

18/09/07

To National Safety and Quality Accreditation Standards Review.

A specific response to the

**Consultation Paper**  
**An alternative model for safety and quality accreditation of health care**  
**August 2007**

**Re: The Appropriateness and effectiveness of separating safety assurance and quality improvement.**

Whilst the concept of separating the two in non-clinical and technical areas is reasonable the advantages of doing so have not been clearly established in this Consultation Paper, against the further costs involved in creating separate bodies, and the inconvenience it would bring to health care organizations (HCOs) of an extra survey/review process.

However of more concern is that the complexity of the relationship of safety and quality in clinical care defies separation.

In the interests of brevity I shall provide just one example from each of the main disciplines of medicine, surgery and obstetrics

1. The medical oncologist, to effectively treat a patient with cancer, has to administer toxic drugs in such dosages that normal tissues are damaged and patient safety is compromised. One of the resulting complications, for example, is “febrile neutropenia”, in which the reduction in the white blood cell count is so marked that a life-threatening septicaemia may result. Thus there is a need to seek a balance between the safety and quality of care with cancer chemotherapy
  
2. The surgeon, operating for bowel cancer, may perform a very limited resection of the bowel, confining it to the portion containing the tumour. This can be accomplished in a short period of time, with minimal blood loss and little risk of leakage of an anastomosis, as the blood supply of the bowel would not be compromised and there would be no tension on the join. However the resection may be an inadequate cancer operation, compromising the patient’s chance of long term survival, for several reasons. It may:
  - Fail to remove involved lymph glands
  - Overlook local tumour spread outside the bowel
  - Fail to reduce the chance of future cancer by leaving excess “at-risk” bowel behind

A more radical resection would have increased the risk of significant blood loss and the possibility of an anastomotic breakdown, but reduced the likelihood of cancer recurrence. Thus there is a judgment required between performing an operation with a lower morbidity and mortality risk, and one with a higher cancer survival rate.

3. The obstetrician, in managing the delivery of a woman who has had a previous caesarean section may, at her request, opt for “a trial of scar” i.e. let her continue in labour, with the expectation of a vaginal delivery. This approach, however, is associated with an increased risk of uterine rupture and subsequent loss of the baby. Close monitoring of both the mother and the baby are required to achieve this balance between quality and safety.

It therefore appears inappropriate to try to separate the pursuit of safety and of quality improvement in direct patient management.

It is also very doubtful if an accrediting body could effectively confine its review of the care provided in an HCO to an assessment of the safety of the care, without any awareness of the quality of that care and its outcomes, either short or long term, and the further efforts of clinical staff to improve the delivery of the care and its results.

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