Playing by the rules ...

It is indeed a laudable objective of this journal to promote a truly integrated multidisciplinary approach to quality health care evaluation. As previous issues of the journal have illustrated, the job of the editorial team has been to ensure that a balance between medical, nursing, managerial, and paramedical views of a quality service is achieved. Yet already there are several issues emerging. For example, it is often reported to me that while nursing colleagues are really doing a lot on quality at grass roots level they are not prepared to write up their work for journals such as this. The consequence is an overrepresentation of quality issues in medicine rather than in nursing or an integrated view. Similarly, managers are allegedly too busy to put pen to paper, thus facing the same potential disenfranchisement when it comes to defining quality.

One conclusion drawn from this is that medical practitioners, given the volume of audit articles being generated, are the only members of the team with sufficient time and resources to document their work! The rest of us are too busy doing the job! Though this view may quickly be dismissed as a false conclusion, the question of why there continues to be a disparity in the volume of information generated by different members of the health care team does need to be addressed.

My own view is that this situation reflects a profound and complex problem. Fundamentally, if there is no description and interpretation of a discipline in the language and terminology it chooses then there is little possibility of that discipline developing its expertise. So if nurses and others do not document their efforts in quality improvement they are making it impossible for others to see their particular perspective on quality. And if the particular contribution of one discipline is not clearly recognised it is virtually impossible to have a collective approach to quality – all that results is a monopoly in which one group dominates the whole proceedings.

Definitions of quality are context related and are influenced by the values and beliefs of those individuals involved in the activity. The definition of quality agreed on also affects the methods used to audit the aspect of quality under investigation. That medical views of what constitutes a quality issue may often be diametrically opposed to a nursing perspective is illustrated in the following example.

A group of nurses were concerned about the dignity of elderly men who had undergone transurethral resection of prostate operations. Often several of these patients when mobile were found to be exposing their genitals because of bulky catheter bags, inappropriate drainage systems, and ill fitting pyjamas. The nurses decided to set a standard to improve the situation, part of which related to evaluating the range of catheter equipment used routinely in the ward. When invited to attend a lunch time seminar on the quality problem, one surgeon asked whether there was a problem with infection. When told that there was not he asked why there needed to be a meeting at all and departed.

The example is clear enough: a medical interpretation of what constituted a quality problem in this case related to incidence of infection rates; a nursing perspective defined the problem in terms of patient dignity. The questions to be answered are: is patient dignity a legitimate topic for audit? If so how would one go about auditing it in a way that was accessible to all members of the health care team? Why, in this case, was there little or no appreciation of the quality issue that the nurses wished to explore? Was it the way they presented the problem or the language they used?

This example reflects the different ideological perspectives that doctors and nurses tend to hold regarding definitions of quality – with medicine being located in the technical-rational domain and nursing moving into areas of interpersonal relationships. It also raises the question of how either group would choose to audit their quality improvement. Infection rates lend themselves more easily to the routine quantitative audit process whereas the measurement of a concept such as dignity may require a more qualitative audit approach.

The issue then becomes one of questioning whether the whole audit process is more oriented to solving what could be called technical problems, which more traditionally locate themselves within a medical context. Perceived nursing problems tend to be more interpersonal in nature, areas notoriously difficult to measure precisely using conventional approaches. (This is not uniquely a nursing problem – specialties within medicine such as general practice, psychiatry, or palliative care face similar issues.) The challenge then changes. Should nurses identify quality problems that are more technical in order to fit in more comfortably with the dominant approach to audit? Or should the audit process itself begin to accommodate a much more eclectic approach to quality evaluation?

The experience of nurses involved in continuous quality improvement using standard setting shows that when the objective is improvement in the service the methods required for evaluating practice must be broad ranging. Chart audits are of value, but they certainly are not the only means of evaluating practice. Because nursing has not emerged from a traditional, technical-rational approach to problem solving the skills associated with it are often underdeveloped, and opportunities to
Uncertainty in medicine: can it be reduced?

"Nous sommes dans un nuage d'inconnaissance et d'incertitude, et la connaissance a produit ce nuage."

E. MORIN

The development of medicine as a science began in the second half of the nineteenth century. The "paradigm of certainty," inherited from the mechanistic model of scientific knowledge, was applied to medical science by Claude Bernard in the 1860s. Conclusions from observation and research admitted as "true" facts were believed to reflect, in medicine as in physical sciences, the true organisation of matter and determination of disease. Modern doctors and the general public have been brought up to believe that knowledge of the mechanisms of disease was sufficient to establish correct diagnoses; provide accurate prognoses; and, through application of medical research, produce cures.

**Diminishing confidence**
But confidence in medicine has faltered. Influential writers have expressed doubts about the effectiveness of medicine. Some medical interventions which were assumed to be effective have proved to be ineffective, and some untreated patients have fared better than treated patients. Diagnoses and opportunities for treatment are missed despite the emphasis on the technical possibilities of early detection and prevention of diseases. Slower progress than anticipated in the development of effective treatments for solid tumours and chronic diseases; the unwanted secondary effects of chemotherapy, radiotherapy, and other treatments; and, more recently, the impotence of therapeutic agents against viral diseases and AIDS have all contributed to a wave of scepticism. Doctors are criticised for failing to inform patients about treatment options and the likely consequences of available treatments.

Moreover, many unexplained variations in the use and appropriateness of medical interventions and variability in medical judgements have been described. Such variations seem to be counter to a discipline which has a scientific basis, and they suggest either important gaps between the results of research and medical practice or a profound uncertainty in the practice of medicine.

We can now begin to sense the problems posed for a journal such as this. Do we continue the conspiracy and play by the (medical audit) rules? Or do we begin to bring in a new set of methodologies, with different rules and different techniques? Is there sufficient respect among members of the health care team for the varied contributions we all make in order to expand the perspective and methodologies of audit. Only if this is possible will the objective of this journal be realised and, more importantly, will assessment and improvement of the quality of care become a truly patient focused experience.

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1 Kitson AL, Hyndman SJ, Harvey GL, Yerrell PH. Quality patient care – the dynamic standard setting system (DYSSSY).