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# Practice visits: A learning experience

## An interview with Keith Harrison

Keith Harrison has been specialising in obstetrics and gynaecology for approximately six years. Originally from South Africa, he undertook his specialty training in the United Kingdom and then New Zealand. He now works and resides in the provincial centre of Hawke's Bay, home to a population of 170,000. Five specialist obstetricians and gynaecologists manage approximately 2000 public deliveries per year.

His current clinical workload consists of a 50-50 split of public and private patients. There is a strong gynaecology bias in his clinical casemix, although he has been performing approximately 140 deliveries per year from his combined public and private work. He describes the New Zealand obstetric climate as a more 'midwifery-led system' compared to the Australian setting, which results in private obstetrics being 'low volume and high input'. For lifestyle reasons, he will cease all private obstetric cases at the end of 2003.

Dr Harrison participated in the New Zealand practice visit program established by the New Zealand Regional Committee's Practice Improvement and Audit Subcommittee with great interest and enthusiasm. This was in part due to his prior involvement in College and industrial issues. He agrees with the perception that obstetricians and gynaecologists are 'vulnerable to inadequacies in practice', which can 'creep up on you'. He viewed the practice visit program from the outset as a positive activity, in which collegiality could be promoted and a 'proactive process' of identifying areas of



**Keith Harrison: 'enthusiastic' about the practice visit pilot project.**

risk could occur. He felt that this would assist in remedying identified risk areas before they could result in 'untoward events'.

### DILEMMAS IN DATA COLLECTION

Preparations for the visit included participation in stage one of the RANZCOG patient satisfaction questionnaire. Copies of the results were sent to participating specialists for direct feedback and to the Practice Improvement and Audit Subcommittee to provide background information for the Fellows who would visit each specialist. Participants were also required to complete a logbook of patients for a month to give an overview of their casemix and workload.

Originally, there was going to be a six-month surgical audit included but this was shelved due to time constraints. 'Ideally we would have liked to identify complications over a six-month period', Keith Harrison

says, 'but we didn't quite get that together in the time frame.' Instead, a record of his theatre lists one month before the practice visit were reviewed. He was disappointed at the omission of the surgical audit and felt that possibly with refinements of the program, a firmer outline and structure of the prerequisite process could have been established. Dr Harrison also suggests that a more comprehensive audit of a clinician's obstetric caseload could be included due to it being an 'area of highest practice risk'. He feels that the practice visit seemed to place more of an emphasis on his gynaecology caseload.

Although the data collection before the visit was time-consuming, Dr Harrison agrees that 'to get full value from the process a more comprehensive self-examination before the auditors' examination' would be ideal. However, he adds that specialists need more encouragement to conduct their own self-audits and data collation.

Keith Harrison was issued with criteria that consisted of six main areas/elements that the visiting Fellows would assess at the visit. However, he did have the flexibility of deciding the order and times that this sequence of review activities would take place. This allowed him the flexibility to incorporate the assessment tasks as best as possible into his weekly schedule. Although he acknowledges that it would be rare that the full assessment could be integrated 'seamlessly' into a clinician's daily workload, this flexibility is certainly appreciated to minimise disruption of the usual work routine.



**Although there is a strong gynaecology bias in his clinical casemix, Keith Harrison still delivers 140 children each year.**

#### **MAINTAINING CREDIBILITY AND SENIORITY**

On the whole, Dr Harrison was satisfied with the processes and structure of the program. He had a high regard for the Fellows that assessed his practice, describing them as 'credible and senior'. 'If these visits are going to work', he states, 'then the visiting assessors need to be people of high standing within the College.' There has been discussion that Fellows who are visited should in turn be part of a visiting team in the long-term, but Dr Harrison believes that for 'the purpose of both standardisation and credibility', it is necessary for the program to have a 'core of experienced Fellows'.

Keith Harrison is in favour of a Fellow's multidisciplinary team being interviewed independently by the visiting Fellows about communication issues that they had observed between the Fellow and patients. However, he also feels that for future visits, it would also be useful to evaluate a Fellow's first hand patient interaction 'in a similar fashion that we do for our trainees'.

Keith Harrison was impressed by the

method and approach that his peers employed when discussing their findings of his practice with him. Although he was aware that there were some insufficiencies within his practice, he felt that the way the visiting Fellows presented the issues to him were appropriate, practical and provided an 'impetus for change'.

'If you are not doing something as well as you should be, you may be aware of it, but you do need it pointed out to you', he says. 'To have it pointed out is extremely valuable.' He has since followed up on all the issues that were discussed.



**Keith Harrison on being audited: 'I greatly valued having the opinion and the input of outside consultants ...'**

Clearly, the most valuable outcome of the practice visit to Dr Harrison was the affirmation that his practice was 'sound in the eyes of the examination, which is what we really most want to know'. He found this conclusion to be a reassuring and objective assessment that provided necessary feedback. He notes that with the continuation of the practice visits program, there may well be the eventuality that an individual's practice may be deemed to fall 'outside the square', and may need further review and assistance. To accommodate this, he feels that there needs to be a defined process that caters for inadequate practice and provides appropriate assistance and support.

'Although the primary function of this process is to support Fellows', Keith Harrison says, 'to be credible, it may also require a mechanism that will, if you like, compel changes to practice methods that are considered to be inadequate.'

Although Dr Harrison has been extremely supportive of the program from its inception through to the results of his own practice visit, he has found it 'remarkable' that some of his peers view the prospect of a practice visit with unease. He feels Fellows should view it as an exercise that enables them to 'improve their practice' and 'protect them from risk'.

'It seems to me that the people who feel most threatened by it are probably the people who will benefit most from it', he adds. 'I think the philosophy should continue to be the same. It should be a positive and helpful exercise, and the ideal outcome is to provide impartial guidance to your colleagues, in as much as you can, and assist them in improving their practice.'

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