that can affect themselves and others when they make a wrong decision; and social workers may on occasion feel justified in neglecting standard procedures or seeking advice, if the urgent nature of the situation demands it. Nonetheless, the number of complaints is currently diminishing, a trend that is expected to continue as the work of the GSCC and the effect of the codes of good practice continue to improve the standard of social workers in the profession.

4.3 Health Sector Netherlands: Regulatory Structure and Guidelines

4.3.1 Health Sector Netherlands: Structure for handling complaints

The Individual Health Care Professions Act provides the legal framework overseeing the provision of care by professional practitioners, and all physicians are obligated by law to participate in the disciplinary system. Patients can register a formal complaint to one of five disciplinary tribunals comprised of legally qualified members. Patients can also file complaints to be dealt with internally by a hospital complaints committee or family practice, and to the insurance company of the hospital or a civil court if seeking financial compensation for malpractice. Hospital complaints committees are obliged to report yearly[13] on lessons to be learnt from recent cases, and measures taken and changes introduced in response. They act as intermediaries between the hospital and the complainant, and are required by law to work in compliance with transparent written procedures and to give a well-reasoned decision on whether a complaint is well-founded or unfounded. The committees are characterized by their focus on improvement of health care organizations, as reflected by the expectations of complainants; in a study by Friele et al (2008), the issue considered to be most important by 94% of the patients at the start of the complaints procedure was a recommendation from the committee to the hospital to change things in response to the complaint. Disciplinary Boards are characterized by their high status and capacity to issue a verdict on the accused health care professional (Kruikemeier et al, 2009). Lodging a complaint at a disciplinary board has been found to result in higher patient satisfaction with the outcome of the verdict, although patients who lodged a complaint at a complaints committee have more often noted that the organization made improvements resulting from the inquiry (Kruikemeier et al, 2009).

Existing literature has focused on the nature of complaints filed at Dutch disciplinary tribunals, where information is most readily available. Complaints in general practice have centred on insufficient self-organisation and communication by the practitioner, with a

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[13] It was not possible to gain access to these reports for this study.

common complaint concerning doctors failing to appear at scheduled home visits. According to one long-term study, the vast majority of complaints registered between 1982 and 2002 concerned physicians (92%). The complaint density was higher for general practitioners than specialists and generally higher for surgical specialists than non-surgical specialists. Approximately half of the complaints concerned 'lack of care or inadequate care' or 'incorrect treatment'. Of all complaints 20% led to a sanction, the majority to a warning (62%). Appeals were lodged against 29% of the verdicts, and in 22 cases the licence to practice was withdrawn definitively (Hout et al, 2007). Individual cases held at the disciplinary tribunals and considered to be of general interest are published weekly in Medisch Contact, the journal of the Royal Dutch Medical Association (KNMG), and the publication most widely read by doctors in the Netherlands. Friele et al (2008) conducted an empirical study of complaints handling in hospitals, examining discrepancies between patients' expectations and their experiences. The study surveyed 279 patients who lodged a complaint with the complaints committees of 74 hospitals in the Netherlands. Two thirds of the complaints (66%) concerned medical treatment, often in combination with shortcomings in interpersonal or informational conduct (57% and 41% respectively). Nearly all complainants considered the incident to be serious and many reported physical and/or mental suffering (82% and 85% respectively), or financial consequences (64%). The majority of patients (63%) were satisfied with the way in which their complaint had been handled by the complaints committee, although 71% of the patients were dissatisfied with the response of the hospital management and 82% with the reactions of the professional who gave cause for the complaint.

4.4 Non-Mandatory Guidelines

The Dutch college of general practitioners issue stand alone, non-mandatory guidelines for specific topics. Knowledge of the guidelines is not uniform and is partially dependent on the success of dissemination strategies. Despite the considerable efforts in developing and implementing evidence-based guidelines, Lugtenberg et al (2011) states that only a modest impact has been found on clinical practice. General practitioners (GPs) do not optimally adhere to guidelines, with adherence levels varying largely between practices and providers. In a cross-sectional electronic survey among 703 GPs in the Netherlands, Lugtenberg et al examined GP attitudes to sixteen key recommendations derived from four national guidelines. Six statements were included to address the attitudes towards guidelines in general, and in addition, GPs were asked to rate their perceived adherence and the perceived barriers for each of the key recommendations. Over one third of the GPs reported difficulties in changing routines and habits to follow guidelines, whilst perceived adherence varied between 52 and 95% across recommendations (with a mean of 77%). The majority of GPs have been found to support the guidelines, believing them to improve patient outcomes, and with the perception that they are guidelines for GPs developed by GPs (Lugtenberg et al, 2011). The guidelines focus on clinical compliance rather than general standards of care.

4.4.1 Dutch Healthcare Inspectorate

Regulation of health care is performed by the Dutch Health Care Inspectorate (IGZ), an independent agency within The Ministry of Health, Welfare and Sport. IGZ was founded

in 1995 by integrating the then Medical Inspectorate of Health, the Medical Inspectorate of Mental Health and the Inspectorate of Drugs. The new Health Care Inspectorate was well received in the field (Ngo et al, 2008). IGZ introduced a system of performance measurement for hospitals to be used for their quality inspections, and is involved in the development of a second system promoting public information on the quality of hospitals.

IGZ guards the quality of care and enforces 25 laws, including the Care Institutions Quality Act. It has various measures at its disposal to ensure compliance with legislation, professional standards and guidelines. It can offer advice and recommendations to encourage improvement, and impose corrective or coercive measures. IGZ performs regulation of healthcare by a combination of three methods of detection. First, theme-based regulation is directed at specific issues in care, sometimes asked for by the minister or parliament, which require the attention of the regulator. Second, IGZ deploys regulation in response to calamities in the event of emergencies that indicate structural shortcomings in care provision. Third, IGZ has been developing risk-based supervision from 2002 to assess the quality of health care by means of indicators. Based on an analysis of the data collected with the indicators, institutions are designated as being at risk. Inspectors visit the selected institutions, which are then obliged to improve their care on the basis of the inspectors' judgment. Inspectors can decide to plan a follow-up visit if those improvements are not satisfactory, and can also impose administrative sanctions and penal measures (Tuijn et al, 2011).

IGZ does not investigate the majority of patient complaints filed directly to the Inspectorate; where such complaints are received, they will be first deferred to the institution where the subject of their complaint occurred (including hospital complaints committees), who will be asked to conduct an internal investigation and submit a report. Cases will thus be investigated by IGZ only if they cannot be dealt with satisfactorily at a local level. In such instances, IGZ will then conduct their own investigation, referring the most serious cases to the disciplinary law tribunals. Such cases are likely to involve a doctor being seen to have broken a law, or being regarded as a potential danger to patients (for example if they have been alleged to have treated patients whilst under the influence of alcohol; and where a patient has died or experienced serious health problems as a result of the doctor's negligence).

In addition to performing preventative visits to hospitals and general practitioners, interview data informed us that IGZ conducts its own research projects to bring general problems of bad practice to attention (for example, it has investigated the extent to which a recent guideline on the telephonic accessibility of general practitioners is being met).

4.4.2 Key Points from the Literature and Interviews

IGZ has been criticised for a number of perceived issues or failings, including that it needs to be more actively concerned with the actual outcomes of healthcare work (Ngo et al, 2008). It has been characterized as a 'silent service', conducting its activities with relative secrecy in order to not to bring unwanted damage to the credibility of healthcare. Ngo et al (2008) have encouraged the Inspectorate to develop into a more transparent 'public service', one that is ''pro-actively engaged in informing both the public and the healthcare

field about its ways of working, standards employed, advices and interventions". As of July 2008, the majority of reports published by the inspectorate have been made public further to the national Freedom of Information Act, although reports relating to individual health care providers, or those which concern events which are subject to criminal or disciplinary proceedings, are not 'proactively' published.[14] As an organisation of around 200 Inspectors, IGZ is felt to be overly reliant on the quality systems of professionals and health services themselves.

A perceived problem with the wider system is the reluctance of hospital committees to refer cases to IGZ, with, according to our interviewee, cases having come to public attention where an issue has escalated due to absence of referral. IGZ has also been criticised for responding slowly in specific cases, notably in a parliamentary inquiry on the 'Biljmermeer Disaster' (a plane crash in Amsterdam in 1992, resulting in 43 deaths). About a year after the crash many residents and service personnel began approaching doctors with physical health complaints, but the first studies on the symptoms reported by survivors were not performed until May 1998. The AMC (Academisch Medisch Centrum) eventually concluded that up to a dozen cases of auto-immune disorders among the survivors could be directly attributed to the crash, and health notices were distributed to doctors throughout the Netherlands requesting that extra attention be paid to symptoms of auto-immune disorder, particularly if the patient had a link with the Bijlmermeer crash site. The parliamentary enquiry concluded that the Inspectorate had underestimated the seriousness of the situation (Ngo et al, 2008).

Literature regarding adherence to good practice in the Netherlands has focused on GP compliance with the guidelines published by Dutch college of general practitioners. Reflecting the nature of the guidelines, this literature has centred on adherence to clinical guidelines rather than standards of general care. The disparity between GPs' knowledge of best practice and what they do in reality is an acknowledged concern (Groll, 1990). A number of barriers to adherence have been identified, including the underlying level of evidence supporting a guideline, organisational, collegial and managerial support for the guideline in question, and the GP's level of personal interest in the topic concerned. Lugtenberg et al (2009) conducted a focus group study in which 30 GPs participated, involving fifty-six key recommendations derived from twelve national guidelines. Perceived barriers to adherence varied largely within guidelines, with each key recommendation having a unique pattern of barriers. The most perceived barriers were lack of agreement with the recommendations due to lack of applicability or lack of evidence (68% of key recommendations), environmental factors such as organisational constraints (52%), lack of knowledge regarding the guideline recommendations (46%), and guideline factors such as unclear or ambiguous guideline recommendations (43%). Schouten et al (2007) examined physician adherence to key recommendations of guidelines for community-acquired pneumonia (CAP), and found that adherence is often sub-optimal. Regarding the choice of guideline-adherent empirical therapy, treating physicians said that they worried about patient outcome when prescribing narrow-spectrum antibiotic therapy, whereas regarding

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[14] http://www.igz.nl/english/proactive_publication/

the timeliness of antibiotic administration, barriers such as conflicting guidelines and organisational factors (for example, delayed laboratory results, antibiotics not directly available, and lack of time) were reported. In a further example, Cabana et al (2000) conducted three focus groups to understand barriers to the use of 4 recommendations within the National Heart, Lung, and Blood Institute (NHLBI) asthma guidelines (prescription of inhaled corticosteroids, recommendation of daily peak flowmeter use, smoking cessation screening and counselling, and allergen exposure counselling). They found the type of recommendation and physician year of graduation from medical school were related to perceived barriers to adherence. For corticosteroid prescription, senior physicians mentioned lack of agreement, whereas younger physicians described lack of confidence in dosing or recognizing contraindications. For peak flowmeter use, senior physicians emphasized lack of training. Only senior physicians described the inertia of previous practice as a barrier, and all groups cited time limitations.

 Based in part on the findings of these and other studies, Lugtenberg et al (2011) conceptualised barriers to adhering to guidelines as consisting of three groups. The first group comprised of lack of awareness and familiarity (GPs may be unaware of the exact content of the guideline). The second group of attitude related barriers comprised of the following: disagreement with the guideline due to a perceived lack or inadequate interpretation of evidence, lack of applicability of recommendations in general or more specifically to individual patients; lack of self-efficacy (GPs may believe they cannot perform the guideline because they lack appropriate training or experience); lack of outcome expectancy (GPs may believe that even if they can perform the recommendation it may not affect patient outcomes); and lack of motivation (including that GPs may have difficulties in changing habits or old routines). A final group of external factors included patient factors (the GP may be unable to reconcile patient preferences and demands with guideline recommendations); guideline factors (the guideline recommendations themselves may be considered unclear or ambiguous, incomplete, or overly complex); and environmental factors within the GP's own practise (including time pressure, lack of resources, organisational constraints within the own practice (e.g. arrangements with practice assistants), in other organisations (e.g. out of hours services, pharmacies) or between organisations (e.g. cooperation and arrangements with medical specialists), and lack of reimbursement).

Elsewhere, doctors have most often underpinned their departures from guidelines by referring to a detrimental effect on the patient-doctor relationship. In a study by Veldhuis et al, doctors attributed their departure from good practice to 'the wish to be nice' in 42% of deviations, and to 'the wish to prevent a conflict' in 30% of cases. (Veldhuis et al, 1998). Compliance has been strengthened where guidelines do not demand too stringent a change to existing routines, and are compatible with existing values (Grol et al, 1998). Adherence to guidelines has also been found to be more contingent on the nature of the individual than the organisation; Smolders et al (2010) found rates of adherence to guidelines on depressive and anxiety disorders were not associated with practice characteristics, but to some extent with physician characteristics.