

## Point of view

### Safety and quality in intensive care

Safety and quality in health care have become increasingly prominent themes over the last decade. "Quality assurance" measures were implemented in many areas of health care through the 1980's, with an emphasis upon clinical audits being followed by the implementation of new or remedial actions, and subsequent measurement of the effect. However, two sentinel studies, one in the USA<sup>1</sup> and one in Australia,<sup>2</sup> caught the attention of clinical practitioners, the public, politicians and the lay press, who have since continued to focus upon the impact of quality on patient safety across the whole health care system.

#### **Epidemiology of adverse events in health care**

The Harvard Medical Practice Study<sup>1</sup> (HMPS) was a genuine landmark study, initiated as a result of a steady increase in the number of malpractice claims and the value of damages in the USA over the previous decade. This had led various medical and legal commentators to argue for the reform of tort litigation, on the basis that malpractice litigation was an inefficient and ineffective way of compensating patients, and of improving quality in health care. However, there was a startling lack of epidemiological information on the incidence of iatrogenic events and poor quality care, on which to base any discussion or decision making process. The only other previous large-scale study of iatrogenic injury, also provoked by a large increase in malpractice litigation, was the California Medical Association's Medical Insurance Feasibility Study<sup>3</sup>, which reported potentially compensable events in 4.6% of hospital admissions.

The HMPS sought to address this issue through the use of a carefully developed methodology to review over 30,000 randomly selected case records from 51 randomly selected acute care hospitals in New York State in 1984. The authors reported that adverse events occurred in 3.7% of hospitalisations and that 27.6% of the adverse events were due to negligence. While 70.5% of the adverse events caused disability lasting less than six months, 2.6% caused permanent disabling injuries and 13.6% led to death. They had defined an adverse event "as an injury that was caused by medical management (rather than the underlying disease) and that prolonged the hospitalisation, produced a disability at the time of discharge, or both". They defined

negligence as "care that fell below the standard expected of physicians in their community".<sup>1</sup>

The Quality in Australian Health Care Study<sup>2</sup> (QAHCS) was conducted as a quality improvement enterprise, following a feasibility study by the Australian Institute of Health and Welfare. The study was supported by the Commonwealth Department of Human Services and Health, and conducted according to a very similar protocol to the Harvard Medical Practice Study, although there were some important differences in the subsequent analysis. The QAHCS results included an estimate that 16.6% of all Australian hospital admissions "were associated with an 'adverse event', which resulted in disability or a longer hospital stay for the patient and was caused by health care management". The authors found that 51% of these adverse events were preventable, where preventability was defined as "an error in management due to failure to follow accepted practice at an individual or system level". While the disability resolved within 12 months for 77.1% of adverse events, in 13.7% the disability was permanent and in 4.9% of events the patient actually died. The headline-grabbing statistics were the Australia-wide estimates, particularly that some 18,000 deaths in Australia each year were due to preventable adverse events. The authors also estimated that there were 470,000 annual admissions associated with adverse events and that these accounted for 3.3 million bed days, for which 1.7 million (8% of all Australian hospital bed-days) were due to adverse events with "high preventability". The public impact of the study was heightened by premature release of results through the mass media.<sup>4</sup>

One of the obvious and striking aspects of the QAHCS results was the purported four-fold excess of adverse events in the Australian hospitals' studies compared with those in New York State. Reviewers have commented on the differences in methodology and suggested that a small part of the differences may have been the result of including the examination of "preventability" in the QAHCS, compared with "negligence" in the HMPS, although the definitions were in fact very similar.<sup>5</sup> More important may have been the measurement of the proportion of admissions associated with an adverse event in the QAHCS, compared with the number of adverse events occurring per 100 admissions in the HMPS. The QAHCS also included the index admission as being associated with an adverse event when the event was detected *prior* to the index admission but was still responsible for the index admission.<sup>2</sup> The HMPS investigators only included such adverse events if they were detected *during* the index admission, not before it.<sup>1</sup> While there are cogent reasons for these differences, they do significantly increase the proportion of admissions

associated with an adverse event in the QAHCS, and attempts to compensate for this effect, by necessity somewhat arbitrary, suggest a reduction in the rate of adverse events in the QAHCS results to 13% or even 8% when seeking comparison with the HMPS.<sup>2,5</sup> The most important and least recognised difference in methodology lies in the confidence levels accepted by the investigators for the element of causation by health care management rather than the disease process, which was a necessary part of identification of an adverse event in both studies. The HMPS investigators required a "confidence score" to establish that an adverse event had occurred of 4 or higher, on a 6 point scale. However, the QAHCS investigators only required a "causation score" of greater than 1, where causation was present if the adverse event was caused by health care management rather than disease process. It is not possible to estimate, from the data presented, the extent to which this difference in methodology may have increased the frequency of adverse events recognised in the QAHCS study, but it is reasonable to presume that effect would be of major magnitude.

Other issues raised in comparison of the two studies include additional problems of imprecision in defining an adverse event when considering errors of omission, such as delays in diagnosis, which were associated with particularly high levels of preventability and disability in both studies.<sup>5</sup> The QAHCS also demonstrated a severe limitation in the methodology of retrospective review of medical records, having discovered that the more complete a medical record, the increased likelihood that an adverse event would be detected. The more complete a system of clinical documentation, the higher the rate of adverse events when using this methodology. The determination of preventability is also known to be subject to bias in retrospective reviews.<sup>5</sup> The knowledge that a serious adverse event has occurred makes it more likely that medical care will be judged to be deficient.

Setting aside the differences in study objectives and methodologies, it is interesting to compare some aspects of the two studies. The target populations were similar in size, being the 2.67 million non-psychiatric patients discharged from acute care hospitals in New York in 1984,<sup>1</sup> and the 2.82 million patients admitted to public and private acute-care hospitals in Australia in 1992, excluding day-only admissions and admissions to designated psychiatric wards.<sup>2</sup> The extrapolations of the HMPS estimated that adverse events would have led to death in 13,451 cases. The QAHCS death rate in cases associated with adverse events was actually lower, 4.9% (95% CI, 3.8%-6.0%) vs 13.6% (SE  $\pm$  1.7), and the projected number of deaths in the target population was therefore 18,000 (95% CI, 12,000-23,000) with the confidence limits overlapping the extrapolated figure

from the HMPS. The Harvard study demonstrated that 56.8% of all adverse events caused minimal disability, compared with 46.6% in the Australian study. Levels of disability in the moderate range are difficult to compare because of different categorisations.

More recently, a set of studies has been performed in Utah and Colorado, closely following the HMPS methodology, with a similar number of case records from 1992 examined as for the QAHCS.<sup>6</sup> The adverse event rate was 2.9% (SD $\pm$ 0.2%) of admissions with a death rate of 6.6% ( $\pm$ 1.2%) of adverse events.

What should we conclude after considering all of the above study outcomes and criticisms? There is good evidence that large numbers of adverse events occur during hospital admissions and that they in turn have significant morbidity and mortality. It seems likely that the incidence of adverse events due to medical management during hospital admissions is around 3-5%. While approximately 50% of these events result in only minor and temporary disability, between 5% - 14% of adverse events culminate in death. Thus it seems likely that there are a significant number of deaths attributable to adverse events, of the order of 0.2% - 0.7% of hospital admissions.<sup>1,2,6</sup> There is inadequate evidence to conclude, as has been suggested, that Australian hospitals have a higher incidence of adverse events than their counterparts in the USA. On current evidence the "hard endpoint" of death resulting from adverse events appears to occur with the same frequency in both health systems. There have also been suggestions that safety is improving and the rate of adverse events is falling.<sup>7</sup> While it is reasonable to conclude from existing studies that a significant proportion of these events are preventable, estimates of preventability and/or negligence range between 20% - 50% and are very susceptible to minor changes in methodology. Although we now have some reasonable estimates of the size and nature of the problem, we still lack rigorous information on realistic goals and means of prevention.<sup>7</sup>

#### **Safety and quality in health care - Commonwealth initiatives**

During the 1990's the Australian Health Ministers established the Taskforce on Quality in Australian Health Care, which reported in 1996.<sup>8</sup> This was followed by the formation of the National Expert Advisory Group on Safety and Quality in Australian Health Care, which published an interim report in 1998,<sup>9</sup> and a final report in 1999.<sup>10</sup>

Areas identified as requiring attention in the Interim Report were:<sup>9</sup>

- Providing appropriate and accessible consumer health information.

- Providing better frameworks for health care organisations to manage quality of care throughout their organisation.
- Improving systems for self assessment and peer review by clinical service providers.
- Encouraging learned Colleges, professional associations, and medical and nursing administrators to actively ensure quality performance through ongoing certification programs
- Strengthening the quality focus of organisational accreditation processes through requiring organisations to demonstrate mechanisms for quality enhancement.

The Final Report addressed specific safety and quality issues to be coordinated at a national level.<sup>10</sup> It recommended the formation of the Australian Council for Safety and Quality in Health Care, with a substantial budget over 4 years to implement a series of national actions:

- Support methods to enable increased consumer participation in health care.
- Facilitate implementation of evidence-based practice.
- Develop strategies and partnerships to improve information flows between all parties about areas for quality improvement, and to ensure that patients, their families and carers and health care agencies receive timely advice about incidents.
- Develop legislative changes that will allow the detailed, thorough investigation of adverse events or “near misses” and the timely reporting of findings for the information of consumers and for action by organisations and health care providers in the system.
- Facilitate agreement on common systems for the collection and analysis of incidents, adverse events and complaints.
- Develop a national framework for health service performance measurement and reporting.
- Facilitate improvements in the quality of current accreditation mechanisms that address the safety and quality of the system in operation.
- Facilitate improvements to the design and management of the health system that promote smoother transitions for consumers across health service boundaries.
- Research and develop clinical and administrative information systems that have a system-wide focus and application.
- Agree on national requirements for education and training for all health care providers to support their involvement in quality management and collaborative approaches to health care delivery.

### Safety and quality in intensive care

Safety and quality issues have played a significant role in the development of Australasian intensive care. The inherent nature of the specialty and of intensive care practice promotes such an interest. Intensive care units may be characterised as environments of substantial professional and technological resource investment in which patients with complex problems receive rapid and often invasive assessment, investigation, monitoring, and therapeutic measures. Adverse events associated with invasive procedures are readily identifiable and relatively easy to measure and report. Similarly, other adverse events, such as drug administration errors, are identifiable and readily reported in the well-circumscribed environments of intensive care units.

The type of adverse events that occur in intensive care units are measurable, are potentially preventable, and are substantial components of the overall composition of health care adverse events. The most common types of adverse events, accounting for over 80% of adverse events in both American and Australian studies, were those involving the performance of a procedure or operation, complications of drug therapy, diagnosis, or a delay in treatment.<sup>1,2</sup> In addition, the levels of negligent or preventable adverse events were particularly high for events due to problems in diagnosis and therapeutic mishap, which also shared the highest rates of death and permanent disability.<sup>1,2</sup>

The most important assets of intensive care practice are the clinical experience and expertise of medical, nursing, and allied health professionals. The carefully structured and supervised systems of clinical practice encourage the identification and investigation of adverse events. Peer review during daily clinical practice is an integral part of the standard operating system of most public intensive care units. Senior medical and nursing staff regularly exchange clinical information directed towards maximising the continuity of care, and accompany each other on ward rounds, often more than once a day. Few other specialties actually rely as much upon a group practice to deliver care to patients in such a collaborative fashion.

Critically ill patients are more likely than most other hospital patients to suffer extended morbidity, permanent disability or die. These are eminently measurable outcomes and may be utilised not only to measure the benefits of new or established therapies, but also to calculate the impact of adverse events. There is also evidence that an adverse event will not be as well tolerated by the critically ill patient, and that the consequences of any adverse event are therefore likely to be more significant. The HMPS found that major risk factors for adverse events included the age of the patient, the complexity of the disease or treatment, and

the presence of severe coexisting conditions.<sup>1</sup> In the Australian study, a higher proportion of deaths and permanent disability occurred among complex and urgent cases or where management was expected to be life saving or provide a major improvement in the quality of life.<sup>2</sup>

#### Adverse events reporting in intensive care

Therefore, the nature of intensive care practice, interventions and patients lend themselves towards the recognition and investigation of adverse events. It is a natural evolutionary step to wish to develop recording and reporting systems for adverse events. As well as providing a permanent record for reference purposes, a structured system encourages a consistency of approach to allow the frequency of events to be compared over time. Most Australasian intensive care units will therefore have developed an "in-house" system for recording and monitoring adverse events. Through the Australian and New Zealand Intensive Care Society (ANZICS) Research Centre for Critical Care Resources (ARCCCR, previously the ANZICS Intensive Care Unit Registry) we know that 83% of all units, and 96% of all Level III units, had implemented a unit-based quality assurance program by 1997. It was not possible to ascertain if these specifically included adverse events reporting.<sup>11</sup> These are most often managed by the senior nursing staff, with variable levels of medical staff involvement. However, the *ad hoc* development of most adverse event monitoring systems results in them being idiosyncratic to a single ICU, or small group of ICUs with shared senior management. The systems will be heterogeneous in the type of data collected, the methods of data collection and handling, the reporting systems utilised, and the approach to resolution of professional and systematic issues.

The development of individualised systems for each ICU offers the maximum adaptability to meet local requirements, however it also creates several major problems. For example:

- The mere presence of such monitoring does not provide an assurance that all significant issues are identified, nor that those identified are dealt with in an appropriate and satisfactory fashion.
- There is no method of comparing adverse event types and frequency between different types and locations of ICUs.
- There is no ability to establish a minimum acceptable level of adverse events, other than to seek to eliminate them completely.
- The reports will be regarded as confidential and sensitive information, which will seldom be utilised to inform health systems or the general public about standards of practice.

#### Clinical indicators

An attempt to address some of these issues has been made through the development of "clinical indicators" by the Australian Council for Healthcare Standards (ACHS). In 1996, after a period of development and testing with appropriate specialty consultation, the ACHS clinical indicators were introduced.<sup>12</sup> These included:

- Participation in a national patient database and intensive care registry.
- Inability to admit into an intensive care unit.
- Unplanned re-admission into an intensive care unit, up to (and including) forty-eight hours post discharge from the intensive care unit.
- Pneumothorax following attempted and actual central venous catheterisation within an intensive care unit.
- Accidental extubation of an intensive care patient.

These clinical indicators are clearly limited in their coverage of intensive care practice, and do not include important areas such as adverse drug events, nosocomial infection, incorrect diagnosis, delayed therapy, or mortality. However, they do represent the first coordinated national effort at defining and measuring adverse events in intensive care. They have demonstrated the level of precision required in defining the numerator and denominator for frequency measurements of adverse events.

Although at first inspection they appear quite straightforward, various important problems and subtleties emerge in their application. For instance, the denominator for accidental extubation is the number of hours for which patients are *intubated*, including tracheostomies, rather than the number of hours for which they are *ventilated*.<sup>12</sup> Much of this information is difficult and laborious to collect, and in most ICUs there has not been any additional resource provided by government or health authorities to facilitate data collection and analysis.

Additional significant limitations include the lack of any standardised approach to data collection, and the lack of any sophistication in data reporting. Data collected on a retrospective basis, before each quarterly submission, is likely to be quite different than prospectively collected data entered into an ongoing database or registry. While each institution receives a report in due course of its "performance" compared with the average of national pooled data, this is relatively uninformative compared with a frequency or temporal histogram. Finally, there is currently no system or means of establishing an outcome from this process. Each institution and ICU is able to respond (or not) in any

variety of fashions, with no assurance of establishing an improved outcome.

### **The national intensive care databases**

Illness severity scoring was quickly recognised as an intrinsic part of outcomes reporting in intensive care, for without being able to adjust for casemix and acuity variations, there was no capacity to compare outcomes between different intensive care environments. During the 1980s, the APACHE II severity scoring system became the most widely used system for measuring casemix and acuity, in Australasia and probably the world. This has been followed by the Simplified Acute Physiology Score (SAPS I&II), APACHE III, and organ failure scores such as the SOFA Score. As part of developing a standardised minimal data set for acute physiological scores and diagnosis, the APACHE systems focused upon diagnostic classifications and demographic information that would correlate with patient outcome. Large investigational databases allowed the development of sophisticated algorithms that would allow the prediction of outcome for groups of similar patients. As well as being able to measure intensive care performance, measured by mortality, against a centralised dataset, clinical practitioners could compare outcomes between different units, types of units, and geographical areas.

However, these systems remain somewhat inadequate, as no single system has been uniformly implemented, either nationally or globally, and data collection is not standardised and is therefore of variable quality. Since 1989 the ANZICS [Adult] Patient Database has provided the most widely applied system of diagnostic, demographic and physiological scoring in Australia and New Zealand. The number of participating units has averaged 40%-50%, depending on the region and ICU level.<sup>11</sup> The construction of a bi-national database allowed units to compare their casemix, acuity and outcomes with their own historical data, and with national pooled data for their level of intensive care unit. The ANZICS data set includes the demographic, diagnostic, and physiological variables necessary to calculate APACHE II, III, and SAPS II scores. The diagnostic data set is a modification of the APACHE III classification. Predicted mortalities and standardised mortality rates can be calculated using APACHE II and SAPS II algorithms. This is not possible for the APACHE III system, as the algorithms remain the property of a commercial entity.

The Australian and New Zealand Paediatric Intensive Care Study Group (ANZPICS), led by Dr Tony Slater, commenced development in 1996 of a Registry for the data collection, collation and analysis of patient variables and outcomes relevant to paediatric intensive care. They have successfully identified and

calibrated a minimal data set and performed data quality and outcome studies. All paediatric intensive care units in Australia and New Zealand are participants.

Development of the adult database, with data collection and reporting software, has been largely the work of a dedicated group of clinicians at the Royal Prince Alfred Hospital, Sydney. Alternative data collection and reporting software has been developed at the Alfred Hospital, Melbourne. Some professional programming and operational assistance has been made possible through a series of State and National grants. However, adequate recurrent funding has previously not been available, and there is no financial or operational support for the ICUs involved in data collection and interpretation. Consequently, software development, standardisation of data collection, reviews of data quality, and incorporation of new fields have all been faltering in their progress. Recent initiatives, pursued by ANZICS through the Australian Health Ministers Advisory Council (AHMAC), seek to improve recurrent funding and management for the ANZICS [Adult] Patient Database, ANZPICS Registry, and ARCCCR.

### **AIMS-ICU**

The Australian Incident Monitoring System - Intensive Care Units (AIMS - ICU) was developed following the implementation of a similar system for Anaesthesia, under the umbrella of the Australian Patient Safety Foundation. The principles of the system were that while adequate recording and investigation of adverse incidents were central to clinical quality, mandatory and attributable reporting lent itself to punitive resolution systems, that discouraged subsequent reporting. In addition, the significance of events that occurred at relatively low frequencies would be missed, unless centralised reporting and processing was made available. Dr Ursula Beckmann led the AIMS-ICU Project, over a four-year period from 1995-1999. Many ICU's embraced the system of voluntary, anonymous reporting, particularly where punitive attitudes had rendered previous systems unworkable, or in situations where introduction of a non-threatening system of incident monitoring was required to initiate quality measures in a new environment. AIMS-ICU had the advantages of a common system across many intensive care units, which would provide a single large, cumulative data set.

Although developed with an initial Commonwealth grant, and acknowledged by ANZICS, the AIMS-ICU project was unable to attract adequate recurrent funding or the continued support that was required to provide Y2K compliant software and continued central data processing. Many ICUs had chosen not to participate in the project. While there are a variety of reasons for this, it seems that the most common reasons were to avoid

duplication with an existing incident monitoring system, concerns over the handling and publication of data, and perceived deficiencies in the nature of the data collected. The voluntary nature of incident reporting in AIMS-ICU meant that there would be reduced likelihood of complete data submission, and, as the denominator rates of interventions were not available, it was not possible to provide, determine or compare the frequency of events between units. The anonymous nature of reporting within an ICU limited the amount of direct investigation and interpretation of an incident that could be undertaken to determine likely contributing factors and remedial possibilities.

#### **Adverse events, medical errors, and confidentiality**

The impact of the existing literature and its public review in the media has led to a presumption that the majority of adverse events are due to errors, and that those errors are made by medical practitioners.<sup>13</sup> In fact, "as in other complex systems such as aviation, adverse events in health care seldom arise from a single human error or the failure of one item of equipment, but are usually associated with complex interactions between management, organisational, technical and equipment problems, which not only set the stage for the adverse event but may be the prime cause".<sup>2,5</sup> The implicit and often explicit culpability and presumption of error associated with adverse events is exacerbated by study references to "negligence" and "preventability".<sup>1-3,6</sup> However, authors and reviewers of the literature are at pains to point out that negligence and preventability are highly subjective judgements that are also influenced by health system expenditure, the presumed efficacy of prophylaxis or treatment, and the uncertain pathogenesis of some complications.<sup>5,7</sup> Furthermore, the definitions utilised in the literature do not equate adverse events with medical errors. Brennan makes the point that "neither study...on the incidence of injuries due to medical care involved judgements by the physicians reviewing medical records about whether the injuries were caused by errors. Indeed, there is no evidence that such judgements can be made reliably".<sup>1,3,7</sup>

Professional and public perceptions, and the ability of both groups to distinguish between adverse events and medical error, will determine the nature of future adverse event collection and reporting schemes. It will indeed be unfortunate if professionals, health care systems, and the public continue to interpret adverse events as synonymous with individual or systematic error.<sup>13-15</sup> Professional and institutional reputations, and fear of liability under our current litigation system, will demand that all relevant data collection and analysis either cease or be heavily protected by confidentiality legislation. The former has recently been the case in some Victorian hospitals, and the latter has already been

the case for the ANZICS and AIMS databases for some years. If such confidentiality is not guaranteed to effectively secure data from bureaucratic interference, political abuse, and individual freedom of information requests, then dutiful and voluntary reporting of an identifiable and interpretable nature will decline. All data collection would then require either compulsion by regulation or completely anonymous contributions. Participation rates would be expected to decline and remain incomplete and uncertain.<sup>15</sup>

#### **The future**

Safety and quality issues are not going to fade away, and whatever the preferences and fears of clinical practitioners, some degree of public reporting and accompanying accountability seems almost inevitable. The Australian media are continuing to raise public awareness through print and television coverage.<sup>13,14</sup> Politicians and the community are responding by supporting regulatory and legislative measures to make regularly and publicly available "report cards" of individual practitioners, services and institutions.<sup>16</sup> Aggressive medical lobbying and resistance may slow or reduce the extent of these activities. However, it is ironic that some of the same medical lobby groups have instilled in the community an appreciation of the value of choice, particularly in private medicine. Consumers of health care now wish to be informed and empowered to participate in the referral process to medical specialists and institutions. The community is too experienced and sceptical to allow medical practitioners and health care institutions to be the final arbiters of safety and quality – unfortunate anecdotes, systematic failings, and experiences with other professional groups have made sure of that.

Intensive care medicine is a specialty area where death and disability are commonplace, interventions frequent and invasive, large numbers of health care personnel are involved, and the health care and general communities aspire to the highest standards. A series of agreed, uniform, and high quality measures for data collection and reporting, together with appropriate remediation systems, require urgent development and implementation. Following suitable analysis and review, possibly with broader community representation, some of these results will have to be made available to the general community in a suitable and meaningful format. The challenge is to develop these systems with appropriate consultation before similar data is obtained and disseminated in a less satisfactory manner without appropriate health professional participation.

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## FICANZCA's, it's time to vote with your subscriptions

The specialty of critical care medicine has an important step to take to move forward in Australia and New Zealand. Critical care specialists who are certified by the Faculty of Intensive Care, Australian and New Zealand College of Anaesthetists (FICANZCA) are being asked how they would like to pay their subscriptions. In particular, whether they want to subscribe primarily to the Australian and New Zealand College of Anaesthetists (ANZCA) or FICANZCA, and whether they also want to pay a 20 % loading for dual subscription. Let us not be confused: this upheaval in the College finances is not about achieving more financial independence in an enduring Faculty, this step is another timid or 'feeling the water' type of step, towards the formation of the Australian and New Zealand College of Critical Care Medicine (ANZCCM).

Critical care specialists must reject the idea that there is a financial impediment to the formation of ANZCCM. We have seen from the limited financial data in the latest ANZCA bulletin, that the certification of specialists by the Faculty is virtually self-funding.

Some time in the near future we will face the inevitable step of compulsory re-certification to continue to practice. All Colleges performing re-certification will then have the luxury of not chasing membership of practicing specialists. Currently the Committee of Presidents of Medical Colleges is actively pursuing the requirement of re-certification for registration. There is broad political and community support for this step. The major obstacle to the change is the process of amending separate legislation in each state and territory. In a financial sense, ANZCCM must be operational and credible before this eventuality.

What are the implications of the new subscription arrangements?

The need to be certified in both specialties of anaesthesia and critical care medicine has inappropriately influenced the development of our specialty during the late eighties and early nineties. Many leaders of our specialty were aspiring to roles necessitating dual certification such as chairpersons or academic heads of departments of anaesthesia and

intensive care. These positions are disappearing and increasingly will belong to a bygone era. Currently, at a practical level, registration requires only a recognised postgraduate qualification as certification. There is no requirement to be a financial fellow by paying subscriptions to be registered as a specialist. In the future, with compulsory re-certification, it won't be just the paying of subscriptions that will determine registration, it will be the fulfillment of the re-certification process. Dual certification will become increasingly difficult as competency will be the criteria rather than subscriptions.

It is unlikely that an adequate re-certification process would allow widespread practice in two specialties. There may be some geographical areas where specialists will have to practice across two specialties, but if the need is real from the perspective of providing necessary medical care, then exceptions will be made.

Will I be able to change specialties in the future should I change my mind? The answer will be 'yes' if I can satisfy the re-certification process. Can ANZCA deny me access to the re-certification process because I have not been paying my subscriptions during the intervening period? I suspect not. The legalities of restraint of trade would surely offer protection.

As you might expect these issues have not been considered by ANZCA. My inquiries have determined that the only short-term consequence of not paying the ANZCA loading to my subscriptions will be that Dr. Andrew Holt and the initials ANZCA must part company. While this is not unreasonable, anaesthesia will lose the recognition of the role it has played in the training of critical care specialists. Regardless of whether fellows of FICANZCA opt for the 20 % ANZCA loading as an "insurance policy" for credentialing purposes, the taking out of a primarily FICANZCA subscription is a vote for a separate college of critical care medicine. I also welcome this step as an opportunity to more clearly identify some of my fellow critical care specialists.

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