

A Duty of Quality

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The process of delivery of health care is complex and includes aspects which concern the clinician, the patient and the treatment process itself. Training imparts skill and knowledge to the clinician. The outcome of any care should be subjected to audit to enable intra- and inter-hospital comparisons to be made. Patient option and the level of satisfaction should be part of the overall assessment. In any organisation that provides this service, there should be documented statements for each clinical process that are derived from evidence-based protocols and consensus statements from the profession. The management of patients with craniofacial malformation or trauma demands a high level of skill, not only for function to be restored but also for aesthetic goals to be realised. New biomedical materials for hard and soft tissue replacement and new techniques such as distraction osteogenesis are expanding the armamentarium of the reconstructive surgeon and redefining treatment protocols for this complex disorders. It is even more important that these new approaches are adequately audited and are evidence based. To try something out “to see what happens” is indefensible from both a moral and legal standpoint. When new approaches are used, the autonomy of the patient should be fully respected, sufficient information should be provided to help in the decision-making process and alternative approaches should be discussed.

The stakeholders in the delivery of care are all concerned with risk management. Universities and Surgical Colleges, Registration Authorities, Professional Organisations, Ministries of Health, Life Insurance companies, Hospital Managers, Customer Organisations, Payment Agencies and Professional Protection Societies all have a role as stakeholder to ensure the risk of each procedure is well managed and understood. Patients are the consumers, and customer satisfaction is the most important concept for success because treatment according to expectations has a big impact on satisfaction, well-being, and a positive approach to recovery. It is essential that clinicians who carry out treatment are well trained, up to date, and have continuous assessment and audit initiatives in place to maintain quality of care and continuous improvement in knowledge and skill.

A “duty of quality” exists for all. The new Health Bill in the UK has become law, and the government has recognised the importance of quality in the health care environment by establishing a Commission for Health Improvement that will have wide powers to ensure institutions comply with the fundamental aspects of quality of care. This Commission will have widespread powers of inspection and action. It has a focus on the development of quality indicators for the treatment process, and will be able to ask for inter- and intra-hospital audit information to assist in the development of consensus statements for clinical process management and quality improvement.

Information systems have been developed for storing medical records and new knowledge management models are now being integrated to assist with information delivery during the consultation and the clinical process. Telematics and distance conferencing are now becoming more readily available and utilised in this process, and the ready storage of data on “smart cards” enables patients to be able to carry and to provide all personal health information to assist with the diagnostic and treatment planning. It may be in the future that the patient carries medical data in this way and is the custodian of the information

Hospitals in the future will have to look at the management of knowledge within the institution, and not only coordinate the collection of data i.e. medical records, but to store information and create knowledge banks for future reference and audit. In an industrial concern there is already emphasis on the development of a knowledge management team and a new area of human resource development is occurring. Knowledge resides in the mind of the clinician, which is an organisation’s most precious commodity. When a clinician leaves the institution, the data and

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information stays but the knowledge is lost, and a different approach and interpretation of the information takes place. To disrupt the continuity of a delivery process would not only create problems for audit but also leave uncertainties of performance that can only be judged by outcome assessments some time in the future.

In an effort to maintain a quality environment, all clinicians have a “duty of quality” to themselves and to their patients. Hospital managers will have to provide access to data and information from within and from outside the institution, and establish new knowledge management services. An acceptance of patient autonomy, working towards agreed patient goals using consensus approaches, audit assessments and continuous education is the way forward not only for all involved in cranio-maxillofacial surgery procedures, but all clinicians, nurses and professionals involved in the delivery of health care.

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