made between micro and macro perceptions of public services.

Repeated interactions between individual patients and the healthcare professionals who care for them provide those individuals with a series of specific experiences on which to draw.[5] As a result, whatever public confidence they bring with them to the clinic is soon superseded by a far more direct and concrete set of experiences that inform their level of trust.[6] Calnan and Stanford's work suggests that it is these experiences—rather than abstract knowledge of systems—that most closely informs subsequent overall assessments of what they term ''trust''. However, public alarm over periodic scandals and crises may be articulated as a loss of trust and lead to calls for more systems of scrutiny and control to be put in place.[7] These systems in turn may modulate the nature of subsequent care giving episodes, impacting on trust. Thus, two distinct but interacting processes may be being conflated and muddled because of the non-specific use of terms such as ''public trust''. As a result, concerns and remedies may be badly mismatched.

These papers therefore pose two very important challenges for policy makers and service managers. Firstly, they emphasise the primacy of interpersonal contacts in maintaining and moulding public perceptions. Notwithstanding the need for confidence building systems, greater attention may need to be paid to the microdynamics of the professional/user interface. Secondly, these papers highlight the potential interactions between these macro and micro issues and further suggest that such interactions may work in both directions. ''Public'' confidence building systems may hamper the development of interpersonal (that is, ''private'') trust building consultations between patients and professionals. We suggest that this is because explicit and systemic measurement of accountability can serve to lessen the value placed in the implicit and personal trust relationships (with, for example, patients, clients, relatives or even co-workers) that ultimately enable professional work.[8] At the same time, however, excellent interpersonal skills and the development of high levels of ''private trust'' may serve to shield the incompetent (Dr Shipman, of course, was very well regarded by many of his patients).

Effective and safe healthcare systems that command public respect thus need serious attention to be paid to both the macro concerns of ''public'' confidence building systems and the microdynamics of ''private'' interpersonal trust between all the individuals concerned with health delivery (patients, nurses, clinicians, managers). In both these areas there is potential for dysfunctional consequences as well as desirable outcomes. Getting the balance right will be difficult, but neither approach on its own will suffice.

Qual Saf Health Care 2004;**13**:88–89.
doi: 10.1136/qshc.2004.010173

Authors' affiliations
M R Dibben, Commerce Division, Lincoln University, Canterbury, New Zealand
H T O Davies, Centre for Public Policy & Management, School of Management, University of St Andrews and Associate Director, Social Dimensions of Health Institute at the Universities of Dundee and St Andrews, St Andrews, Fife, UK

Correspondence to: Professor H T O Davies, Centre for Public Policy & Management, School of Management, University of St Andrews, St Andrews, Fife KY16 9AL, UK; hd@st-and.ac.uk

REFERENCES

1 **Davies HTO**. Falling public trust in health services: implications for accountability. *J Health Serv Res Policy* 1999;**4**:193–4.
2 **Calnan MW**, Stanford E. Public trust in health care: the system or the doctor? *Qual Saf Health Care* 2004;**13**:92–7.
3 **Checkland K**, Marshall M, Harrison S. Re-thinking accountability: trust versus confidence in medical practice. *Qual Saf Health Care* 2004;**13**:130–5.
4 **Smith C**. Trust and confidence: possibilities for social work in ''high modernity''. *Br J Social Work* 2001;**31**:287–305.
5 **Dibben MR**, Eley-Morris S, Lean MEJ. Situational trust and co-operative partnerships between physicians and their patients: a theoretical explanation transferable from business practice. *Q J Med* 2000;**93**:55–61.
6 **Dibben MR**, Lean MEJ. Achieving compliance in chronic illness management: illustrations of trust relationships between physicians and nutrition clinic patients. *Health, Risk and Society* 2003;**5**:241–58.
7 **Davies HTO**, Shields A. Public trust, and accountability for clinical performance: lessons from the media reporting of the Bristol enquiry. *J Eval Clin Pract* 1999;**5**:335–42.
8 **Davies HTO**, Lampel J. Trust in performance indicators? *Qual Health Care* 1998;**7**:159–62.

Change management

Are we suffering from change fatigue?

P Garside

Clinicians must be motivated to accept the changes necessary to achieve improvements in quality and performance

Quality improvements require change. Performance improvements require change. When a health system aspires to both over a sustained period there is a serious risk of ''change fatigue''—key players getting tired of new initiatives and the way they are implemented—invariably the key players needed to make the changes work and bring in the improvements.

The National Health Service (NHS) in England has pursued improvements in performance and quality for almost 10 years, but particularly since the Labour government came to power in 1997.[1 2] Significant extra funding has been made available by central government, and structures and systems have been established to ensure that the NHS ''modernises'' its practices. These programmes have achieved results: waiting times are down for elective procedures, access to care has improved, and more resources for staff and treatment are available to managers and clinicians. The improvements in performance have been achieved through the relentless application of targets via a managerial regime working ''top down'' in the NHS. Quality and service improvements are encouraged through a wide range of initiatives embraced principally through the Modernisation Agency, an agency of government focused on changing processes and systems to improve both quality and performance.

In this month's *QSHC* Gollop *et al*[3] address the issue of scepticism and resistance to changes in working practices. The authors rightly point out that this resistance is principally among medical staff, and that the reasons include personal reluctance to change, misunderstanding of the aims of improvement programmes, and a dislike of the methods by which the programmes have been promoted.

Managers cope with change in a different way from clinicians (accepting that many clinicians have significant managerial responsibility). It has become almost customary practice for

managers to pursue new centrally dictated imperatives and targets in publicly funded health systems. Clinicians are motivated by different incentives and dwell in a professional domain where individual professional autonomy is paramount and allegiances tend to be to professional societies and peers.[4] They dwell in these domains for a lengthy period of time, in contrast to managers whom they perceive to move through the system as quickly as any number of new initiatives (''revolving entities''). Gollop *et al* acknowledge that doctors are the key players to engage with the change process, and the ones offering the most powerful resistance. Ask if clinicians are suffering from change fatigue and the answer is most probably ''yes''. Delve a little deeper and we may understand why.

Clinicians want to change things for the better for their patients and for working practices. They perceive an endless stream of initiatives, see many of them ''fail'' and reappear with a new name, see conflicting directions of change, and a plethora of initiatives so great that they fail to see the final purpose or connecting logic. They believe that ''managerialism'' has eroded their autonomy. What is probably more important is that they do not have the space or the time in which to pursue these programmes. Publicly funded health systems do not offer the luxury of resources which similar change programmes receive in private industry. There is little time in their personal schedules, little dedicated resource, and little room to manoeuvre to make changes happen—sometimes, literally, no physical space to rearrange services.

The answers should be in the field of organisational development. Ironically, this is not a body of knowledge and practice generally accepted by clinicians.[5] What does motivate people is a shared vision ''hooking'' into personal desires to improve practice, evidence that the process behind the programme might work, and resources to help them do it. Trust in the leader and in the process taking change forward is also essential. Leadership is critical as people cannot simply be ordered to change. There must be a sense that the prize at the end of the change process is greater than the sacrifices they are making.

One major change programme which did engage clinicians successfully is clinical governance.[1] This major programme in the NHS focuses on the organisation's duty of quality and provides clinical and management responsibility for systems to ensure quality of service. As a new development it probably encountered the least resistance of any of the new national initiatives within the NHS—why? It was ''going with the clinical grain'' in terms of service improvement and had a set of aims which were clearly understood. Furthermore, its title and the terminology seemed to make sense and resources were attached for its implementation over a programmed time scale. Contrast this with the introduction of so-called hospital ''re-engineering'' initiatives in the early and mid 1990s—frightening terminology, minimal evidence base from the US, and a patchy process of introduction. It was a good idea badly implemented and it failed to engage the majority of clinicians.

Are we suffering change fatigue? There is a danger that we are. Can we avoid change fatigue among the followers we wish to create? The answer is ''yes'', if we align the incentives such that there is congruence of aims, lead in the right way, avoid jargon, attach resources and time, and engender trust through delivery. Difficult—but worth it.

Qual Saf Health Care 2004;**13**:89–90.
doi: 10.1136/qshc.2003.009159

Correspondence to: Ms P Garside, Judge Institute of Management, University of Cambridge, Cambridge CB2 1AG, UK; pg@pamgarside.com

REFERENCES

1 **Department of Health**. *Quality in the new NHS: a first class service*. London: The Stationery Office, 1998.
2 **Department of Health**. *The NHS plan*. London: The Stationery Office, 1998.
3 **Gollop R**, Whitby E, Buchanan D, *et al*. Influencing sceptical staff to become supporters of service improvement: a qualitative study of doctors' and managers' views. *Qual Saf Health Care* 2004;**13**:108–14.
4 **Sutherland K**, Dawson S. Power and quality improvement in the new NHS: the roles of doctors and managers. *Qual Health Care* 1998;**7**(Suppl):S16–S23.
5 **Garside P**. Organisational context for quality: lessons from the fields of organisational development and change management. *Qual Health Care* 1998;**7**(Suppl):S8–S15.

Primary care malpractice

Learning from primary care malpractice: past, present and future

B Hurwitz

Understanding of UK primary care malpractice lags behind knowledge of US primary care malpractice

> ''Medications that clean bile and phlegm are a source of danger, and of blame for the person treating''. Hippocrates. Affections 33.[1]

The tangled relations between disease, treatment, patient harm, medical fallibility, and physician culpability have been debated since classical times. But it is only historically recently that actions alleging negligence by doctors have become a commonplace feature of the health care landscape.

One hundred years ago an experienced Scottish judge, while hearing a legal case against an Edinburgh general practitioner (see box), commented on its rarity: ''This action is certainly one of a particularly unusual character. It is an action of damages against a medical man. In my somewhat long experience I cannot remember having seen a similar case before.''[2]

Only a century later the medicolegal landscape of health care could hardly be more different. In the year 2000 the UK General Medical Council received 5000 complaints which alleged doctors' misconduct or poor performance and National Health Service (NHS) hospitals in England faced 23 000 outstanding claims for compensation.[3 4] The annual incidence of NHS written complaints concerning GPs' behaviour or the organisation of primary health care in 2001 relating to GPs and community dentists amounted to 44 000, an increase of 12% on the previous year and an overall increase of 20% since the current complaints procedure was implemented in 1996.[5] Although legal cases against GPs