

# 15<sup>th</sup> Gordon Arthur Ransome Oration: A Journey of Care—Mission Impossible?

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Minister, Mr Lim Hng Kiang; Master, Academy of Medicine, Malaysia, Datuk Dr Yeoh Poh Hong; Master, Academy of Medicine, Singapore, Dr Walter Tan; Immediate Past Master, Academy of Medicine, Singapore, Dr Chee Yam Cheng; Previous Masters of the Academy; distinguished ladies and gentlemen.

I am deeply honoured by the invitation to deliver the 15th Sir Gordon Arthur Ransome Oration.

Ransome was born in England in 1910, and was the first Master of your Academy and a former President of the Association of Physicians of Malaya. He is warmly remembered as the founder of modern medicine in Singapore. Always available to the rich and to the poor, to the mighty and to the lowly, he was an outstanding and masterful clinician. He retired in 1971 after 33 years of leadership and dedicated service in this region.

An oration is defined as a harangue designed to provoke, stimulate and perhaps to irritate, annoy and challenge. An orator is allowed the luxury to dream the impossible. In this oration, I wish to address some fundamental challenges which health services face. Despite their importance, the issues are seldom debated because few dare face the difficulties.

In the first part of the Oration, I will discuss the present status of some “journeys of care”. I will then move on to describe developments which will impact on future “journeys of care” and benefit patients and health services. My remarks relate principally to the management of chronic diseases.

## **Journeys of Care: The Present**

There are unacceptable variations in practice and in the delivery of journeys of care. The public has become increasingly well informed about misadventures and malpractice through the press, telecommunications and the Internet. Soon the public will no longer tolerate “journeys of care” which are something of a lottery, might be successful, might involve “near misses”, or preventable disasters and unnecessary delays. Nor will funders in

government or as insurance payers accept processes of care that are not evidence based and cost effective. Public confidence in health services has been eroded and requires to be regained.

Working practices have moved from the days of Ransome to the present systems of partial shifts, discontinuity and fragmentation of care. Today, in the UK, in some hospitals, an inexperienced junior doctor may be required to supervise overnight up to 200 in-patients whom they do not know. Senior doctors are extremely stressed and are retiring early. Manual case records are chaotic and disorganised. Sharing of information across the primary to secondary care divide is inefficient. Most clinical information systems are rudimentary.

## *The Journey of Care: Variations in Practice?*

In diabetes care, many regions or practices do not maintain registers of diabetic patients. Local policies are variable with respect to eye, foot and cardiovascular examination. Similarly, there is variation in policies for the measurement of glucose, glycosylated haemoglobin, microalbuminuria, lipids and blood pressure. Care of adolescent and pregnant diabetics is not always structured.

Stroke patients are disadvantaged in many areas where there are no organised system for stroke care or for early swallowing assessment despite the high levels of evidence that show unequivocal benefits to such patients.

The care of heart failure patients is also suboptimal. Patients with severe grades have a worse prognosis than some types of cancer, yet, audits show that evidence-based therapies such as ACE inhibitors, diuretics, beta blockers and spironolactone are not being optimally delivered.

Implementation of prophylaxis against deep venous thrombosis in patients admitted to hospitals is inconsistent despite the overwhelming evidence of beneficial effects on a reduction in preventable mortality.

Patients awaiting emergency admission to hospital wait on trolleys for hours due to bed shortages caused by delayed discharges and lack of forward planning.

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The rule of halves continues to operate in hypertension care. Only half of the patients are diagnosed, only half of that group is treated and only half of those adequately.

Lung, colorectal and breast cancer care is variable. Long delays may occur before being seen by a specialist who may be a physician, surgeon, oncologist or radiotherapist. Delays may also occur during cross referrals. In some recent instances in the UK, delays have led to the tumour becoming inoperable. The variability in the patients' journeys lead to variations on outcome.

I will not go on.

### **The Journey of Care: Who are the Players?**

*Everybody, Somebody, Anybody, Nobody!*

*There was an important job to be done. Everybody was sure that Somebody would do it. Anybody could have done it but Nobody did it. Somebody got very angry because it was Everybody's job. Everybody thought that Anybody could do it but Nobody realised that Everybody wouldn't do it. It ended up that Everybody blamed Somebody when Nobody did what Anybody could have done.*

In the design of "quality" journeys of care, clear guidance and definitions of roles of several players are required. Otherwise confusion and discontinuity will result.

The *patient and carer* want accessible, intelligible, plain English "gold standard" information. This information should be free of advocacy and commercial overtones. By strengthening and empowering patients and informing public debate, expectations are raised

The *multi-professional health professionals* involved in team work, including nurses, pharmacists and professionals allied to medicine, require agreed guidance as to the objectives of care, the methods to be used and the outcomes to be measured.

*Specialists* require to discuss and agree "best practice" with colleagues in allied specialties who are also involved in the journey of care. Monospecialty tunnel vision which does not take into consideration the views and evidence base of others specialists, for example the radiologists and the clinical chemists, will result in suboptimal journeys of care. There is a need to "work together".

*Primary care physicians* are the principal lifetime carers of patients. Agreement with secondary care practitioners on referral and discharge practices, including shared care arrangements, are essential, particularly with the shift in the balance of care away from secondary and tertiary care, as with the care of diabetes and hypertension, to primary care.

Finally the key players include *management*. In the UK, the internal market caused managers to focus on the financial

"bottom line" and not on the quality of the service being delivered. Clinicians and managers became disconnected and confrontational. The connecting rods were lost.

### **The Journey of Care: The Solutions?**

The urgent solutions are to regain the confidence of the public and to restore the morale of the professions. A "big stick" approach is favoured by some managers and politicians. This leads to resistance, opposition and tension in health care workers in the UK who already feel under major pressures without added political imperatives, sanctions and burdens. The "bottom up" approach allied to "carrots" allows changes in practice to be professionally led. Ownership is gained as valid and valued guidance is developed. Peer pressure can be applied to obtain behavioural change.

A combination of "top down" and "bottom up" approaches is required and the Royal College of Physicians of Edinburgh has attempted to suggest and cooperate with pragmatic solutions—or levers—to the pressing problems.

The first lever relates to *evidence-based guideline development*. The College has led a process of evidence-based guideline development through the Scottish Intercollegiate Guideline Network (SIGN). The topics are closely aligned to national priorities for "journeys of care". The guidelines are developed using a methodology (now internationally accepted) which requires multi-professional input, a systematic review of the literature, and graded recommendations based on a hierarchy of evidence levels. Minimum data sets are suggested which increasingly form the basis of audit and information technology initiatives. Forty-five SIGN guidelines have now been published but they alone do not change practice and other levers are required.

A second lever is the evolving process called *clinical governance*. The Chief Executives of Trusts have been charged by Government with accountability for clinical quality. The availability of professionally owned and valued SIGN guidelines facilitates the setting up of local procedures by clinicians and managers for the delivery of clinical governance (e.g. diabetes, stroke, coronary artery diseases, etc) in the Trusts. Through the processes of clinical governance, there is an expectation that risk management procedures will identify failing services and dysfunctional doctors much earlier than in the past and nip them in the bud. Earlier correction of deficiencies should also attenuate adverse publicity.

A third lever is external quality assurance by the recently set up *Clinical Standards Board for Scotland (CSBS)*. This statutory, independent, health authority has over 50% of its Board as non-health service members. The Board has already started to visit Trusts to review local services (e.g.

cancer) against defined generic and specialty specific criteria which have been principally derived from the SIGN guidelines. Prior to CSBS visits, the Trusts are invited to prepare a self-assessment document for scrutiny by the CSBS teams. The results of the CSBS visits will be available to the public. In England, a similar quality assurance body has been set up—the Commission for Health Improvement (CHI)—again as a Special Health Authority. The methods to be used by the CHI will be more those of a semi-punitive inspectorate than those of the CSBS. The CHI will concentrate on clinical governance issues in “red” i.e. problematic rather than “amber” or “green” i.e. non-problematic Trusts.

A fourth lever which is again under very active and controversial discussion relates to the proposed 5 yearly *revalidation of doctors* by the General Medical Council. Clinicians will be expected to complete a personal folder in which details of continuing personal development, personal development plans and participation in clinical functional services will be recorded. The trick will be to integrate revalidation of doctors with the external quality assurance (CSBS) and clinical governance processes. Otherwise there will be “paralysis by analysis”!

The fifth lever, referred to earlier, is the *empowerment of patients*. By making the guidelines, such as produced by SIGN, available to the public in accessible language, and

on the Internet, there will be major pressures to improve the funding of health services and the quality of the journeys of care. The involvement of patients and the public in developing SIGN guidelines, and in the work of CSBS and Trust Boards is a very powerful tool to make the problems in the delivery of services at a local level explicit.

These five levers need to be intelligently ratcheted up over a feasible timescale and the different players need to work together.

### **Conclusion**

I wish to end on a positive note. I firmly believe that the levers that are being put in place at present will result in increased staffing and resourcing of health services to release the time of individuals to deliver the journeys of care that all aspire to. An increase in funding has recently been announced in the UK.

Once the systems described above are in place, the public can then be reassured of the safety of their journeys, and the paymasters of the cost effectiveness of the journeys. A move is essential from the gentlemen players of the past to accountable, evidence-based and transparent “journeys of care”

I believe that the Royal Colleges and Academies of Medicine across the world, working with specialist groups and patients have major roles to play in setting the standards.

I am sure that Gordon Arthur Ransome would agree.