Médecins Sans Frontières and medical quality

Michèle BECK,
Rony BRAUMAN

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Authors: Michele Beck, Rony Brauman - **Editing**: Judith Soussan - **Design and layout:** tcgraphite

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Introduction

Rony Brauman

The question of quality in the work of Médecins Sans Frontières has been asked from the very beginning of MSF's existence. That should come as no surprise: on the one hand, the issue of improving the quality of practice is a part of ordinary professional activity; on the other hand, Médecins Sans Frontières' work – even at a time when it was still very tentative and limited, in quantitative terms – involved working in distant lands and very specific environments, which demanded adjustments to medical practice as a result. The field work was limited, given the lack of resources, but concerns about improving it, developing it and therefore thinking and talking about it, were already in evidence. The same concern can be seen in the publication, by Médecins Sans Frontières' founders, of a first joint book in 1976 – an extremely theoretical work that shares the latest findings on the subject of resuscitation and which teaches how to manage a displaced population, insert a chest tube or run a vaccination campaign, which bears no relationship to the reality of work on the ground at the time. Nonetheless, even then, this publication flagged up the necessity of reflecting on quality and practice.

As the next generation of MSF and the development of work in refugee camps came along in the late 1970s and throughout the 1980s, the concern about quality became stronger and more tangible, with the previously contentious question of professionalising and organising Médecins Sans Frontières having now been decided. An embryonic medical department was set up in 1982. I say "embryonic" because at the time it was just one person, but from whom the medical department (known as "med-tech" for "medical techniques") later developed. Its role was to answer the questions that came in from the field: which antigen to use for a vaccination campaign? Which type of medicine, which diagnosis? These were very practical questions. MSF's activities, particularly in refugee camps and conflict zones, ranged from curative medicine to various preventive practices, as well surgery and nutrition. As a consequence, it was important to complement everyone's knowledge by providing back-up at head office. The medical department's role was therefore to provide documentation and technical support, and it has grown consistently ever since.

Later, in 1986, came the creation of Epicentre and the introduction of guidelines.

The clinical and treatment guide – famously known as the "green guide" – was the first in a series that has been steadily expanded and re-worked to keep it up-to-date. Our concern, in this case, was on the one hand, to ensure a degree of continuity of care for the benefit of patients, since team rotations and the individual habits of carers resulted in repeated disruptions to treatment methods and practices; on the other, it was about simplifying the work of providing support at head office, by making a set quantity of equipment, medicines, everything needed for an operating theatre and essential resources for medical work available in the field. It was essential to improve consistency and standardise; otherwise, a whole array of different practices would have developed and it would have become impossible to answer the very specific requests of every volunteer in the field.

The result was the gradual development of lists of essential equipment and medicines. The creation of Epicentre, on the other hand, expressed a desire to establish a quantitative assessment of an initial situation and the impact of action on that situation, in other words, the health profile at the start of the mission and how it changed over the months, again mainly in the refugee camps. It is worth remembering that clinical practice was not well viewed at the time. MSF was often described, in international health circles, as a band of unthinking cowboys, not unpleasant but amateurs, who handed out medicines and contributed to maintaining bad habits and to spreading resistance to antibiotics and other medicines. Epicentre was our way of showing that we were serious to those who challenged us, and for whom public health was the only thing that mattered. MSF had the courage to talk about "medical care" when the common expression in aid settings was "health care" and behind this little battle of semantics lay seriously conflicting viewpoints. From this perspective, MSF – anchored as it was in the refugee camps – practised in a way that justified curative medicine, but in a less than promising atmosphere. It is important neither to exaggerate nor underestimate the hostility to medical work, given that today it is broadly accepted as both necessary and self-evident. This was not the case in the 1970s and 1980s.

Against this background, the first difficulty I personally observed related to data starting work on gathering and developing standards, which were beginning to become more uniform in a refugee camp, in this case in Malawi. The first paradox was that while MSF was organising its epidemiological data, a measles epidemic was raging in the camp without anyone realising, because of the time lapse between entering and processing the data. The reason I spotted it was not because I was better than anyone else, but because I was visiting, so I spent my days in the camp and had the chance to talk to local personnel. At the fourth dispensary

I visited, having heard Malawian nurses talking about measles cases in each of them, I realised there was a measles epidemic in the camp. This raised a lot of questions within the team, which was one of the first to have to spend a lot of time in front of a computer screen, entering data.

Moreover, and again in Malawi, cholera outbreaks had occurred in parts of the camp where there were latrines and taps installed by MSF, yet no cases had been reported in the area around the camp, where no *watsan* installations had been possible because of the type of soil. This unexpected situation prompted questions over what results could be expected from *watsan*. In short, questions were raised pretty quickly, in a context where increasing the scale of MSF's missions and budgets was prompting increased interest in quantitative indicators and assessing activities in numerical terms.

In spite of some undesirable side effects, which we were gradually becoming aware of, a more structured approach to practice was unanimously seen as necessary and was beginning to develop. It speeded up significantly at the beginning of the 1990s, as MSF increased in size at both the national and international levels and new communications methods appeared at the same time. Satellite phones, the internet and e-mail led – at least this is when I date them back to – to rules around validating practice, resulting in a kind of medical micro-management that has increased ever since. It seems to me that it was during the 1990s that the word "validation" began to invade every sphere in a way that makes a lot of people smile almost everywhere, although we use it about anything and everything.

In terms of the organisation of medical work, we have seen an accumulation of layers of control, from advice to medical supervision, with the Medref, the Comed, the CP, the desk doctor, the Medical Department and so on… it is difficult to figure out who is ultimately responsible in medical terms. This division of medical responsibilities has been heightened by an organisational division of specialisms: construction, watsan, HR, finance, admin, procurement, etc. In brief, we have created silos, whose members are all driven by a desire to improve quality within their own area of work. The underlying idea is that overall quality will be achieved by attaining the best quality in all these separate areas, which undoubtedly makes sense at an intuitive level, but breaks down when put to the test.

All of this contributes to improving the overall quality of the work, but at the same time makes decision-making *processes* more cumbersome, which can sometimes ruin efforts to drive improvements. The question of quality needs to

be examined with both these things in mind. I would add, with regard to the temptation of constant control – the famous "micro-management" – that I do not believe there is any more mistrust of what is happening in the field or desire to control missions today than there was in the 1970s and 1980s. The main difference is that the means to exert control did not exist in those days, while since the 1990s, everyone has been just a click or a phone call away.

Everyone, at every level of MSF, is proud of what we have achieved and maintained consistently over the years, and everyone acknowledges the efforts made to improve quality, which is one of the trademarks of Médecins Sans Frontières' actions. There are failures, which need to be examined, but also successes we can be proud of, and an overall dynamic that must, obviously, be maintained. That's why questions of dosage and the gap between what is stated in the standard and what actually happens in practice remain unresolved. The complexity and in some cases opacity of procedures, and the gap between procedures and expectations in the field, is always a subject for discussion, question and criticism.

This is the reason we decided to turn our attention to quality for this event. It is not about producing a set of new recipes, which would only prolong the problems we are trying to resolve. It is a matter of thinking collectively about our relationship to current good practices, and to the gap between standards and practices. Should we focus our efforts on processes or outcomes? Who should assess them and based on which criteria? Moreover, is there one overall set of criteria or several possible sets? I am thinking, for example, of the patient point of view compared with the population point of view, or the potential tensions between clinical care for individuals and public health.

These are all questions we intend either to tackle head on, or touch on in passing, but which we will try to examine critically over the course of the day, which has been organised by Michèle, to whom I will now hand over to introduce and lead the day.

I. Current practice and questions about medical quality standards and procedures in MSF operations

Michèle Beck

From my point of view, it was my experience as an adviser in hospital management and my reflections while writing my Master's dissertation that prompted me to start thinking about the relationship between standards and the work done by Médecins Sans Frontières. The ongoing complaints from the field and discussions about the threat that bureaucracy presents to the organisation guided my research on the approach to quality and its effects. We're going to start the day by examining this research, which I will outline now.

A. INTERNAL DISCUSSIONS: RESULTS OF INTERVIEW-BASED RESEARCH

Quality is a vague concept that encompasses a multitude of different ideas, which everyone uses according to their own definition. Everyone supports so-called quality work, but are we all talking about the same thing?

Because of this, I felt it would be sensible to take the perception of quality as the starting point for my research into the state of current practice. I therefore opted to use interviews as the basis for my research and I outline below the various perceptions and points of view I gathered. The results were summarised for the workshop in order to fit the format of the day. Here I would like to outline the results in full, to supplement the presentation.

A total of 31 interviews were carried out: 11 in the Medical Department, 10 in the Operations Department and 10 with people in the field, working either in a coordination role or on a project. A summary table of the roles and experience of the people interviewed, plus the two questionnaires used, can be found in the appendix.

1. CONCEPTIONS

The first question the interviewees were asked was to offer their own definition of medical quality. The vast majority replied by offering a definition of quality of care:

"It's the best care you can give" (CH), "It's looking after the patient using the best and most appropriate care" (LS) and "Administering the right treatment to people based on the right standards of care" (RM).

The other people questioned can be split into two groups. For one group, quality was synonymous with effectiveness, i.e. achieving the objectives set through clear strategies, coupled with an ability to evaluate the extent to which they had been achieved. Their definition was similar to the idea of a project.

For the others, quality was defined in relation to standards or norms to be achieved, which might be different in different areas: the relationship to norms and standards is measured using indicators.

2. WHAT LEVEL ARE WE WORKING AT?

a) Patient level

In the literature[1], the quality of patient care is addressed from two perspectives:
- "*The quality patients expect*", i.e. the level of quality patients hope to see in the care they receive.
- "*The quality patients perceive*", i.e. patients' actual experience during and after care. This is linked to expected quality and the quality actually delivered to patients.

During the interviews, around a third of the people questioned spoke about patients, either in their definition of quality or in response to other questions.

For some people, high-quality care is about **not harming** the patient. It's therefore about getting the right balance between the benefits and risks of treatment for the patient. Some of the examples mentioned during the interviews were the risks of hospital-acquired infections, iatrogenic effects and medical errors.

1. Douguet, F. & Muñoz, J. (2005). *Les effets de l'accréditation et des mesures d'amélioration sur la qualité des soins sur l'activité des personnes soignantes*. Post-survey "Working conditions and organisation in health care facilities" (2/5) (page 38). Department of Research, Studies, Evaluation and Statistics DREES. http://drees.social-sante.gouv.fr/IMG/pdf/serieetud48.pdf

For others, quality must include a consideration of **patients' rights**, i.e. the right to be informed about one's treatment, but also about the therapeutic choices available. This also implies taking well-being into consideration. Several interviews regretted the fact that we tend only to see patients from the point of view of their condition, rather than taking a more holistic approach.

The example below illustrates the limitations of dispensing medicines without an explanation.

"Someone in the team had the idea of carrying out an evaluation of how medicines are dispensed. The result: 80% of patients didn't know how to take their treatment, after it had been explained to them. 80%! I was shocked." (LS)

The same observation came up regularly in the interviews: MSF doesn't pay enough attention to the patient; not enough consideration is given to their needs. Hence the idea that is now emerging, in order to improve the level of quality, of evaluating patient satisfaction in our facilities. This would not necessarily be done systematically, but as a means of understanding their expectations more clearly and being able to respond to them.

"When I went on a visit to Koutiala2 (…), the nurse in the neonatal unit asked me if fathers were allowed into the department. It was forbidden… We measure what it means to take the views of patients and families into account at an intellectual level, but in practice it's more difficult.
When a child is taken into the resuscitation area, the mother is often left waiting outside on a bench, and she ends up with a child who's been swaddled because they've died, but she doesn't really know what's happened in the meantime and hasn't been able to follow what was going on.
(…)
Patient satisfaction is an aspect we'd like to do more on in Katiola3 and produce some kind of focus group outside the hospital, which would give us an opportunity to get feedback from the population." (IM)

As a number of people mentioned, it is also important to take into account the fact that MSF structures generally operate within an existing care setting. They offer one choice among others, which can in some cases, such as traditional medicine, be combined.

One should also mention the work currently being done in nutritional

2. MSF project in Mali
3. MSF project in Côte d'Ivoire

programmes on improving the relationship between carer, mother and child, to build relationships of trust. The aim is to give mothers the confidence to identify complications when they appear and leave them to have their child treated as an outpatient.

Finally, according to one last group of respondents, the best form of patient care is one that makes use of the **most appropriate techniques and knowledge**, i.e. one that takes current knowledge into account and adjusts practice in line with the latest findings and publications.

Still looking at patients, a number of people added a higher level that included the **carers' view** in their definition of quality.

According to the literature, "the quality professionals want is expressed in the form of explicit criteria, based on which it is possible to assess whether the quality delivered is correct" (DRESS, 2005, p.38), i.e. it is about whether a technical action complies with a standard or protocol. This very technical view of quality needs to be balanced against the importance of the relationship with the patient during their care. For carers, it's therefore as much the technical aspect of care as the relationship with the patient that produces so-called quality care[4].

The caring relationship also appears in the interviews as a key element of quality. As a result, the emphasis was on welcoming the patient, behaviour and interactions with them during their care. Another thing mentioned for achieving a satisfactory level of quality was the need to get the right balance between the autonomous decision-making of the carer and the reassuring framework of the protocol, while providing appropriate working conditions enabling staff to provide the best possible care. The emphasis in this area was on work station ergonomics, a commitment to best means and comfort, as in the following example:

"The cleaning trolley for cleaners in the operating theatre in the hospital in B. was ordered and then cancelled several times. It cost 400 euros – OK, that's expensive. But an ultrasound machine is far more expensive and it isn't questioned. If we make the work simpler for the cleaners it will be easier for them to clean according to the rules, and they'll do it. For the time being, they have two buckets that they have to pull behind them…" (HD)

4. CCEQUA – Anaes (2004). *Les coûts de la qualité et de la non-qualité des soins dans les établissements de santé: état des lieux et propositions*. (page 24) Published by the Anaes (National Health Accreditation and Evaluation Agency). http://has-sante.fr/portail/upload/docs/application/pdf/Couts_qualite2_2004_Rap.pdf

b) Programme level: prudent and pragmatic allocation of resources

At this level, those interviewed describe the best care as fitting within a **pragmatic strategy**. For example, tuberculosis screening should only be carried out where treatment is available or there is somewhere patients can be referred to.

Care is also dependent on an **optimal allocation of resources**. Two examples can be used to illustrate this. On the one hand, if admissions criteria are too broad and too many patients are included, resources will be used for actions that were unnecessary. On the other hand, by changing the nutrition protocol for patients in hospital, it has become possible to refocus the care teams on the patients who need them most.

"The mortality rate in the neonatal unit in Kabul was very low, which was surprising. So we had a look at the admissions criteria, which were arguably too broad and included too many children. By reducing the number of children, we were also able to reduce the number of mothers accompanying them, who were forced to sleep two to a bed, because of the lack of space. But everyone there was aware of it, so it was easy." (BV)

"From my own experience in the field, I knew that once children are stabilised, they want to eat: they don't just want F100 milk. We started off in the Central African Republic, because there was a stock-out of F100 – hence the test – , and because it worked, we made it standard practice in other areas. Once they accept RUTF [Ready-to-Use Therapeutic Food], we send them home. So, in phase 1, they get F75 milk and as soon as their appetite returns, we try them on RUTF for a few days (…) and then they go home. It reduces the risk of hospital-acquired infections, the carers have more time for the children who really need them and once they're back home, mothers also have the time to look after their other children. So, we hand over to the mothers for phase II." (KH)

The programme level also includes the social environment, i.e. the population. At this level, the best care is care that does not create **additional risks for the population** and other potential patients. The most commonly used examples in this context are antibiotic, anti-malarial and tuberculosis treatments, which can lead to resistance and therefore a public health problem. In this case, the patient level and therefore an individual's treatment, comes into conflict with public health, because of the risk of resistance. This increases every time a patient is given treatment.

Another aspect mentioned was the importance of taking into account the **expectations of the population** in terms of medical quality, i.e. understanding their

expectations in relation to the provision of care, to help us ensure the project is viewed positively.

"It's about taking into account the provision of a high-quality system that will be accepted by the population. It's also about considering what the population expects in terms of medical quality. Hence the importance of a field-based approach, which includes listening to people at the grassroots level and assessing what they want. It can't be done on the basis of a top-down approach where quality is a theoretical issue." (MS)

A project will be all the more attractive if its activities are in line with the expectations expressed by the population, which can clash with what we believe their needs are.

"In Grozny, if you just look at the medical technicalities, it's fine. We put in stents and have state-of-the-art medical treatments for cardiac conditions. But it's a project that's completely disconnected from reality and how people actually live there [totalitarian system]." (BV)

In Syria, a project to treat people wounded in the war began in the north of the country in 2012. Exploratory missions continued to be carried out, to identify the needs of the population that were not associated with the conflict, which the project was not addressing.

Some reservations were expressed, however: some of the population's expectations may be unjustified in technical terms, for example a preference for injections rather than oral treatments, or asking for a scanner and other sophisticated biomedical devices. The people interviewed emphasised MSF's role in demonstrating that it was possible to achieve a level of treatment that was perfectly acceptable in terms of quality, using basic techniques.

To conclude, these levels can be complementary but can also come into conflict. Public health priorities, for example, cannot always be reconciled with the best treatment for the patient. If we had not reached this conclusion, we would not have argued for moving from DOT (Directly Observed Therapy) to SAT (Self Administrated Therapy) in tuberculosis control programmes.

3. HOW DO WE BENCHMARK QUALITY CRITERIA?

Three different positions emerged in the interviews, with two minority positions,

focusing solely on the resources made available or achieving satisfactory results. The third – majority – view expressed was that quality is assessed at the point where processes and results meet.

Examples of the obligation to provide resources included a sufficient number of trained team members, infrastructure, equipment, medicines and medical products, as well as the organisation of care, including medical protocols and work-station ergonomics.

Results can be assessed objectively on the basis of the indicators collected, activity reports and/or observations made during field visits. For those who define quality as an obligation to achieve specific results, there is a need to stay within acceptable standards, measured objectively on the basis of indicators. I will come back to standards shortly.

"I measure rather than define quality, particularly in terms of mortality. So, I see it as a relatively low mortality rate, with people who leave us cured (…). Another indicator is bed occupancy, which helps me assess comfort for both patients and carers (the number of patients per bed, etc.)" (AM)

"My definition of quality is how to stay within standards or indicators, which are defined by ourselves or external organisations, and how we position ourselves in relation to them. I say external because, for example, we can no longer reuse needles, and that's an external standard MSF complies with." (CM)

A few people oppose this position: for them, getting good results takes time and they feel we need to focus more on resources.

"For me it's less a question of results than what we actually do. I'd be inclined to rely less on indicators and more on what you've put in place to make sure the patient is treated as well as possible. That's more about resources than results." (LS)

So, we can see that, once again, opinions diverge depending on the position taken. When people talk about resources or results, the issue is what we use to assess whether or not they are acceptable. What is the benchmark we are using? And where do we draw the line between what is acceptable and what is not?

A wide range of terms emerged when I talked about benchmarking during the interviews. A total of 14 terms were used to talk about the standard or rule people were using as a point of reference. They ranged from "best practice", an

expression currently used to talk about quality in hospital management training courses, to "minimum standards", "basics" and other "prerequisites", as well as "protocols", "procedures", etc.

In order to make the relationship to benchmarks as clear as possible, I will separate the answers given by advisers in the Medical Department from those given by people interviewed in the Operations Department and in the field.

The advisers from the Medical Department are the people who produce the benchmarks made available to the areas in which MSF operates in the field. During the interviews, it emerged that the advisers used a range of concepts, of different origins, to construct the benchmarks used by MSF. It can be a matter of personal experience, of "evidence-based medicine", even if there are not always robust benchmarks available, as some advisers emphasised. Benchmarks also include our collective experience, expressed formally in the form of guidelines or standard protocols. They also use official normative and regulatory benchmarks, such as the latest publications and protocols from WHO and Unicef, while bearing in mind that MSF may not agree with them.

The wide variety of sources and the multiplicity of advisers and therefore benchmarks can result in discrepancies that mean a judgment has to be made:

"In paediatrics it's complicated: for example, if you have a child with malaria, is it a matter for the paediatricians or for the specialist in tropical diseases? Similarly, if there's a problem with a pregnant woman and she needs a Caesarean section: is it the obstetrician's responsibility or the anaesthetist's?" (BV)

Benchmarks change and need to be updated. For some areas of specialisation, they are only just being invented and trialled. This is particularly true of nutrition, tuberculosis and emergency medicine.

"In Georgia, we're looking for a new TB treatment, so it changes all the time. It means having direct contact with the field in terms of quality, protocols, medicines, etc. (…). [This technical dimension of support, recognised in its own right] offers more freedom for working directly with the field." (CH)

While the majority of advisers agree that a benchmark is a minimum acceptable starting point and not a level of "excellence to achieve" (HD), two groups coexist.

In some areas, benchmarks are fixed and inviolable. They are based on an

absolute requirement. This is the case in anaesthesia, pharmacy and the laboratory. These areas were identified by the advisers as sources of major iatrogenic risks, where it is better to do nothing than do the wrong thing. In these cases, the advisers position themselves less as advisers and more as guarantors of compliance with a certain level of requirement.

"When I arrived, I defined the red line below which we could not do surgery, or what we called the minimum standard (…). The argument that we're working under bombardment doesn't stack up, when only 1% of our projects are carried out in conditions of that kind. The other 99% are stable projects – you can't just do anything." (XL)

"But for me, that's the role of the advisers. We're there to maintain the level of quality and provide continuity, because we're there for a long time, more than the teams in the field." (CL)

In other areas, benchmarks are negotiable, adaptable or changing. These are the areas where the balance of risk to reward tilts in favour of taking action rather than holding back. In this case, the advisers see themselves as having more of an advisory role.

"For me, the key thing is adapting to what's happening in the field, if that's feasible, but it's difficult with some advisers, who have their own objectives and define quality on the basis of European standards. For me, it's more important to have the basics in place wherever you are." (KH)

Benchmarks are therefore viewed differently, depending on whether they are safeguards, prerequisites or protocols that should either be followed or act as a source of inspiration. Overall, the majority position is one of compromise and discussion.

From the point of view of the Operations Department and the field, one of the first observations to emerge was the lack of clarity on the nature of the benchmark: is it an acceptable minimum or an ideal to attain?

For the Operations Department and people in the field, prerequisites no longer apply in emergency situations. It is better to act than do nothing, provided no harm is done and patient safety can be guaranteed.

Outside of emergency situations, a project can still be launched in "restricted" conditions to speed up the process. In some cases, the start of a project has been

so delayed that the authorities have started to have doubts and view us as inconsistent, as in the following example:

"In Katiola, we launched the project in "degraded" mode, though I don't like the term. Quality wasn't necessarily all it might have been when we started, because the operating theatre was in a room in the hospital used for dressing wounds, but in terms of safety, the basics were all in place (…). The aim was to open once the renovations were complete. But given various internal and external constraints, such as approval of the medical plans, the MoU and plans for the hospital, it all took so long that at one point the whole project was at risk. We had to get on with it." (IM)

Although operational staff accept that they may have to start before all the standards are in place, everyone insisted on improving the situation as time went on and more resources gradually became available.

Nonetheless, two prerequisites came up repeatedly as essential: the quality of medicines, and anaesthesia.

As with the medical advisers, there was a question around the teams' relationship with benchmarks. A third of the interviewees spontaneously made the link between quality and context. For them, the level of quality should be adjusted on the basis of compromise. "It's the context and environment that determine the level of quality that's acceptable and that we're going to implement in each country, combined with our own requirements" (LS). Quality cannot be a dogma or an aim in itself, but needs to be rooted in reality, as "otherwise, we run the risk, for example, of seeing patients turned away because they could have a negative impact on the statistics" (LS).

When people speak about context, they define it as including safety, access to populations, the epidemiological profile of the population, negotiations with the local authorities, the level of quality in the country, the competences of local teams, and so on.

It should be noted that people in the field place particular emphasis on the importance of their experience as a success factor in implementing tools and recommendations in practice. For them, it is clear that experience is extremely important in being able to adjust the rules to the reality on the ground as effectively as possible and make the necessary compromises. That said, they never question the interest of establishing rules and their beneficial effects.

"The checklists and protocols gave me a guideline. And for the staff, it helped them to find answers to their questions without always having to come and see us. The guidelines were very useful to me during my first mission in the DRC in terms of tackling the issues. (…) And you also have the advisers on hand to provide training support if necessary, and update you with the latest news." (AM)

They feel that the field teams know how to adapt the level of quality required to the context.

"In Gaza, we face problems with pain management, because of an external factor [the authorities prohibit the use of opioids]. So, there's no high-quality pain management, but the team manages without analgesics, using whatever resources they have to hand. They even look at it from a psychological standpoint to find technical tricks. The team is very proactive. They also look for other medicines, which aren't on the banned list." (MB)

It is adapting benchmarks to the context in this way that gives rise to the difficulties expressed during the interviews. In most cases, the quality requirements are too high for the "traditional" countries in which we operate.

"The level of hygiene in Amman can't be a common standard for all our projects. We don't have "Amman" situations for all our projects." (MB)

"In South Sudan, setting up a bacteriological lab is difficult; the blood bank has already failed. So, while we'd like to stop blindly giving out antibiotics, it's complicated without a lab." (CM)

Conversely, there are situations where the quality level is actually set too low compared with what is expected in the country where we are operating. Some people call these the "new intervention countries" and cite examples such as Ukraine and the Middle East. In these situations, the advisers are seen as preventing an adjustment to higher standards.

"There's a tendency in MSF to base everything on Africa. I was in discussions on the question of quality levels in the Middle East, where the demands were much higher. We stopped ourselves from talking about this level of quality, because we thought ours was acceptable." (LS)

"Quality requirements are very high in some areas, but they don't coincide with the Middle East. More tools, guidelines and materials are needed for these types

of context, but it's the other way round: the Medical Department is an obstacle to change." (AG)

Some people in Operations explained that the difficulties they faced in getting people to understand the reality on the ground often came from the fact that some advisers were still new to the job and that they came from increasingly technical backgrounds.

So it is clear that adapting benchmarks to the areas in which we operate is not as smooth as the advisers may think: the closer you get to the action, the stronger the feeling of blockage and inertia.

4. HOW CAN WE ENSURE THE BEST DELIVERY OF CARE?

a) By the Medical Department

Most of the advisers questioned stated that they trusted the field staff and tried to understand when they saw that their recommendations were not being followed on the ground.

Few people talked about quality indicators as such. On the contrary, it emerged that the kind of indicators collected in French institutions are often difficult to gather. Ultimately, the advisers talked much more about the tools and quantitative indicators that help them to establish what's happening in the field. First and foremost, they cited quantitative data (such as OPD, IPD and Surgery, before they were replaced by Praxis[5]) but also mortality reviews, field visits, briefing and debriefing sessions, and finally specific tools for particular areas of specialisation, such as a quality review for anaesthesia, quality control of laboratory tests, Isystock, etc.

The advisers outlined the various obstacles they face in improving quality.

They bemoan the lack of appropriate resources and as a result, the quality of treatment provided when a project lasts longer than was originally planned.

Because of the various approval levels, the complexity of the decision-making process and the number of people involved, the dilution of responsibilities came up regularly in the discussions. The following example shows how warning

5. Electronic files used for gathering medical data. Praxis is the interface for the new data collection system used in the field.

signs are sometimes only identified by medical advisers, with no-one taking responsibility for checking the next or previous step in the process.

"The rate of positive TB cases should be between 6 and 20% and remain stable over time. So, if you see results above 20% or below 6% or which vary, it's odd. You have to check the lab: what the quality control is like, whether people are overloaded, etc. and work with the medics to see if there's been a change in context. But it's often at head office that people make the connection, either my colleagues in the tuberculosis section, or me." (CL)

The advisers do not feel sufficiently involved by Operations once programmes are underway. Some bemoan what they call the "almighty Operations". Others regret that they are viewed as a source of pointless complications, adding that they regularly intervene to "sort out errors" that could have been anticipated at the start, based on their experience.

Another obstacle identified, this time in the field, is the fatalistic attitude of some teams, which lack ambition, as illustrated below:

"I had a discussion with a few expats who were willing to sacrifice quality, because in their view the context meant that was their only option. (…). The message you get is "That's how it is, you can't change it." There needs to be more willingness to question and look for solutions." (MO)

The same advisers still note the production by some expats of unregulated protocols in the field. It is even more of a problem when the protocols displayed in the departments are contradictory. More generally, the turnover of expats has also been seen as a problem in terms of maintaining quality, because it results in a lack of continuity and long-term vision, which was also observed by the interviewees from Operations.

For the three sample groups interviewed, the advisers in the Medical Department are seen as the guarantors of quality and its maintenance over time. This means that, among other things, they ensure compliance with certain criteria when new initiatives are introduced, for example SIPAP[6] in Irbid. Their role also includes being informed about the latest advances, studies and research in their respective areas, in order to update protocols. Finally, they provide specific technical support to their area of specialisation at the various operational levels. One person emphasised the importance of having advisers working both inside and outside MSF, to broaden MSF's view.

6. "Synchronized Inspiratory Positive Airway Pressure" or non-invasive ventilation for children in neonatal units.

B) The Operations Department's perception

Two kinds of obstacle appeared during the course of the interviews.
First, the lack of flexibility in standards and benchmarks. The following situation shows that quality requirements can sometimes contradict the realities experienced in the field:

"In Yida, we have no operating theatre and we know there's a risk of finding we're stuck if a woman is giving birth and needs a Caesarean, and there's no way of referring her. So, the desk asked if we could have a Caesarean kit with some ketamine just in case. It's better than leaving the woman to die, anyway. In the end, they got the equipment, but it took a lot of discussions, justifications and time." (CS)

The second obstacle is related to the introduction of new strategies or medicines pushed by Operations, as illustrated by the following two examples.

When Sondalis®[7] was introduced in Atmeh, the interviewee said that it took a month and a half of discussions with the Medical Department and around 30 e-mails to get three patients onto treatment. The Department was unwilling to send the equipment and approve the protocols until it was sure that everything was in place. The interviewee's position was that they wanted to have the equipment to be able to carry out proper training before any treatment began.

In the following example, the interviewee talked about a situation where the desk wanted to start a new activity, but the technical skills were not available in-house. The Medical Department therefore stopped the activity from starting and the desk had to look for the necessary skills outside.

"In Chechnya (…) we had decided that we needed to stay in the country but the project at the time had more of a social component (…), while there were people dying alongside because of cardiac problems. The main obstacle was internal, with the Medical Department, because we didn't have the skills in-house. The project needed technical knowledge and a good level of hygiene. (…) There were skills available locally, but they lacked resources. (…) so we had to seek specialist skills outside the organisation and VJ put us in contact with people who could offer us the skills and benchmarks with the minimum requirement and the necessary resources to launch the project." (LS)

7. Food that can be given to patients via a nasogastric tube.

Two obstacles were mentioned: approval of medical protocols and approval of pharmacy orders.

The people interviewed do, however, understand the responsibility these decisions imply. Who will be responsible if a patient develops a complication following the introduction of a new drug?

"It's a question of responsibility, which is why there are obstacles for certain rules; if it goes wrong, they're going to be responsible, like with Ebola and the fear of contamination." (CM)

C) Perception in the field

Before going into detail about perception in the field, it is important to note that none of the people interviewed drew a distinction between the Desk/Cell and the Medical Department. The job of "desk doctor" is the one where there is least clarity.

During discussions about monitoring quality levels by people at head office, two main themes emerged: reporting and the decision-making process.

Reporting includes entering information into all the files and tools required with the aim of monitoring both activities and quality. For most interviewees, it represents a significant workload. As a result, they complain about spending more time at their computer entering information than actually monitoring what is happening in reality.

"Out in the field, you see everyone behind a computer screen, monitoring all these tools. It isolates people as well as lowering the level of quality. For example, people no longer know how to manage stock: they monitor it on the computer using software with the wrong data and in practice, it's the staff who actually manage it. As a result, people steal the stock and it has a negative impact on our local image and our credibility." (TH)

Because reporting is such a burden, some people experience their work as "passing information up to the next level" and systematically having to justify themselves. They have the impression that they gather data and make proposals, but that decisions are made at the next level up, between the coordination team and the desk, with no feedback. This is particularly true of discussions that take place during a fundamental review, which the teams say they get very little information about.

Several people also emphasised the impression of inertia they get when they ask for support. In return, they are asked for a lot of information and justifications, to the extent that they end up with more questions than answers to their problem.

"Because of a fear of taking risks. They don't know the whole picture and they want absolute quality, i.e. to have all the information. As a result, people do nothing and it can block things for a long time. As for a drilling: people would want to have all the information possible about the water quality, type of soil, etc. the result being that the hospital doesn't get any water from the drilling for a long time." (TH)

Another example cited by one interviewee took place in Monrovia, where the project executives spent their energy justifying HR ratios appropriate to their context. It should be noted that these ratios are provided for information purposes only, but in this example, they became prescriptive.

"The fact of having a few more staff also means we have a good level of quality. On the other hand, it generated quite a lot of discussions with head office on the ratios and the fact that we were above "MSF ratios". We have one nurse for five patients in the ICU and one nurse for ten patients on the wards. In the discussions, we were talking about ratios of one to 15 but with the way our space is organised, it isn't possible. At first, they didn't believe us, but finally, with the visit from the hospital management adviser and a discussion, they accepted it." (OM)

The last two examples show that from the point of view of the field, the requirements in terms of quality from the different support departments are cumulative, whether they are HR-related, logistical or medical. People in the field view them in the round rather than by speciality.

Viewed from the field, **the decision-making process is no longer clear**, as the final decision-maker is not clearly identified. Hence the feeling of not being included, although everyone agrees on the fact that it is the field teams that have the clearest view of the context and the reality.

"The advisers from Bordeaux were there in Zaatari. But there was no chance to say what you thought. People didn't ask what I thought, but I was the one going to work there. And when I did say what I thought, no-one paid any attention. When I saw the plan, the water points weren't in the right place, so it was clear the staff weren't going to wash their hands." (AD)

As a result, a number of people expressed the feeling that they were simply operatives, stripped of their role, forced to follow the rules and verify checklists without challenging them, both at the level of the Project Coordinators and national teams. They also had the sense that they were losing the ability to reflect in the field, which they view as a side effect of the working methods referred to previously.

"For me, a good PC was someone who made sure that all the right procedures were in place; I almost had a sort of checklist to make sure that everything was done (…) My head of mission challenged me a lot, on why we used these standards and whether it was always necessary (…) I have the impression we're losing that capacity to reflect in the field." (RM)

"It's like the example of the paediatric evaluation chart, which is too complicated for the staff. People tell us we have to complete it to guarantee quality care. But people die, because the staff fill in the chart without really understanding it and knowing what it really means. So, you have children dying with really well completed charts." (AM)

This attitude, of having to justify everything with data or tools, is so powerful that someone asked if it might be possible to have an evaluation tool for national staff, for each country. The idea was to be able to justify adapting the standard to the skills available in the country. She explained that she knew her team's skill levels, but needed objective – i.e. quantitative – arguments in order to be heard.

This formatting of the field teams was also observed by the medical advisers and people from Operations, but from a different perspective. They believe that a lot of information is collected in the field without being asked for. They are also regularly surprised by requests for approval from the field, which go all the way up the chain for points of detail that could be sorted out in the field. Finally, they see that the tools are systematically completed, without a clear understanding of why they are useful.

"Again, the problem with checklists and indicators, is that they fill them in systematically without knowing why they're doing it and without checking what they should be, which is pointless." (HD)

To conclude this chapter, we see the contradiction between the demand for information to be fed back from the field to head office, for Operations and the support departments, which has a cumulative effect, and the demand on the

teams to be more closely involved in their activities, to guarantee the quality of the actions carried out.

There is a further contradiction, between the way the Medical Department perceives itself as a support department and the feeling of increased control experienced by the teams as a result of the validation process. It is all the more contradictory insofar as some still assert that they always, in the end, get what they want, but that it takes a lot of energy and creates a certain weariness. The risk is that people choose their battles, abandoning others that might perhaps have been relevant. The other risk is getting around the rules, which results in a loss of control by higher levels of management and increased risk for patients. The example that is routinely given in this respect is purchasing medicines locally. This resolves the acute problem of a team in the field that needs a specific drug but do not get a timely response or face a refusal of the proposed solution.

"I have an order for drugs that I put through without approval, to speed things up. You have to get the right balance between urgency, benefits and risks and sometimes you choose to wait, and hope the blockage resolves itself." (AG)

5. DOES THE BEST CARE COME FROM COMBINING AREAS OF SPECIALISATION?

Is overall quality the result of combining quality requirements in each area of specialisation? How do the various advisers coordinate with each other and with other departments?

According to the interviews with the medical advisers, there is little coordination between the different areas. It is not formalised as such, but some groups of advisers work in teams on specific topics, for example tuberculosis, HIV and laboratories, or surgery, anaesthesia intensive care and emergency care. But this is specific to these groups, because when a hospital combines surgery, paediatrics and maternity care, for example, the interviews do not suggest that there are specific conversations about their respective requirements.

As we have seen previously, the interviews also point to an overlap between areas of specialisation, with some activities covered by two different medical advisers. A telling example of this kind of verticality and overlap was given by one person in the field, who explained that the patient's medical file has become a compilation of records specific to each area of specialisation, with no links between them, and few resources offering an overall view of the patient. The result is files that can run to up to 20 pages, repeating the same information

several times and becoming impossible for the teams to follow. Another example is the difficulty of finding relevant information among all the resources available:

"What makes it difficult is that there are too many references. For a malaria protocol, you have the green guide, the malaria guide, the nutrition guide and the medical advisers at head office, and you get different information from all of them. At the end of the day, which one do you choose?"

This specialist silo effect contradicts the multidisciplinary, cross-cutting approach that many people cited as an important aspect of high-quality care. Splitting medicine into separate areas of specialisation is not unique to MSF, but linked to the changes in Western medicine in recent decades.

Coordination with other departments is done almost exclusively through the Operations Department, but it is highly dependent on the relationship of trust between individuals. Other departments were only rarely mentioned. The exceptions, however, were the laboratory and the "flying"[8] role, which represent a possible avenue for improving coordination. In fact, the laboratory, which has specific needs linked to biomedical equipment, for example, is obliged to work with the Logistics Department. Similarly, "flying roles", which spend most of their time in the field, have to coordinate with other disciplines to check that the changes made to the project are being applied by the whole team across the board. They are responsible for setting it up but also providing implementation support over the long term, which field visits rarely allow.

According to the people from the Operations Department interviewed, an approach to quality based on distinct areas of specialisation results in losing an overall, cross-cutting view of projects. The same observation was made by two medical advisers:

"There are all kinds of initiatives, but they're not necessarily very well coordinated and move in all directions. (…) The tools need to be simpler too: there are too many, all over the place, and in the field it's overwhelming – they no longer know which way to turn." (KH)

At the same time, people in the field point out the mismatch between the recommendations made by the advisers when they visit, and the operational strategy:

8. The flying role is carried out by technical specialists who go out into the field to help the teams implement activities specific to their area of specialisation or to provide technical support.

"In Rutshuru[9] we were in a completely schizophrenic position, with the operational view that we'd be closing in four or five years on the one hand, which we were talking a lot to the Ministry of Health about, and the medical advisers' view on the other, who had a very vertical approach and saw Rutshuru more as a testing ground. (…) They would decide to implement a particular activity, like limb blocks in anaesthesia and things like that, which are more why you would start a project and the complete opposite of deciding to shut it down." (RM)

They are also unhappy about recommendations that are made without considering their direct impact on the project, for example in terms of logistics or human resources or, as in the following example, for the pharmacy.

"What annoyed me were the visits from the medical advisers, who are certainly doing their job, but who make changes directly in the field without talking to the coordinators or the desk. It means wasting medicines that are no longer used and increasing the consumption of other medicines, which hadn't been anticipated. The timing was never discussed. (…) Another example is deciding to wear gloves for everything, but suddenly you find you haven't got any more gloves for the teams when they need to do something high-risk." (DC)

Finally, some people commented that the medical advisers' objectives are not always in line with practical needs in the field.

"For example, with anti-D immunoglobulins for pregnant women, we wanted to go further in some areas, but that wasn't the way things were done at MSF. As a result, there were internal obstacles between the field teams, who can see what the needs are and what resources are available in the field, for example in Turkey, and who can see what ought to be done, and the Medical Department, which doesn't listen and isn't familiar with what's happening on the ground.

Every adviser has detailed knowledge of specific subjects, but they're not necessarily linked to the field. But they [the advisers] also have enough power to block progress. We've been trying to move forward on the immunoglobulin issue for two months now." (AG)

Specialisation is therefore a factor in making procedures more complex, in addition to the quality requirements of the other support departments. We are therefore seeing an accumulation of quality requirements, without there necessarily being any link between them (though it should be noted that some advisers

9. MSF project in the eastern Democratic Republic of Congo

are aware of these effects and try to address them by making tools and protocols as simple as possible, so that they are useful in the long term). This increased complexity is all the more contradictory when the prevailing message is to simplify both protocols and the information available, so that everyone can find what they need quickly. The term "basic" came up frequently during the interviews, with the idea that simple – if not necessarily easy – things were sufficient to produce high-quality work.

"We have very good hospitals: they're basic, but the quality is good." (MO) "Even with minimal resources, it's still possible to have a good level of quality." (M)

There were two opposing points of view on the effects of specialisation in the responses given by people working in the Operations Department.

One group of people defends the idea that it is better to take your time and avoid rushing at the start of medium- or long-term projects. The aim is to do things properly, rather than trying to deal with errors made at the start, which is both time-consuming and takes a lot of energy.

For the second group, the specialisation of quality requirements hinders the ability to respond quickly, which can go as far as threatening the launch of a project or delaying the start of new activities, as happened, for example, with internal fixators in Aden.

"In Aden, our quality requirements hamper us from fitting internal fixators. I'm afraid that, because we don't have a microbiology laboratory, we're not going to be able to launch this activity. I get that impression because the requirements change over time: in Port Harcourt, we didn't have a microbiology lab. We need to be careful that quality requirements don't become an obstacle (…)." (CS)

All the people interviewed were aware that quality comes at a price, but it is accepted. Another effect of specialisation highlighted the constraints it places on HR. The increased requirement for specialists in expatriate teams, who can work in specific areas such as neonatal care, was one of the examples given. This requirement causes additional delays because of the difficulties in finding people with the right knowledge and skills. It also causes problems for the expatriates, who have a very vertical view of the project, in understanding the compromises needed in the context, as illustrated below.

"For example, when I presented the team with the plan to support other mater-

nity units outside our project, the two neonatal expats insisted that we should provide neonatal care. They needed to understand that these units didn't have the resources for that, and that providing them with birthing tables and the basics was already a step in the right direction. They're specialists without a broader vision; often they've only had a briefing from their medical adviser and they go out into the field without that broader view." (RM)

6. IS THE BEST CARE SYNONYMOUS WITH SYSTEMATIC INTERVENTION?

To conclude this first section, the interviews revealed a contradiction between how we operate and the direction of some current medical practices. We know that we tend, in MSF, towards action, or "interventionism". The resources are available, so why not act? Yet as some people have remarked, action is not always synonymous with quality.

First, providing high-quality care to a patient may, in some cases, be limited to palliative care. This is an attitude that requires teams to take a step back from the technicalities and provide care that offers comfort. This approach is gaining increasing support within the association but it clashes with our operational culture and the realities the teams face in the field.

In the following example, the field teams faced difficulties in restricting themselves to admissions criteria and therefore providing palliative care to children who were underweight. They were confronted simultaneously with the reasons for their commitment, "saving lives" and the incomprehension of families and local care teams. It was a particularly uncomfortable position for them as a result. Yet providing palliative care in these scenarios is a mark of quality.

"Today, it's difficult to do paediatrics without neonatal care, but everything's more complex as a result. When the Deputy Director talks about it, it sounds simple, but that's not the case at all in the field. The criteria aren't as clear and simple as they are in theory. Underweight children need palliative care but it isn't what the teams do. In practice, it doesn't work. It's 20% of cases, of which we save one out of two, but what future do they face? It tries the teams' patience and it takes a lot of time. (…) From the teams' point of view the resources are there, so why not do everything for these children, rather than just palliative care." (AM)

Secondly, interventionism sometimes clashes with the principles of "not doing harm". In the following example, because the hospital has no in-patient beds,

all surgery is done on an outpatient basis, which means some patients are excluded.

"In Gaza, when it comes to reconstructive surgery, technically our surgeons can do maxillo-facial surgery but we can't hospitalise our patients afterwards. So, cases that might bleed can't be dealt with as outpatients. It's the same with a grandmother with diabetes. Do no harm! We can't guarantee proper monitoring after surgery here, so we refuse these types of case, even though the surgeons are pushing to do them." (MB)

The surgeons' desire to take action clashes with the project's operational constraints.

Finally, our tendency towards action and continuous improvement also raises the question of the sustainability of treatment facilities after we have left. There are two opposing positions, between those who believe you have to do your best for the patients you are treating at the moment, and those who think the level of quality should be increased gradually by involving the Ministry of Health, so that progress is maintained after MSF has withdrawn.

"When we arrive and do surgery, we do it with the right level of quality. The idea of implementing a system that can be "passed on", with average quality at the beginning, telling yourself we're not going to stay long –well if you're going to stay for five years, you may as well produce good quality during that time. You never know how long you're going to stay. So, you shouldn't restrict yourself too much just because you're planning to pass it on. Actually, restricting yourself is worse, because if you provide good quality you also establish good habits." (TH)

"No government can maintain so many people with limited budgets, let alone the physical resources (equipment, medicines, disinfectant-detergents, etc.). I love the idea that poor people have access to high-quality care, but you need to bear in mind that it won't last." (JP)

Along the same lines, the discussions revealed a critical attitude to the belief that we always provide better quality of care than other actors or the Ministry of Health, as in the example of neonatal care in the Philippines, where our resources did not allow us to offer high-quality care. Or even in France, where the desk has to deal with the teams' reluctance to transfer activities to other actors.

"In Calais, the team doesn't want to hand OPD activities over to PASS [the state's Permanent Access to Health Care programme] because they say PASS won't cope. They have concerns about the additional workload for doctors. But we know that patients will go and get advice from both places. The fact of not needing a translator will reduce consultation times. (…) There's this part of us that believes we can always do better than anyone else, even in a French context…" (MB)

So, quality of care can also involve reviewing how we work and referring patients if we believe they can get better treatment from other people. This is the operational choice we made in Syria, where project management in "remote" mode made it impossible to ensure a satisfactory level of quality in treating patients.

"In Atmeh, we had discussions about the appropriateness of our presence in light of the quality we were offering. We want to work in Syria, but the quality we can offer isn't very good. So, we decided to limit ourselves to the less complex patients and refer patients with severe burns or complications to Turkey, rather than putting them at risk. Since then, we've significantly increased the number of referrals and avoided the hospital collapsing. We've also had discussions about increasing our capacity in terms of the number of beds, but in the end, we opted to keep the same number of beds but increase quality by leaving more space between beds and improving the areas used for physiotherapy and psychiatric treatment." (CS)

To conclude, quality is the right balance, as some people put it, between "what we can do and what we ought to do.

"It's a balance between quality and common sense, between what we can do and what we ought to do. Just because you have the resources doesn't make it the right thing to do." (NR)

7. AUDIENCE DISCUSSION

Suna Balkan – Infectious Diseases Adviser
As specialists, we need to look at the whole of the project. We can't just come in and say, "OK, this is what we're going to do," without seeing the whole population and the context. Obviously, we have to adapt to the context. We're gradually losing that in the Medical Department, because we're less and less involved, and I must say I don't really agree with the idea that we make the decisions. We are losing this overall vision, because we're increasingly less

involved in the overall project than we were previously, when we had our specialist area but also had a general understanding of the country; as a result, we could implement a specialist activity intelligently, in a country where we were familiar with the context.

Michèle Beck
In terms of decision-making, that's what emerged from the interviews. People don't have a clear idea of what the decision-making processes are. The involvement the advisers now have in terms of decision-making is around approving protocols, and pharmacy orders. What some people at the desk level told me, is that they didn't have final decision-making authority and had to justify why they were doing numerous things. At the time, it was really either one adviser or several who were creating an obstacle.

Annette Heinzelmann – Medical Director
On final decision-making, I'd invite you to read the document we produced about how operations functions: the final decision is always made by the desk. The Medical Department's role is to provide support.

Pierre Mendiharat – Deputy Director of Operations
It's true that we constantly have to remind people that at the end of the day, it's actually Operations that makes the decisions, including all kinds of medical decisions. MSF is also about working together. We don't have departments that are simply for technical support to then back away from decision-making. In practice, that isn't how it works and I don't think we would want it to work in that way. We want detailed support and teamwork, which is what we often get.

However, we also need to understand that when there are visits from the Medical Department or other support departments, with very experienced advisers, their arguments sometimes put the teams under a lot of pressure. Even more so if they say things like "Ultimately, if you don't do it, patients are going to die!" or "You risk killing your patient". With this kind of radical argument, people necessarily have influence and you must take account of what they say, even if "Operations have the final say". Everyone needs to have the same attitude and the same understanding of what the rule, or standard, or protocol might be and how it applies in context.

Carine Tesse – Project Coordinator
When I was in Yida, I saw how, in the field, we tended to wait for the specialist to start an activity, or work in restricted mode at a lower level of volume until the specialist arrived. We had never treated victims of sexual violence but we

had a few protocols. Yet we waited until someone had come to advise us before we started. It's true for security too, people want to wait for the security specialist before they'll launch an activity. It's self-censorship.

Suna Balkan
I find the example of Yida really sad, the idea that they don't dare start something until the specialist has arrived. I'm flabbergasted: I don't understand how we've managed to get to this point! Because of course, you need to give the people in the field a free hand to some extent; they have good ideas and you need to use your common sense, be pragmatic and make decisions. I'm thinking perhaps we've created something and now we're paying the price for it.

Pierre Mendiharat
I have a question about the interviews you conducted. They certainly reflect the things people talk about in the field but there's often a paradox in what the people who are in the field today actually say. On the one hand, they are unhappy and complain that there are too many tools and a lot of reporting. But often, in another context – training, for example – they are extremely demanding about tools and complain that we're a bunch of amateurs at MSF, particularly OCP[10] compared with other sections, and that there aren't enough tools and guidelines. Did you also come across both things and how do we resolve this paradox?

Alfatih Osman Suliman – Medical Coordinator
Do you think we have a mechanism for checking quality in MSF, apart from supervision and visits? I don't think we do. All these comments, and visits, and reports get the same standard response, because people say, "Yes, but in the context, we can't do anything else." I think we should be doing audits from time to time, which would help us compare different projects in different places. Otherwise, we're going to be in a permanent dilemma.

Cécile Brucker – Project Coordinator
As far as reporting goes, for me the difficulty is aligning the expectations of people in the field with those on the desk. For example, if we produce 20-page sitreps[11] but on the other hand, the desk doesn't feel it has enough information, there's no consensus: what are people's expectations and needs? Perhaps that's what we should be working on.

If a technical adviser makes recommendations, people in the field think they should be implementing them immediately, even if there's no budget. It's the

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field teams that put themselves under pressure. We're so keen to get things right that we no longer build in enough flexibility or prioritise things so that we're not doing everything at the same time.

Rony Brauman
What you've just said, and what we've heard previously, resonates with what Pierre was saying about the ambivalence in the field, between demanding freedom on the one hand and an expectation of control on the other. Ambivalence is a perfectly natural human reaction and we find it in all kinds of areas but I think that whatever the situation, it's important to explain it and bring it out into the open, because that also helps to avoid many misunderstandings and perhaps take a more liberal stance when people with a certain level of skills demand freedom.

David Olson – Deputy Medical Director, based in New York
I'd like to propose a number of pillars for defining quality, which have been discussed internationally and in other sections, on which there has been more or less broad agreement:
- patient safety, i.e. doing no harm
- how effective care is
- "patient centeredness" i.e. being focused on the patient and embracing their point of view…

Suna Balkan
I recognise pretty well the description Michèle gave of feedback from the field, because they're the same questions I get when I'm out in the field. At the end of the day, does an accumulation of specialisations guarantee the best care? I'm not at all convinced. Since we've been split into areas of specialisation and heaped multiple specialisms onto one patient, we've lost that holistic view of them and the same thing has happened in Europe too. I think we're following a Western model, where we're splitting the patient up into specialisms. It's obviously valuable to improve quality in anaesthesia and technical skills in surgery. But in what we think of as ordinary treatment, the loss of a holistic, rather general view is more negative than not.

Deane Marchbein – Project Coordinator
Do we have minimum standards, which are the threshold below which we won't intervene? When we talk about tools, it's also about understanding from the outset what benchmarks and terms of reference we are supposed to be using, and against which criteria we're going to be assessed.

Michèle Beck
That's exactly what the advisers say: that there are non-negotiable prerequisites in terms of surgery, the resuscitation area, access to high-quality medicines and the laboratory. The position of operational staff and people in the field tends to be, "When it's an emergency, there are no real prerequisites. We're there to act, and we're not going to leave someone to die just because not all the prerequisites are in place."

Rony Brauman
I'd like to hear, from both head office and the field, what happens in situations that are not so clearly classified as extreme urgency or life-saving but run-of-the-mill. Is there a sort of package, a set of prerequisites, which prevent us from working, or can we start gradually?

Cécile Brucker
As far as standards and minimum standards go, I think that if we're working on quality and quality standards, there also needs to be a clear margin of flexibility. We set requirements, but we don't discuss what room there is for flexibility.

If we take just the Middle East, we can also talk about patients' standards. For example, in a maternity unit: based on our protocols, the level of pain management for a woman who is giving birth is nothing like what pregnant women want.

Outside of emergency situations, there are programmes we need to comply with in cooperation with the Ministry of Health, which have already improved. Even if we're thinking of staying for five years, we need to work on our exit strategies. Only with our standards and resources, it's impossible to tell ourselves we'll be able to go, leaving them with quality standards as they are. Can we really tell ourselves we'll work to our standards for five years and that it will all collapse when we leave? Do we plan ways of reducing the quality level so that they're left with a minimum standard? None of this is obvious and there's no consensus.

Pierre Mendiharat
I have the impression that MSF has a guideline for practically everything. If you take the trouble to look for it, you can generally find one quite quickly. We have a huge number of benchmarks. So, I'd say that yes, we have prerequisites and benchmarks and once again, we need to be able to adapt them on an ongoing basis. I find there's a link between the different departments and ourselves, in

Operations, in how we work together to understand what adapting really means and how we arrive at a common understanding of quality. We all need to have the same understanding so that then, as a team – since we work as a team – we can deliver quality as we understand it.

David Olson
One way of looking at this issue of prerequisites and minimum standards is to ask the question: are we really going to take the risk of harming someone? Is there a risk of hurting someone? There was a report in the US that said medical error is the third-highest cause of mortality in hospitals in our parts of the world.

When we talk about minimum standards, for example, should we start offering neonatal care without a neonatal specialist? Perhaps it won't harm the patient, but is it effective? You were talking about audits: we ought to know whether what we're doing is effective and whether or not we're harming our patients. We conduct mortality surveys and have conducted them for several years with tuberculosis and HIV, and it's something we hope to be able to carry on doing in our programmes in a completely transparent way in the future. It's not about over-defining things, but really pinning these issues down and examining them in detail. They're the points we're talking about today.

A participant
I have questions about the fact that we're moving more and more towards specialisation and high-quality medicine. How do we combine that with the fact that we work in very difficult conditions and that in the long term, there are a lot of gaps in the field? In Pakistan, for example, we have a very high-quality neonatal unit, but we have problems with HR. Either we haven't recruited a neonatal specialist or they haven't been able to enter the country, and the local staff are not so experienced and haven't been able to maintain a high level in the unit. I wanted to make the point that we set these hugely ambitious targets for ourselves in terms of high-quality care, but we don't have the human resources we need to guarantee them.

Maurice Nègre – Field doctor
I just wanted to remind everyone that it's the human resources who count. I'm talking about our level of incompetence when we're in the field. That's the point at which we ask for help and we get out the guidelines, which represent a minimum requirement.

That's the great thing about Jacques Pinel, who was the first person to help us, to give us the resources to work with these famous guidelines as a back-up. But

he was also the first to say, "Careful! This guideline, it's because you don't know, but if you do know, you're breaching it, you're going beyond it. It doesn't matter that it's the MSF standard. And frankly, what I think we should be relying on is more the minimum level of competence you ought to have if you're going into the field.

If you have a minimum level of competence and you know how to look around a bit… and we're never in the middle of nowhere: there are other doctors, and carers, and other practitioners. You can look at how they practise: it may be a long way from "MSF standards" but our strength lies in being able to contribute the resources they don't have. That's where we're very strong.

B. CASE STUDIES

Michèle Beck
To continue the discussion on the state of MSF's current practices with regard to medical quality, we are going to explore two controversial situations linked to quality requirements. The aim is to try to respond to the following issues:
How far do we want to go in terms of quality and what are our limits?
Who makes the decision, and how (what determines the decision?)
How can we ensure a particular level of quality?
How much room for manoeuvre do the project teams have?

1. KOUTIALA: THE EVOLUTION OF AN AMBITIOUS PROJECT

Koutiala is currently one of our major projects in terms of activities in the OCP portfolio. Its aim is to demonstrate that with proper decentralised treatment and a good referral system, we can reduce the number of children who are hospitalised and therefore offer good-quality treatment to children who are in hospital. This is an important research area for everything that affects nutrition, microbiology, neonatal care, burns, etc.

Christopher Mambula – Medical Officer for Cell 3
The Koutiala project was launched in 2009, in the Sikasso region in south-east Mali. The city has around 130,000 inhabitants and the project serves a total population of 575,000 people in 42 health districts. When the project began, the mortality rate for children under the age of five was above emergency levels

and the health system was failing, particularly because of a lack of HR in health care facilities.

The aim at the start of the project was to reduce the mortality rate from relatively common diseases, mainly by working at the decentralised level. The intention was to reduce the number of simple cases that developed complications and required hospitalisation. The target population was children under the age of five. The project consisted of two components: a preventive component based on external activities, and a curative component based in the hospital. The latter has grown significantly since the start of the project.

The preventive component encompasses what we would call the "paediatric package", in five health centres supported by MSF. This package includes activities to prevent malnutrition, including monitoring of children's growth to screen for severe acute malnutrition and distributing food supplements. It also encompasses the whole malaria prevention component, based on seasonal chemoprevention, distribution of mosquito nets and malaria workers, who test and treat sick children in the villages. Finally, the package includes annual health checks and the Expanded Programme on Immunization.

The curative component is focused on activities at the Ministry of Health hospital in Koutiala. This includes the referral system and medical care for children but also a therapeutic nutrition centre and neonatal care unit. The medical hospitalisation service also provides treatment for children who have suffered severe burns, in spite of the lack of surgical capacity. Children who need skin grafts or other techniques involving surgical flaps are referred to the American health centre. Another feature of the project is the microbiology laboratory opened in 2014, a unique development for MSF.

Between 2010 and 2015, the project carried out between 50,000 and 80,000 external consultations every year. Over the same period, there were between 8,000 and 11,000 hospital admissions. It should be noted that 30,000 to 35,000 patients are treated for malaria every year, either as outpatients or in hospital. These figures do not show the seasonality of peak periods of activity. A key characteristic of the hospital in Koutiala is that it varies from 80 beds in the so-called off-peak period to around 320 beds in the period when malaria peaks, which leads us onto the difficulties encountered by the project.

The first issue the hospital faces is its size. The context has a significant impact on its capacity to provide in-patient services, which quadruples in peak periods. Spatial organisation and construction requirements therefore need to be taken

into account: are three-quarters of the beds going to be put in tents for a few months every year, or should there be "permanent" facilities that will be empty for part of the year? Also, in terms of staffing, the hospital has to estimate the number of people who will be needed at peak times so that they can be hired and trained before the critical period. However, people's contracts are soon over and it is difficult to find them again the following year. In addition, there are implications in terms of logistics, biomedical requirements and the whole watsan area. The project goes from one extreme to another every year.

As we have just seen, Human Resources are one of the difficulties associated with scale. It is difficult to reduce the number of people working on the project once the peak period has passed. But it is also important to take into account that Koutiala is a project where lots of advisers want to try out new techniques or new approaches, which involves dedicated resources each time. Another HR aspect that is currently the subject of debate is the high level of specialisation among the national teams working on the project. In spite of their training in general practice, MSF's Malian doctors have become extremely specialised in malaria, respiratory infections and diarrhoea. The positive aspect is that at busy times, they can diagnose and treat these types of condition very quickly. The downside is that with such a large number of patients, diseases that are usually rare in other projects are proportionately more significant in this context. Complicated cases of this kind, which represent between 5 and 10% of admissions, require even more specialised care, such as intensive care, which MSF's Malian doctors are not trained to provide. Today, we have a project with 12 to 15 full-time doctors for all the reasons we have just seen, whereas the same project a few years ago would have needed just two.

The presence of complex diseases also explains the discussions we sometimes have on how technically complex we want intensive care to be. Although children under the age of five in Koutiala are not radically different from children in the other sub-Saharan regions we work in, the sheer number of them creates pressure to increase the level of intensive care. In another project with 300 admissions a month, the staff might see one complex case, which will not need a further investment of resources. But in Koutiala, with around 300 deaths a year, there are inevitably questions about what could have been done to prevent more children from dying. Yet there is no guarantee that adding more staff and increasing the level of technical complexity would save more children, particularly when they arrive in a very severe condition. Where do we draw the line? Do we need more specialists? Should we rely on SIPAP, as in Irbid?

Overall, of course, we have seen an improvement in treatment in our projects,

thanks to new techniques, for example when we moved from Lovibond® to Hémocue® to measure the level of haemoglobin in the blood more accurately. But at every stage, we make managing the whole project more complex. Biomed is a good example. Based on the idea of improving reliability and the quality of care, we now have very complex maintenance procedures for all equipment, which means having a biomed technician on hand at all times. Exactly how much added value does this increased complexity provide? The additional equipment also increases the risk of incorrect use, for example creating inaccurate results for Hémocue® if it is used wrongly.

The constant change of medical protocols is another difficulty in Koutiala. Some expatriates change the protocols, and the regular visits from various medical advisers further increases the confusion when they bring in new developments from their respective disciplines. The new protocols are put up before the old ones are taken down and they forget that national doctors can be somewhat reticent about change. Alongside the internal problems of a lack of coordination between actors, there can be differences from the national protocols and those produced by Unicef or WHO. How do we guarantee a level of quality in these conditions?

The issue of aligning our ambitions and resources is also interesting on this project, particularly in terms of the preventive package. Effectively, the aim was to have a paediatric package that could be rolled out across the whole district and even beyond. But the implementation and monitoring methods are too complex for us to replicate it easily. How can we deploy the strategy in a less complex way without undermining quality? How can we space out medical appointments and weight monitoring after we've handed out food supplements, without reducing the quality of care?

One final difficulty in this project that needs to be taken into account is the context. We are seeing an increase in insecurity in Mali with armed groups such as AQMI or Boko Haram. In Tombouctou, we're forced to have a smaller, streamlined expatriate team to limit the risk of kidnapping. It's very likely that Koutiala will find itself in a similar situation quite soon. That will involve changing the profile of our expatriates, reducing their number and even evacuating all expatriates from Mali. How can we continue to manage these kinds of activity, on this scale, with the appropriate human resources? What compromises will need to be made between the levels of different areas of specialisation, for example between nutrition, paediatrics and microbiology? Will we still be able to offer this range of specialist activities without having specialist expatriates here? Have we anticipated this eventuality?

AUDIENCE DISCUSSION

Rony Brauman
A question on seasonal malaria chemoprevention (SMC): the idea was to reduce paediatric admissions and reduce the complications associated with malaria. Did this happen in practice?

Christopher Mambula
We saw a significant decline in malaria cases in the first year. But in the next few years, if anything we saw an increase. A lot of discussions are going on at the moment to understand the reasons for the increase, but most of these children are treated as outpatients. I think we are seeing fewer cases with complications.

Isabelle Defourny – Operations Director
I was on the desk when this project started. In my view, one of the difficulties the project faces from a management perspective is juxtaposing medical activities that appear to be disconnected from each other. It is difficult to figure out what the project is about and what it is aiming to achieve, as though those things had been lost along the way.

As far as SMC is concerned, it has never been a case of telling ourselves we had found the perfect method, but working on reducing the number of cases of malaria. SMC was an initial tool that could be improved and needed to be rolled out across the district. It's impossible to say whether it's working or not, because we've only worked in one village.

When we launched the project, we wanted to keep to very simple activities: immunisation, ACT, food supplements and prevention. The idea was to roll it out across the district, not trying to do everything ourselves, not trying to control everything, but trusting other actors.

Today we have something that's much too complex, with too much control. Whether it's a question of quality, or norms, or standards, I couldn't say. But it's preventing us from moving to the next level.

And the project has shifted its focus towards the hospital and specialist activities, which have increased in number. Are we right to provide neonatal care in this context? What's driving us to offer a higher level of intensive care?

Elisabeth Szumilin – HIV adviser
I have the impression that there was a desire to make Koutiala a research project, by putting a huge amount of resources into it and particularly MSF personnel, whom it is easier to motivate. But what about the other hospitals, where we work with teams from the Ministry of Health, and where things are much more complicated? What is our experience in Koutiala going to bring to this kind of organisation?

Kerstin Hanson – Nutrition adviser
The problem is indeed about getting the right balance between quality and resources. Koutiala is a good place to learn. It offers an opportunity, for example, to get a better understanding of how to treat septicaemia or shock, but in an applied way that can be used on other projects where resources are limited. External activities are a convoluted mess. And part of the problem now is knowing how to simplify them so that one day they can be handed over to the Ministry of Health.

Rony Brauman
It seems to me perfectly reasonable and acceptable that Koutiala should have an experimental dimension. That's how we make progress. But it does assume that there are analytical conditions and assessment criteria that are clearly established at the outset.

In this situation, it seems to me that there's a contradiction between the fact of producing a kind of prototype that's more complex than we would have liked, and an experiment, which will help us to learn lessons that can be applied in other areas. The comment made by Elisabeth a moment ago on the huge amount of resources implemented by MSF contrasts with the lack of resources all around us. That should give us pause for thought.

Cécile Brucker – Project Coordinator
I'd like to come back to the question of specialisation and particularly neonatal care, which raises a lot of questions for us. In Koutiala and elsewhere, we have very little visibility on what happens to these children, how they grow and what kind of burden they might represent for their families. Do the families in these countries have enough support and do they want to find themselves with children who have mental or physical disabilities?

Isabelle Mouniaman – Deputy Operations Director
It's true that the teams have been pushing for neonatal care for a long time. Children were being born in maternity units or at home and arriving in intensive

care or the resuscitation unit. We were overwhelmed by these children. So, it was decided to start gently, with limited criteria in terms of weight. As we gained more experience and with training and the expertise of the national teams, we now have a neonatal unit with 14 beds. We're not planning to introduce SIPAP as in Irbid. Even if the resources are there, the question is: why would that be the right thing to do?

Kerstin Hanson
I'm not entirely convinced that we're making their lives better. And the same question arises for children who come out of paediatric intensive care, for example with pernicious malaria or very severe meningitis. We often hear criticisms of the consequences for neonatal care, but not so much for paediatric intensive care.

A participant
We need to make sure that quality is not about rushing to use more equipment and sophisticated tools. We also need to think about patients and the teams. I don't know if it's patient-centred, but I think it's important to keep people at the heart of the care we provide.

Isabelle Mounamian
Again, thinking about specialisation, I'd like to draw a parallel between Koutiala and Haiti when it comes to burns patients. In Drouillard, we have a project for patients with severe burns involving surgery, where 40% of the patients are children. In terms of quality of care and results, I think that what we're doing in Koutiala, with 10 beds for burns patients, is extraordinary, in spite of the fact that we have to refer for surgery. When you compare the two projects, you realise that we're getting equally good results in Mali as we are in Haiti, with fewer resources.

Fabrice Weissman
What the debate is illustrating, in the form it has taken, is the question asked in the first part: at what level do we assess the quality of a project?

What emerges from the initial thoughts is that we were talking about project quality in terms of its aims concerning the population, in the sense that the main ambition was to tackle a pocket of high mortality in infants and children. The evolution of the project and what we have discussed a great deal during the debate, is about quality as it affects the individual patient. That is to say, the debate has moved away from the quality of the project to the quality of care one can provide, which raises the question of how far one can go, with how many

specialisations and how many pieces of equipment? There are two contrasting ideas of quality here, which have been judged in a way that raises a number of questions.

2. KABUL: PUTTING NEONATAL CARE INTO PRACTICE

Renée Madrolle – Dasht-e-Barchi Project Coordinator in Kabul for six months

Following a break for security reasons in 2004, MSF returned to working in Afghanistan in 2009. Three sections were involved: the Dutch, Belgian and French. What's unusual about the way we operate in Afghanistan is that all three work under MSF Belgium as the lead section. This approach has led to numerous discussions about the standards of the three sections. They don't all share the same starting point and adjustments have to be made around medical issues, HR, logistics, etc.

In December 2014, OCP launched a maternal and child health project in Dasht-e-Barchi. This district in south-west Kabul is mainly occupied by a Hazara community, an ethnic and religious minority in the country, which has seen particularly rapid demographic growth in recent years. Between 2001 and now, the population has grown from around 200,000 inhabitants to 1.2 million, without the infrastructure development to support it.

When it was launched, the project was intended for about 600 births a month, with a 30-bed maternity unit, 20-bed neonatal department and an operating theatre. However, we were quickly overwhelmed and today we deal with 1,400 births a month[12]. In my view, the project has evolved in two phases. The initial launch phase necessarily focused on implementing standards, tools and protocols in areas such as HR, medical, logistics, etc. The second phase saw an increase in activities and involved maintaining standards, with important questions being asked about what standards were desirable and realistic in a context with this level of activity.

In neonatal care, for example, the questions were: how do we define the scope of our activities? Where do we draw the line? The main difficulty we encountered was that we were overwhelmed, with a 160% bed occupancy rate in January 2016. In spite of adding a few cots, we were limited in terms of hospitalisation capacity. That forced us to make choices based not on our technical capabilities but problems of space.

12. See the graph in the presentation in the appendix.

Our admissions criteria are babies born in the unit weighing more than 1.5 kg after 34 weeks' gestation; children who do not meet these criteria are referred to other hospitals in Kabul. Referrals were difficult, first because families were often opposed to them but also because other hospitals in the city were often overwhelmed themselves. Finally and above all, our teams had acquired skills over time, which could have enabled them to care for newborns of 1.2 kg, for example.

Referrals declined in early 2016, because the expatriate paediatrician worked to introduce palliative care in the neonatal unit. As a result, children whose chances of survival were poor were kept in the hospital. The result was an increase in the mortality rate, but better support for the children and their families.

But moving a patient over to palliative care was not easy for the medical teams. Some, perhaps because of an inability to step back or the ability to imagine what the future might hold for these children, felt that there was more they could have done. After six months' training, two national paediatricians out of the five in the team really had the clinical maturity and confidence to discuss palliative care with the families.

Another example of medical quality in neonatal care is *Kangaroo Mother Care* (KMC)[13]. Quality is often associated with complex, highly technical and very specialist practices, but the simplicity of KMC challenges this idea. There are five dedicated KMC beds in Kabul and the results are conclusive. Nonetheless, we had to deal with reluctance on the part of the teams, who didn't view this as medical care and couldn't see the added value it offered. They had more faith in incubators and more technical forms of care. The keys to the success of this method were the mothers who believed in it and became its ambassadors.

One final example linked to neonatal care is the different level of attention paid to newborns in different departments. During a visit, one paediatric adviser commented that little traditional post-partum care was given to babies in the delivery room. The consequence was cases of hypothermia and hypoglycaemia that resulted in children being hospitalised in the neonatal unit. By encouraging breastfeeding immediately after birth and covering babies up, we could improve children's quality of care by avoiding unnecessary hospitalisation.

Medical quality cannot simply be addressed in isolation. It involves the other departments. In that last example, it's the distribution of human resources that

13. The Kangaroo method involves carrying the child skin-to-skin on the belly.

creates a problem. Indeed, the operating theatre and neonatal unit were provided with competent expatriates to monitor the quality of care. The maternity unit, on the other hand, faced numerous gaps, particularly in terms of gynaecologists, but no more expatriates went in to work there. Breaking down the expatriates by specialisation had a significant impact on the quality of our project and meant the hospital was working at two different speeds, in vertical silos that were difficult to overcome. My impression is that the more technically sophisticated we become, the more we lose sight of an overall, cross-cutting approach.

Lastly, here is one more example, this time in anaesthesia, to illustrate the question: where do we set our standards and requirements? In Afghanistan, there is no training in anaesthesia for nurses or doctors. It is still not widely recognised as a specialism, and is only practised by anaesthetic technicians. The Belgian section of MSF works with anaesthetic technicians whom it trains, and with expatriates. OCP, on the other hand, has always taken a very clear position in its standards with respect to anaesthetic technicians: they are not considered to have the necessary skills to work independently. Obviously, because we couldn't find a doctor or nurse with experience in anaesthesia in Afghanistan when we launched the project, we had to make sure there was at least one anaesthetic nurse on the expatriate rosters all the time.

In practice, that created a number of problems. First, the pace of work for the expatriate anaesthetists was very intense. Because things were very busy, the expatriates were called several times a night but they also had to be available the following day, for medical visits and training. It was difficult for them to contribute to the overall direction of the project as well. Another problem was the lack of continuity, which affected us as well, given the time it took to get visas and the insecurity of the situation in Kabul.

In response to these issues, some anaesthetists in the field suggested allowing technicians to work independently on certain selected procedures, or only being present at the start of the operation and leaving them to continue on their own. But these proposals were not validated by the medical department. If there was a gap of two or three days, we doubled the technicians' rosters and added a general practitioner. This highly precarious situation was not sustainable over the long term, since we only had one general practitioner.

The medical advisers' proposal was to refer patients who needed a surgical operation to Ministry of Health facilities. Yet anaesthesia in Ministry of Health hospitals is carried out by technicians, which raises questions about the limits of our quality. Does it stop at the door of our facilities? How do you explain that

to the community, when until now, Caesareans used to be done in our hospital, but that for a month, women are going to be referred because we have a gap?

When the project began, the field teams were very worried about the enormous responsibility of managing gaps, without an acceptable solution being found. Training initiatives are now underway. But for me, the situation has continued to be paradoxical: even though we all have an enormous amount of respect for our quality requirements, it has been difficult to implement them properly.

This type of situation is an invitation for us to question our mechanisms for exchanging information, alerts, responsiveness and passivity in the field. Finally, no-one has a ready-made solution for these kinds of problem, but we all have a responsibility for reflecting on them together, collectively and honestly, and confronting the real constraints that exist in the field.

Do we currently have these platforms between head office and the field, between the Operations Department and the Medical Department? Are we satisfied with the "mises à plat" as decision-making processes? Do these platforms really allow us to define joint priorities with the level of ambition we want?

Thank you very much.

Marco Olla – Flying paediatrician
As far as the admissions criteria are concerned, we chose criteria where children have a chance of survival. That's why we recommend taking children at more than 34 weeks' gestation or more than 1.250 kg, because given the current state of our technical facilities, we know we can provide them with good quality care.

There will always be children who are very small or who are born very early, who need advanced care. We're not currently able to provide the care they need. But that doesn't prevent us from asking the question, "What level of care can we offer these kinds of children?" In general, we refer them to other facilities, which is possible in somewhere like Jordan, where the health system allows it. But elsewhere, it's more complicated.

Another challenge in neonatal care is establishing a standard for the different levels of project. It's still a recent discipline, for which we don't currently have flexible care models to offer, depending on the context. But we need to bear in mind that neonatal care can be provided without a specialist on site, in terms of basic interventions.

AUDIENCE DISCUSSION

Maya Fehling – Quality adviser OCG and OCA
OCB[14] had to tackle similar problems to the ones raised here. They began by comparing alternatives and risks: having an expatriate anaesthetist available at all times provides high-quality anaesthesia but in certain cases, the expatriates have to be evacuated. Today, only expatriates can provide high-quality anaesthesia in Afghanistan.

They therefore recruited two young Afghan doctors. At the same time, two expatriate anaesthetists committed to remaining for longer missions to set up an intensive theoretical and practical training course.

Fabrice Weissman
If I've understood correctly, in spite of this, OCB still uses anaesthetic technicians for some operations. If that's the case, doesn't our quality standard do more damage than anything else? What I mean, is having trained technicians in our teams is any better in terms of mortality than referring to Ministry of Health facilities, when there is no qualified anaesthetist on the mission?

Brigitte Vasset – Deputy Medical Director
In the north, the Belgian section of MSF trained a doctor. It's not the same as operating on a woman with an anaesthetic technician, whose training lasts for two years. We had suggested to send an Afghan doctor for a training in Pakistan or elsewhere, but getting a place in India or Pakistan with an Afghan degree is complicated.

We were talking earlier about deteriorated situations. In Somalia, we had degraded protocols for emergencies, where there was no other solution available. But here, we're talking about a long-term project. And for anaesthetists, putting a pregnant woman to sleep is the most complex situation of all. They are dealing with someone who is healthy, not someone who's been injured with bullet wounds all over their body. They have a healthy woman in front of them, but suddenly they can have a disaster on their hands. And disasters were avoided in Dasht-e-Barchi thanks to the anaesthetists who were on hand.

I don't think we should accept restricted situations in Afghanistan. We need to try to move things forward, taking the time it needs.

14. Operational Center Brussels

Rony Brauman
It seems to me that there's a link between the present and future quality we're talking about, and our exit strategies. We are indeed involved in a long-term project, where we know we're going to stay for a few years, but we're in a country with its own standards and practices.

The question that arises at a practical level is whether it is conceivable to take the anaesthetic technicians as they are at the moment and improve their skills by trying to find out what their results are. Do we know what results anaesthetic technicians get in Afghan hospitals? Is it absolutely disastrous? Could their skills be improved in a way that would also allow us to keep an eye on our exit?

As we were reminded just now, assessing quality also depends on the geographical and time scales we use to examine the issues. For example, if we look at both other medical facilities and what's going to happen after we leave, we have the impression that we should try to align with local health standards and requirements. "Align with" doesn't mean get to the same level, but try to improve them.

We can try to develop an existing standard, but replacing it with a new standard, for example a new examination for anaesthetists, is far beyond the scope of what we do.

Do we have an idea of how these anaesthetic technicians are viewed on the ground, what their results are like and whether there is any scope for improving them?

Jade Pena – Desk doctor
According to the results of the evaluations carried out by various expatriates, the level is very poor. The majority have difficulties doing calculations, and they don't have a grasp of basic physiology or anatomy. We've given them some standard procedures, but as soon as the situation differs, they're lost.

A large number of studies in developed countries have shown that mortality associated with surgery and anaesthesia decreases significantly when a trained individual devotes himself entirely to anaesthesia. We have no reason to think that in developing countries, results will be improved by relying on technicians with no knowledge. We therefore need to improve and adapt our standards and make sure they are applicable in these particularly difficult contexts.

We are considering a range of options. One interesting avenue is a training institute for nursing care, which delivers a four-year training course, to which

we could add specific training in anaesthesia. There is also a specific course for intensive care, which doctors could take, part of which would include anaesthesia. Whatever we decide to do, we want to move forward rather than standing still, and that's going to take time.

Ania Zolkiewska – Current Project Coordinator in Dasht-e-Barchi
It's important to remember that there are very few qualified, trained anaesthetists currently working in Afghanistan. So, anyone we're going to offer additional training to will be approached by private health care facilities and offered a fabulous salary.

We also need to consider the cultural aspect of the country. Most of the staff are women, so it's not only a case of convincing the individual but also and above all, her husband, her mother-in-law and the whole community.

None of this is simple: there's a lot of pressure from the people around these women and the state of the labour market in Afghanistan means that the problem won't be resolved in a few years. So, what do we do in the meantime?

Annette Heinzelmann – Medical Director
We have a standard, largely driven by evidence-based medicine, which is that it is better to be put to sleep by an anaesthetist than a technician. Nobody is questioning that. On the other hand, what happens during those short periods when there's a gap in the project, or the choice is either to treat them here with a technician, or send them to another hospital? Do we ask the patient which they'd prefer?

And another question still linked to the patient, but on the extremely delicate ethical aspects raised by the admissions criteria for neonatal and palliative care: do we involve the mothers in the discussions? Is that possible in the Afghan context?

Ania Zolkiewska
In my view, there's no ethical dilemma when there's no alternative: we do the best we can. I have an ethical problem when a long-term mission hasn't been adequately prepared to do things properly right from the start.

As an institution, MSF is under an obligation not only to examine the choices we're facing but also to look ahead and establish a 10 to 15-year vision. It may be the case that in some areas we're forced to make do with technicians, but there's no reason to make that an absolute standard. It mustn't be the standard.

In situations of extreme urgency, you take the person you have in front of you who can do the work.

When we talk about medical quality, about medical norms and standards, we need to be clear about what we're trying to achieve, what our target is, and what we do when we don't have the resources or there's a temporary shortfall.

Renée Madrolle
I couldn't say to what extent the patient is involved in medical decisions. But significant efforts have been made to provide medical counselling. Previously, for example, only mothers had access to the neonatal unit. And we had children who stayed in the units for months without their fathers being able to see them.

Isabelle Defourny
I'd like to come back to the example of the kangaroo method. How did we decide to choose this method? It's one that requires a lot of effort in terms of patient education and counselling. But it's also a method that requires huge efforts from the mother, who has to have the child in contact with her for 18 hours a day, which means she's unable to look after her other children.

It's an approach that is very heavily promoted by Unicef and USAID, in the same way that exclusive breastfeeding was. These are relatively inexpensive approaches, but they demand huge efforts from mothers. We're here today talking about quality and technical choices, but I don't think this is the most appropriate method for the context of a capital like Kabul. Why couldn't incubators be an alternative technical choice?

Marco Olla
We chose this method because it forms part of the guidelines that are supposed to be followed in neonatal care. We know it's difficult, particularly in certain contexts, but the child can also be held by other members of the family, such as a grandmother or aunt.

Incubators raise other problems in terms of staff skills, but also in terms of hygiene. We currently only have incubators in some countries, such as Jordan.

Ania Zolkiewska
It's very difficult in Afghanistan to ask a mother to stay in hospital with her baby, even for a fortnight. These women are threatened with divorce if they stay in hospital, because they have to look after their other children and do the housework.

This is typical of the obstacles we have to overcome in these situations. Apart from the purely technical or HR aspects, or the availability of resources, we also have to take account of all these cultural factors.

II. Current practice and knowledge about the approach to quality in other areas of activity

A. TAKING CARE OF QUALITY: SUPPORTING THE RELATIONSHIP BETWEEN REGULATION AND MANAGEMENT

In her research, Adélaïde Nascimento has examined the area of patient safety, of which quality is a part.

Adélaïde Nascimento – Ergonomics lecturer at the CNAM
The presentation (see attached PowerPoint slides) is entitled *Taking care of quality.* "Taking care" in the sense that quality needs to be looked after, discussed and debated. Quality criteria vary between individuals, between senior management and those in the field, and depending on the context and country.

1. HOW TO LINK REGULATED QUALITY AND MANAGED QUALITY

My presentation will be discussing the link between what we call "regulated quality", or everything that is prescribed or driven by rules or standardisation, and so-called "managed quality", which is more about what we're doing, here and now, with a particular patient or in a particular country.

This relationship is on the agenda of research into patient safety, but it appears in other contexts as well. It also relates to human and organisational reliability, as we call it in the jargon. Beyond the human aspects, it relates to everything associated with work situations in either industry or services, because it's the point at which two worlds meet.

These two different worlds could be described as "cold" and "hot". The "cold" world is the one where we try to develop general knowledge based on actual

experience. This type of knowledge is based on general phenomena, which are used to manage day-to-day activities and create a framework for practice, thus avoiding any undesirable deviations. All of this, which we'll call "regulated quality" is fundamental and important. I don't think anyone would disagree with that, based on the discussions we have just been having.

Then we might want to ask ourselves the following questions: how is regulated quality actually used in practice? Is it effective, particularly for people in the field? And what is the relationship with another kind of quality, which we might call quality in action or managed quality?

This notion of quality belongs to the "hot" world. It is about arbitrating, based on people's know-how. It encompasses the skills of those actually taking action, who have know-how, experience, a life story, and who take into account all these aspects when acting.

This type of reflection is already well established in organisations such as hospitals, whether you look at an individual unit, a hospital or a clinic. It becomes more complex when you consider the realities of the areas in which you operate, in different countries, with different specialisms, and so on.

Today, the search for quality is based on quality standards and pervades all areas of society, from public policy to business, particularly but not only in the industrial contexts of mass production. In fact, it was in those that standards appeared, in the aftermath of World War II .

Quality processes involve a preparation phase followed by an implementation phase, with controls to improve quality. These are called quality circles. They began in industry but are no longer limited to industrial contexts. The logic of the quality process has been implemented everywhere there are high-risk situations, and medicine has certainly not been spared. It arrived in hospitals through accreditations and certifications.

These processes aim to define occupational standards, at both the international and local level. Their aim is to produce prescribed ways of working that are deemed acceptable by the people who develop and design them. All ways of working have their own logic.

Problems arise when they interact with each other. For example, if a WHO recommendation runs counter to social norms, i.e. the deontology that one believes needs to be followed as a professional and as a subject, it can lead to

problems. We often find this kind of interference in various work-related situations.

The dream of any organiser and prescriber is that the worker will follow their instructions. That is to say, the prescriber has an interest that all the rules, guidelines and requirements he has established be followed. This is rather a naïve position, however, because it is based on the idea that not only contexts but also the models of action for which the requirements were designed remain stable. Possible changes to the context and individuals variations are forgotten: consequently, such requirements cannot apply everywhere and at all times. People change, for they can be tired or disillusioned, or they may have personal problems that might influence the way they do their work.

This leads us to ergonomics and one of the field's strong postulate, which is the existence of an irreducible gap between the work specified and the work actually carried out, i.e. a gap between what is prescribed by more senior figures, established rules, and actual work.

Indeed, what is prescribed – everything that comes from standards, rules and protocols – doesn't cover every real situation. It does not take account of hazards. Things will happen that weren't anticipated and for which the prescribed is a dead end. So, local solutions have to be developed in response.

The prescribed can be counterproductive or even more dangerous than if it had not been applied. It is in these situations that we rely on people's intelligence to understand how to adapt the rule to the local context. One example is the work-to-rule. In other words, if everyone tries to apply the rules strictly, the system will be paralysed, as has been demonstrated in various areas.

The prescribed can clash with the subject's values. The latter is not a simple operative carrying out tasks, but a practitioner engaging in activities. In ergonomics, we draw a distinction between the task requested – the formal requirement – and the activity, which is what people actually do in their working environment, using their know-how.

Subjects therefore make a whole range of choices, based on the prescribed, to decide on the activity they actually need to carry out. They decide what is essential and what is less so. They prioritise which criteria should be considered, which involve not only the patient, but also protecting themselves, their values and their personal professional ethics.

We need to recognise that behind every example of care, behind the quality of care, there are people. It is men and women at work who deliver care. We mustn't overlook this. There are aspects related to people's skills, but also to their subjectivity.

For ergonomics specialists, activity includes both the actual work, i.e. what people really do in practice, which is not necessarily what they have been asked to do, and the reality of work. The latter includes what they have done and everything they have been unable to do. Day-to-day work activities therefore include multiple obstacles, which can be organisational or the result of conscious choices. I cannot do everything, so I make compromises and leave some things to one side. It is important to be aware that leaving things to one side can sometimes be to the detriment of other, very important things. This needs to be taken into account.

So, what are the links between these notions of activity and quality in the strict sense of the term? How do these notions affect the notion of *quality*? In ergonomics, we believe that men and women aim for quality, as has been demonstrated by research in the field of social sciences. When they do a piece of work, they try to make it a high-quality piece of work according to their way of working. They therefore have their own criteria, either in the way they work or the result they are trying to achieve. We saw the same thing in the different notions of quality that emerged from the interviews. Not everything that is taken into account is explicit in quality, but everyone has their own criteria.

2. CONFLICTING QUALITY CRITERIA: REGULATED QUALITY VS MANAGED QUALITY

Studies done about work in various areas show that difficulties at work often arise from conflicts between quality criteria. What is being asked for contradicts what the individual concerned believes should be done.

Michèle's report included an example that illustrates the difficulty associated with this conflict. Talking about an Ebola intervention, the interviewee said, "I was annoyed when I took part in a discussion about monitoring a woman with diabetes where the doctors were discussing the fact that they were forbidden from taking blood samples from her and giving her insulin. Either she had to do it herself or nobody would. It was out of the question to give injections with a risk of AEB[15], which was absurd, because we've always done transfusions in Donka. I never had the impression that we were restricted when it came to

15. Accidental Exposure to Blood

transfusions. It was the project coordinator who said no blood samples could be taken or insulin given. It really annoyed the two expatriate doctors, who decided to ignore it."

We are therefore getting right to the heart of differences in quality criteria. Some are focused on the safety of doctors, while others, and the doctors themselves, are focused on caring for the patient. What that means is that they look at the patient as a whole. It's important for them to offer care and they don't believe there are that many risks, since they've already dealt with them elsewhere. The other elements that come into play are issues of competence, which strengthen the doctors' position.

There are two possible outcomes in these situations, where prescribed norms conflict with personal or professional values. Either the person will act in accordance with the prescribed norms but be distressed in ethical terms. The term 'distress' is very strong, but it implies that the persons will prevent themselves from taking action because the organisation's ideology or line management will not allow them to do otherwise. Or they will breach the prescribed norms, which implies running certain risks. These risks are both personal: will I be criticised for doing this? Am I going to lose my position or my job? But there are also risks for other people. We heard the most extreme example a little while ago: "You're going to kill the patient if you do that." In that situation, it will inevitably be more difficult to make a decision.

It is therefore understandable that the choice will depend on the dynamic and the organisational set-up in which the person concerned is working. Depending on the context, they may or may not be able to break or adapt rules, or have the flexibility to discuss what can and cannot be breached. Organisational questions and quality are therefore inextricably linked. Operating in isolated silos is impossible, because they have an impact on people's practice.

'Care' therefore has a role to play here: it is studied in the human sciences as a set of material, technical and interpersonal activities that involves offering a tangible response to the needs of others. I think that is pretty much the core of what you do at MSF.

There is therefore a multitude of quality standards. The criticism we could level at the definitions in these standards is precisely the fact that they do not take into account the role of people in their relationship to work. Quality, whether it is expressed in AFNOR or ISO standards, is about ensuring customer and patient satisfaction. The WHO definition of quality of care is guaranteeing the

patient the best treatment at the lowest cost, to ensure their satisfaction in terms of procedures, results and human contact. That seems to me to be associated with 'care' rather than simply focusing on 'cure'.

From an ergonomics point of view, what is lacking in these definitions is the place occupied by the quality of work according to the person doing it. In other terms, what is valued as a job well done in the eyes of workers as well as customers and patients. It is what might be defended by the person doing the work; completing it contributes to making it meaningful. People produce or try to produce high-quality work, which does not necessarily run counter to pre-established norms. What I want you to realise is that the act of caring can be viewed as a collective process, which is ultimately aimed at the patient.

We are seeing more and more research encouraging us to take patients' participation into account when looking at the quality of care. Care quality processes can be approached not only from the perspective of the results obtained and resources mobilised, but also by looking at the dynamics of the actors involved in the action.

From my point of view, this is the question that needs to be asked and which you are already asking thanks to days like this one: what does high-quality work at MSF represent for different groups of people?

3. THE EXAMPLE OF RADIOTHERAPY: DEALING WITH UNFORESEEN EVENTS AND MANAGING CONFLICTING STANDARDS

I am going to use the example of radiotherapy, which I studied for my PhD, to illustrate the points we have just examined. We are therefore in the context of a state-of-the-art French hospital.

In this example, people deal with hazards and manage conflicting standards as part of a "cross-disciplinary" community. There are several professionals involved in radiotherapy, from the radiotherapist who prescribes the dose of radiation, to the various professionals involved in preparing the treatment and finally, to the technicians who administer the dose and are in contact with patients. On average, a patient attends 15 treatment sessions.

My interest in the field was prompted by a request following the accident in Epinal, also known as the "radiation overdoses" case. We wanted to gain a better understanding of what was happening during these treatments. Are people

working in radiotherapy simply careless and lacking in professionalism? Do they have a safety culture?

My research examined the points of view of a range of professionals but today I want to concentrate on the example of the technicians, who work at the end of the line. My starting point was understanding what they meant by the term 'quality'. Two key objectives emerged from their view of quality.

On the one hand, it was about delivering day-to-day care by not cancelling sessions. This was to ensure that the treatments – in the context of cancer patients – were effective. They wanted to avoid any cancellations because each session is important.

On the other, the 'care' was important to them. As patients had to travel to a specific appointment, they couldn't upset them by simply saying, "Your session isn't going to run today."

They therefore take the patient's point of view into account, while ensuring that the treatment will not hurt them. The treatment needs to meet safety criteria, i.e. providing the right treatment, in the right place, at the right time. Normally, these objectives should not contradict each other.

In a perfect world that meets the prescribed norms, they would be able to satisfy both objectives at the same time. But because, in reality, there are all kinds of hazards, we will see that they cannot always do both and that they have to make choices and trade-offs.

During the observations carried out at two hospitals in the Paris region, unforeseen events occurred at treatment stations either as a result of external factors, or errors made by the technicians themselves.

One of the first developments was to realise that, in spite of the fact that accidents take place at the end of the chain, they could also be the result of organisational failures all along the treatment chain. As a result, the simplistic approach of only looking at the technicians, because they are the people who press the button and deliver the radiation, makes no sense. On the contrary, because they are at the end of the line, they regularly find themselves in situations where they have to manage conflicts between the two objectives they have established as defining quality.

a) Making judgements between conflicting objectives

The situation I saw most commonly was one of conflict between regulations and practice. The regulations state that radiotherapy must be only conducted after a radiotherapist and a medical physicist who had determined the dose, approved of it, in the file. This obligation is also supported by good professional practices.

Yet the file often arrives at the treatment station without having been validated either by the radiotherapist or the physicist. The patient has arrived for his appointment and is waiting. The technicians have two choices: either continue with the session in the interest of patient care and the effectiveness of their cancer treatment, which has to take place daily; or cancel the session because they're not certain they have the right treatment, which could put the patient at risk. Presenting the situation in this way may make it seem like a binary choice, but that is how they experience these conflicts and how they resolve them based on their own quality criteria and experience.

In practice, they will try to get the doctors' signatures. But in cases where they are unable to correct the situation, they will have to make a decision, even a medical decision, and may be criticised for it because it falls outside their remit.

These judgements will be situated in time, i.e. each technician will make her decision based on her own experience and knowledge. This knowledge relates to patients: the phase of treatment they have reached and their behaviour during the treatment, if it is their first session. But they also have knowledge about the behaviours of radiotherapists and doctors, for example: radiotherapist X usually trusts doctor Y; if the doctor has signed but the radiotherapist hasn't, the treatment can go ahead.

Together, they create a set of meta-rules to determine what compromises to make in respect of risk. These rules vary from one hospital to another, because the task expected can vary from one to another. The task expected is the behaviour expected from the technicians in the case of hazards, even if it is not set out in writing. It might be to carry on with the session regardless, but quite the opposite in another institution. Practices can therefore vary widely.

It is also often said that these judgements are accepted as long as there are no accidents. It works, but if there's an accident, there will be an inspection. This will highlight the fact that the technician took the decision to carry out the treatment without a doctor's signature. But no-one will question the fact that the doctors don't sign the files.

In light of these observations, we asked ourselves about regulation. If some things are not acceptable, what are the regulatory spaces where the decisions about flexibility are made? What is acceptable and what isn't? What falls under practices that should be embedded for the long term, and what should not?

Again, as part of my research, I gave scenarios involving hazards and judgements to 14 professionals – radiotherapists, physicists, dosimetrists and technicians – and asked them for their opinion on the trade-offs made.

The first thing to emerge was that not all situations are unacceptable. There is a degree of flexibility that means some judgements will be accepted, even if the rule has been broken.

The second thing to note is that acceptance will vary depending on the actor's position in the organisation. As a result, a technician who has direct, daily contact with patients will be less likely to accept certain practices than doctors, who will find it easier to accept a degree of deviation.

Diverse practices and diverse assessments of practices therefore co-exist. Consequently, it is important to discuss quality criteria and the conflicts between criteria. A multi-disciplinary approach is even more important when these criteria vary depending on the trades. The aim is then to delimit what is acceptable and what is not.

b) Workplace spaces of discussion

What can we do to establish such spaces? In the radiotherapy context, we brought together different professions and used real case studies as a starting point.

The first rule of the discussion is that it should be equipped so that it can focus on work and its reality. It must not be abstract, but grounded in reality with an account, photos, video or a situation. For example, we do not accept statements such as "Normally that's how it should be done." We want our starting point to be the reality of people's experience and find out how they decided to approach a particular issue. It needs to be outcome-focused: otherwise the approach will remain at the discussion stage, with no tangible effects.

Another important rule is that the approach must be participatory. Different people at different levels of line management need to be given the opportunity to speak. That implies a conversation based on respect, without passing judge-

ment, which must allow everyone the chance to express themselves. It is important to avoid those who have power within the organisation systematically taking the floor. A positive atmosphere is needed so that people also feel able to talk about errors, failures and situations where they would have liked to act differently. Talking about these situations provides an opportunity to assess whether the actions taken are in line with the organisation and peers.

A set of rules for the discussions therefore needs to be established, so that they maintain an operational focus. They need to take place frequently as part of a long-term approach. By operational focus, we mean arriving not at a consensus, but a majority position that will focus on action. The role of the facilitator will be both to guarantee the principle of discussion within the group, but also to decide whether the proposal is applicable or not.

To illustrate what we have just seen, we will take the example of multidisciplinary medical concertation meetings. These meetings occur when evidence-based medicine does not apply in certain cases and a medical protocol needs to be developed. Each doctor will bring their own ideas for the protocol depending on their area of specialisation. The meeting provides an opportunity to share individual practices, to expand the field of possibilities through collective practice.

Not everything within the field of possibilities is necessarily acceptable. The discussion can therefore be used to dismiss certain practices that it would not be desirable to perpetuate within the group or the organisation. Conversely, an outline of acceptable practices will be established. Positions will therefore be debated and discussed by what is deemed to be a relevant group of people. The latter will have the authority to make decisions and enable flexible practices within the scope of "acceptable" actions. It therefore leaves room for individual actions and retaining a personal "style" of practice, which is still endorsed by the peer group and the organisation.

4. DISCUSSION FORA ON WORK AND THE PRINCIPLE OF SUBSIDIARITY

To end this presentation, I would like to return to the topic of responsibility for decision-making: who takes the decision? What is the decision about? Who is responsible for it?

In ergonomics and management disciplines, we suggest using the principle of subsidiarity to respond to these questions. This principle defines the distribution

of powers within a community. It comes from public policy and the idea is to identify the most pertinent level for action. This means not burdening the upper levels of the hierarchy with tasks that can be resolved by people working further down the organisation.

It assumes that participants have the power to act to resolve the situations under discussion and that, if local resources are inadequate, the discussion groups provide a way of communicating with other decision-making areas. A discussion group decides what can and cannot be agreed at its level.

Subsidiarity relies on compliance with three principles:
- the principle of competence, which prevents a higher level from completing any task that could be done by a lower level;
- the principle of support: conversely, the higher level is obliged to take on tasks that the lower level is unable to do;
- the principle of substitution, which finally prohibits the upper level from offloading the tasks for which it is responsible.

In itself, it is rather theoretical but I think it is open for discussion. It works in public policy and we are starting to see it emerge in some business contexts. The aim is to free up management, at different levels, from tasks and decision-making that are seen as time-consuming, and which could easily be the responsibility of people who are closer to the reality on the ground.

To conclude, let's look at the example of a colleague's intervention on risk management, in a large organisation in the electricity sector. He began by setting up spaces of discussion in the workplace to break what is known as "organisational silence". This is a frequent situation in high-risk organisations, where workers will have a tendency to hide errors so that they are not forwarded up the line to the highest levels. Practices of this kind prevent feedback, which is why organisational silence needs to be addressed. On the contrary, it is by talking about real life that people become aware of constraints and try to find solutions that reflect reality, rather than being modelled on an ideal world.

He began the discussion groups with electricity workers to discuss high-risk situations they had experienced in the field with a local manager. He also implemented this approach at different levels of the organisation.

The workers themselves brought problematic situations to the discussion groups, using photos they had taken in the field. They discussed them between themselves and with managers in practical terms, to try to resolve problems at their

own level. If they were unable to do so, the problem was escalated to the next level of management above the local managers.

5. AUDIENCE DISCUSSION

Laurent Sury – Emergency Desk Manager
Where prescribed norms conflict with reality, the person concerned has two choices: either they obey and are ill at ease, or they object and do what they think is right, but run a risk. You said that this choice was dependent on the people around them, the association and the organisation. Are these the only factors, or do the individual's personal convictions also come into play? I'm thinking about their conviction that the decision is taken in good faith and therefore justifiable, or that the person will have others to back them up, and can rally other people to support their position.

Adélaïde Nascimento
It's fair to say that the choices shown in the presentation were essentially binary. But when I talk about "making a connection with people's questions", I'm implying experience, skills, values, professional ethics, etc. Personality is more a question for psychologists than ergonomics.

So, there are certainly factors that are related to people, but also to the support they're going to have around them. The degree of support will be more or less strong depending on the level of recognition and experience the person has. If they've just arrived, it's more difficult, even if they are confident that their position is justified. Novices are often more inclined to base their judgements on respecting the rules, even if they find it personally distressing. Making judgements based on one's personal ethics and the meaning one assigns to work is also a skill that develops over time.

Fabrice Weissman – Member of CRASH
Are there organisational conditions that favour one or the other?

Adélaïde Nascimento
Of course. From our perspective, it is impossible to dissociate the organisation from individual acts. Even if there are subjective aspects, associated with how people react, they still operate within social environments where the organisation of work will be important. For example, if an organisation works on a more punitive basis, that will have an influence on how people act and the distress they feel by acting in this way. Conversely, if the organisation is more open, and

gives people room for manoeuvre, with discussions and permission to make mistakes, it will support learning and adaptation to the reality of work.

Everyone makes errors at every level of line management, in all areas of work: there's absolutely no doubt about that. The question is: how do we view errors and failures and how can we talk about them? The organisation has an important role to play in responding to this question.

Stéphane Roques
The principles of "managed quality" and "regulated quality" echo all the questions we have been asking ourselves, not only in terms of medical quality but also in operational terms.

I think there is a benefit in regulating a number of simple processes, so that the majority of situations can be handled as simply as possible, without asking for additional efforts from the teams.

As far as scope for acceptable practice is concerned, how did you pursue the discussion and research? If we consider the practice is acceptable, why does it not, after a period of time, enter into the realm of regulated quality? In your example, it becomes acceptable only to have one signature, so one could imagine that the next time there will be no signatures. How do you manage this tension between acceptable practice and regulated quality?

Adélaïde Nascimento
This topic has been discussed in hospitals but it comes up in the literature too. If it's acceptable and if it's what people do, why doesn't it become a rule?

The whole point of this reflection is to say that rules need to come from the field, from how people actually work. That is to say, everything begins with spaces, known in sociology as "hot regulation space", i.e. how the person reacts here and now. Then the observation moves into a "cold" regulatory space, which brings together people who think through and design the rules. So, the process should start with actual constraints and practices and the rules should come from there.

The disadvantage is the risk of inflation of the body of regulations. Everything ends up being written down, planned and turned into rules, with the negative effects we have seen in a number of situations. "People know; we don't need to create an indicator to feed the information back," particularly if it is already recognised as good practice or an inherent part of the job.

These inherent elements don't need to be written down: people who do the job are aware of its history and know the rules. As a result, they don't necessarily have to be prescribed. It's a debate with advantages and disadvantages, but it's important to be vigilant so that prescribed standards don't leach into areas that are unnecessary.

In the hospital example, the connection was made by "normalising" the deviation in some sense. They accepted that the doctors didn't have the time to sign and worked from the principle that if the doctor could speak to the radiotherapist on the phone to confirm the dose of radiation, a box could be ticked on the file. That meant the technicians were no longer responsible.

As far as the relationship between "regulated" and "managed" is concerned, we are still asking ourselves all kinds of questions: how do you join them up, and at what doses? I don't think there is a fixed, universal relationship. It's a social construction, based on the context in which you are operating. The relationship in the nuclear sector won't be the same as what we might expect in MSF.

Maurice Nègre – Field doctor
I'd like to return to the human aspect. There are different ways of knowing how to disobey depending on the individual's personality and experience. It's also why we created the support departments, to provide help and support, not to make rules. Perhaps that's what we should be reflecting on today: how to give people, staff whose competence is based on their qualifications, confidence and have support departments that are capable of saying, "If ever you're not sure, or afraid that you're not complying with evidence-based medicine or the "rule", we're there to help you. We're not there to control you." I think it's important for us to work on how we help people in the field to feel more confident.

Léon Salumu – Programme Manager
We'd love to give people the autonomy to adapt the rules we put in place. Another question relating to this higher level of hierarchy: does it always tend to monitor, control and evaluate based on compliance with prescribed standards?

Adélaïde Nascimento
What comes out a lot from the evaluation questions is that it's the results that are evaluated, without taking the resources into consideration. People are more interested in the final result, than knowing how people have approached it and what constraints they've encountered.

At the Ministry of Public Finance, for example, they have a performance indicator

which states that staff must be able to answer a call from a customer within three rings. So, people don't let the phone ring more than three times. But the quality of the response offered during the conversation isn't taken into account. Avoiding this kind of absurdity means taking not only the results but also the means of achieving them into account. It's about looking for the reasons why a member of staff doesn't manage to achieve the results their organisation expects.

Emmanuella – Anaesthetist
In your experience, are there mechanisms that help workers themselves to become aware of unacceptable practices and apply self-assessment mechanisms to tackle their own problems?

Adélaïde Nascimento
In practice, we all make mistakes, several times a day, in different contexts. And we pick up errors all the time, either consciously or unconsciously. The rate at which errors are picked up by the person who has actually made them is very significant.

The other link in picking up errors is the immediate community. A member of staff may have made an error on a particular aspect without realising it, but their colleague notices it and corrects it when they pick up the file. So, a lot of errors are "rescued" by the people who are directly involved, without people at other levels of the hierarchy being aware of it. Errors that are not picked up can result in an accident. If that happens, people will try to understand the reasons why through experiential feedback. At that point, external experts will judge whether the practices concerned are adequate or not.

Michèle Beck
I would like to add that the tool we now use on our surgical projects for experiential feedback after an accident is the mortality review. It's used to identify errors, evaluate the situation and review the factors that led to the accident, in this case the "non-natural" death of a patient. That's what encourages us to review our practices and improve them.

B. AIR TRAFFIC AND THE NUCLEAR INDUSTRY

A sociology researcher at the Institute for Radiological Protection and Nuclear Safety, Christine Fassert began her training as an ergonomics specialist. She then

worked for several years in the area of incident sharing and sharing information on the relationship between what is "regulated" and what is "managed". She subsequently wrote her dissertation in sociology on the concept of transparency in high-risk organisations and the notion of trust. She is now a sociologist at the University of Paris I Panthéon-Sorbonne.

Christine Fassert
To begin with, I'd like to return to the idea mentioned earlier, that an organisation cannot function without there being a relationship between what is "regulated" and what is "managed". This is entirely accepted and documented in numerous research papers and articles. If an organisation decides that everything has to be regulated, it doesn't work. In official communications for the general public, however, these organisations – whether they are in the aeronautical, nuclear or even the medical sector – cannot convey this message. It is extremely difficult to say anything other than "Everything is supervised, everything is regulated, trust us, because we have everything under control." Indeed, while we recognise that people working in the field have room for manoeuvre, it is not easy to explain what, why and how.

1. COMPLIANCE AND NON-COMPLIANCE WITH STANDARDS IN AIR-TRAFFIC CONTROL

To start off, I'm going to talk to you about air-traffic control. I studied this field for my PhD, by comparing several air-traffic control centres in different European countries. The point that this environment and MSF have in common is that until the 1990s, this was a relatively informal area.

That may seem contradictory compared with the image of a highly regulated organisation that one might have of the aeronautical sector. Regulation is important for aircraft but it was not for air-traffic controllers. The air-traffic controller's job was to give instructions to aircraft using radar in order to avoid in-flight collisions, but it was not a particularly formal system: the controller analysed the situation and made a decision. There was such a wide variety of contexts, in terms of aircraft performance and route configurations, for example, that there were some broad principles but no procedures as such.

Learning was based on peer-to-peer support, with no hierarchical structure. The novice controller began on a simulator but quickly moved into the control room and spoke directly to the aircraft. They remained under the supervision of a senior controller and learned through real situations. After about three years,

the control team decided when the novice could take their qualification. Once again, there was no hierarchical control of the process.

Then, around the 2000s, the European agency decided to introduce more formalised, standardised practices with a view to creating a "single European sky". The diversity of practices in different countries was brought sharply into focus.

To show what's at stake when we talk about compliance and non-compliance in relatively informal contexts, let's take the example of Italy. For a long time, controllers worked with paper strips, where they recorded the situation and noted down the instructions given based on flight plans and radar data. But this information was not recorded in the system. As a result, the decision was taken to move to a fully computerised system and stripping became electronic.

When I arrived in the control centre, the computer system had been in place for some months. But the written procedure required the controllers to continue filling in their paper strips for some time, as they were not sure that the computer system was entirely reliable.

The problem for the controllers was that they could not do both things at the same time, because of their workload. They tried to explain this to their line management, but the latter thought it was largely a problem of unwillingness. My observations led me to the same conclusion as the controllers: filling in both systems was simply not realistic. This conclusion created feelings of bitterness towards their line managers among the controllers: "They're allowing the dichotomy to persist between the official procedure and what we're actually doing. They know how we work but they're closing their eyes to it because they think they can cover their backs if there's an accident or radar breakdown by saying we didn't follow the procedure."

In the second example, we're going to see non-compliance of the standard for separation between aircraft. The standard for separation between two aircraft depends on the quality of radar systems. In European airspace, it is five nautical miles horizontally and 1000 feet vertically. Instances of non-compliance with the standard obviously occur. The controller may interpret the situation wrongly and the aircrafts pass just below the normal standard.

It is important to realise that the controllers' relationship with the standards varies from one country to another and depends largely on the volume of traffic. The more aircraft a controller has to control, the more they risk making an error

that will result in a loss of separation. Obviously, this can lead to an in-flight collision. There have only been a few in-flight collisions in the history of air-traffic control, but it is the most feared accident because there are no survivors. This is why the standards are so precise.

Yet instances of non-compliance occur, either because of workload or for a variety of other reasons. In a single centre, there are also people described as 'cowboys', who are less obedient, take more risks and are often older than the rest. We're back with the question of competence, self-confidence and so on.

It is also interesting to see the relationship between standards and incidents. The International Air Traffic Association defines an incident in very vague terms: "An incident is anything that could have led to an accident". Typically, a loss of separation is an incident and a controller is supposed to declare it. It is also important to realise that only the controller and their colleagues in the room are aware of the event. Some countries have automatic surveillance systems, but in most cases, it is the controller who decides whether they are going to declare the incident or not.

As a consequence, we see extremely variable notification practices. In some countries, following an incident, the controller is suspended for a period while an investigation is carried out. Not only do the controllers experience this situation as particularly humiliating, they also lose a bonus based on the number of times they speak on the radio. Eurocontrol wanted to end this type of practice to ensure better notification, but were hampered by national legal systems, which took the view that controllers would no longer do their work correctly if sanctions were removed.

During my research, many controllers saw incident notification as a quantitative system: either there was compliance with the standard and safety was guaranteed, or it was not. In their view, the reality was much more complex. The standard of separation might be lost for a few seconds, but the controller was in control of the situation because they were monitoring the aircraft closely and there was only limited traffic. In other situations, there was compliance with the standard but the controller realised they had forgotten an aircraft and lost control of the situation more generally. Their workload kept increasing and they realised that their voice was trembling. In their view, there was an incident in this case.

In Sweden, the official definition of an incident has been replaced by "events we can learn from". These events are discussed in groups with no line managers present. The situations are described in the form of an account, without any

taboos, to try to increase the visibility and variability of all the situations they might encounter. The aim is to try not to get caught out by a situation, by learning from a colleague's experience.

The following example comes from France. A feature of air-traffic control is that the radar images are saved for 24 hours, in case an accident occurs. Similarly, images can be saved if there is an incident. A local safety committee was set up to review certain situations. The radar images are projected onto a large screen to relive the loss of separation. The group then analyses them as part of a second stage. The controller explains openly why they lost control of the situation. The reasons may not be brilliant, for example if a trainee is left alone. But when it comes to stating the reason in a written report, it is often standardised so that it fits a particular category, and all the valuable details of the account are lost. Those further up the hierarchy, who are concerned about flight safety all over France, only receive a list of causes that do not describe the situation in detail, which is a problem they complain about.

Another interesting aspect of local safety committees is viewing the incident as a whole. The effect produced is a sort of ritual, in which the group frightens itself by reliving the situation. The important part is the reflection, asking oneself the question, "Why didn't I follow the standard? What happened? Is it defensible?" It includes the idea of accountability, i.e. being able to account for one's actions to the team and the group.

I will conclude this illustration of air-traffic control by saying that the link between standards, risks and incidents varies widely from one place to another. This is why I feel quite conflicted when people talk about transferring good practices from one area to another. Practices are highly context-dependent, both culturally and organisationally, which is why something that may work very well in one place won't be appropriate in another. The Swedish example works in Sweden, because it aligns with a culture of transparency. But it wouldn't work in Italy, where there is still a very punitive model.

2. RISK ANALYSIS IN THE NUCLEAR SECTOR

Moving to an entirely different area, we are now going to look at formal risk analysis in the nuclear sector. Specifically, we will be putting ourselves in the shoes of the technician, who carries out a risk analysis before starting work on a pump or valve, etc.

The request made to the IRSN[16] was to investigate the reasons why technicians, in certain situations and despite a risk having been identified, decide to continue with the task after all, causing an incident.

I began my research by meeting the central authority, which manages the national infrastructure. Their position was that risk analysis should be based on asking a set of questions before entering certain parts of the plant. Individuals should ask themselves these questions to contextualise the task: what are the risks, what is the condition of the plant, what impact will the task have on the state of the valves, etc.

For the next stage, I went into the field. In all the plants I visited, risk analysis was formalised in writing, in a dedicated file. The approach recommended has become a written procedure, which involves answering various questions. Despite the document not being obligatory, the teams complete it systematically. They want to be able to prove that they have asked themselves the right questions in case of an internal audit.

When I met the people who actually do the job on the ground, they admitted that they sometimes only completed the document for the sake of having done it. Some would like to dare not to put anything for no-risk tasks, but it is difficult. People with more experience may dare to do so. In some cases, we even saw people copying and pasting. Yet a risk analysis should be driven by the context, as even if work has been done on the same valve a month earlier, the new task is not necessarily identical. The context of the plant is not the same.

Central management wanted to avoid bureaucratic behaviour, but this is what had happened. It is also important to take into account that risk analysis is part of a broader system. This means there are lots of other documents to complete, for example the job sheet and a whole heap of administrative paperwork from various sources. As one project manager told me, “There are so many things to do, files, filling out paperwork, that sometimes you could forget to do the actual job once you get to the room.”

To conclude my presentation, I think it is important, in an organisation, to understand and assess everything that is “managed” and that is not “regulated”, and examine it. But the “managed” aspect is becoming increasingly difficult to understand in high-risk industries. They are gradually closing their doors to external scrutiny, even by researchers. It is not always easy to admit what is “managed” and intrinsically it remains rather opaque, because it’s close to the

16. IRSN: Institute for Radiological Protection and Nuclear Safety

reality on the ground. If we're going to understand it, people in the field need to trust us, at least to some extent. But the IRSN is still the armed wing of the nuclear safety authority, what journalists sometimes call the "nuclear policeman". The idea of transparency is therefore a difficult attitude to maintain.

To conclude, we need to reflect on the possibility of talking publicly about the mechanisms for managing more complex and less easily handled risks than the usual discourse of command and control. It is what we call "sayability". For how long can we maintain the viability of these managed aspects, when a control system or regulatory authority will struggle to take them into account in its assessment? One of the characteristics of MSF is that it only has an internal control body, which makes it easier to talk about these "managed" aspects.

3. AUDIENCE DISCUSSION

Pierre Mendiharat – Deputy Operations Director
You said that collisions were extremely rare in the history of aviation, which would suggest that the method seems to work, whether it's Swedish or Italian?

It's worth being clear that the results are as good as they are because practices are analysed on the basis of feedback and discussions, even if they don't take place officially.

Christine Fassert
I wouldn't say that all methods work, but nor would I say the opposite. What I mean is that it can be complicated to assess how an incident might lead to an accident. We used to think that assessing safety meant measuring the number of incidents. But that became counter-productive, because the more an organisation hid its incidents, the less the controllers were inclined to report. We might have thought that safety was then guaranteed, but in fact it was just the opposite.

You are quite right to emphasise the impact of feedback. Particularly in Italy, I noticed that the coffee break was typically the moment when informal conversations took place. Of course, for Eurocontrol, this unofficial aspect was not acceptable. That's where the limitations and distortions of audits become apparent. Some things are not acceptable, because the audit won't be satisfied with them.

Sweden found a good compromise in its semi-formal approach. It didn't take place during the coffee break but there was no written record and line management was not present. Despite all of that, a consultant in human organisational

factors was present to help them express what they had experienced, analyse it and create an organisational vision, but without putting it in writing or attempting to categorise it.

David Olson – Deputy Medical Director
I'm very pleased that you talked about good practices. It's an authoritative way of positioning oneself in relation to the teams, based on the fact that these are best practices and therefore not debatable. In our field, the same applies to what we call evidence-based medicine. All of that always needs to be analysed in a specific context.

In all our sections, we have a notification system for medical errors that is supposed to go up to the Deputy Operations Director. I think the examples you have given are excellent, because errors are discussed in the field and decisions are taken in the field. Everyone acknowledges that there are human errors at every level. In the end, they went a lot further than we have managed with our system of reporting medical errors.

Christine Fassert
Indeed, but in certain cases and for certain errors or incidents, it's important not to stop just at group-level discussions. If the situation involves problems at a systemic or organisational level, the discussions need to get to the next level in the hierarchy so that the necessary changes can be made. This is typically the type of situation where it's important to learn from an incident by taking steps: one might realise, for example, that ultimately there had been an incident because a radar was not properly adjusted.

But for most incidents and experiences, simply talking about them by describing them in a group is very effective.

A participant
What struck me in the presentation was the example about the difficulty of standardising what is "managed" in the Italian line management system. They know which aspects are managed, but won't standardise them because of a lack of confidence. And that's not dissimilar to Stéphane's question just now, i.e. how does one move from "managed" to "regulated"? The answer was that people didn't want too many standards. But here we can see that there's also a difficulty of not feeling ready to standardise. Ultimately, in the same way that a relatively inexperienced person is not ready to move from regulated to managed, the organisation, if it's less well-established or working in a new environment, doesn't feel ready to regulate what it has previously managed.

Christine Fassert
It's fair to say that there needs to be a minimum level of experience to be able to standardise, because the standard's legitimacy is derived from a base that doesn't just come from nowhere. In the Italian example, the lack of confidence in the new computer system meant that managers were reluctant to abandon the use of paper strips. That created a contradiction for the teams, which caused them distress at work.

Rony Brauman
I was very struck by the fairly remote relationship between behaviours and consequences in the Italian/Swedish comparison. Ultimately, it's safety behaviours, equipment, how that equipment is adjusted and the frequency of flights that makes air travel safe. It's therefore very difficult to measure safety on the basis of extremely rare incidents. Although they are absolutely catastrophic, they are also extremely uncommon.

As a consequence, I was wondering whether understanding behaviours should include some kind of aspiration towards evaluation. Should we not try to understand the social and human costs that come with a particular level of safety?

We know, for example, that time off work for illness correlates directly with frustration, tension and stress in the workplace. We also know that the frequency with which people change jobs is also an indicator of how they feel about their work. Looking beyond the mega-incident of an in-flight collision and everything that follows, there are also less dramatic ways of seeing what the effects of good practice might be.

Christine Fassert
Are you talking about a way of assessing organisation, not in terms of results, i.e. incidents and accidents, but looking further upstream, at the atmosphere at work?

Rony Brauman
Indeed, because the limitation of the analogy with the question of air safety is both the extreme rarity and enormity of the risk incurred. In what we do, for example, it is not always a question of life or death, but about being around patients more, and paying more attention to results. These things are more nuanced than a black-or-white result. It also relates to how comfortable people feel at work and how much pleasure they feel in what they do. It's what I call the social or human cost of practices.

Christine Fassert
Certainly, those are elements that need a more qualitative assessment. The human cost or well-being at work are relatively subjective notions, which it is difficult to translate into more tangible or quantitative costs without losing a great deal.

The problem is that at the moment, the trend is towards transforming these assessments into more tangible, more quantitative elements and the consequence is losing sight of things that should be assessed.

III. Possible directions for quality policy at MSF

Michèle Beck

We are getting to the final part of the day, which aims to identify the possible directions that have emerged from the multitude of points addressed. In the three discussions, we identified three angles from which to approach medical quality.

The first is the patient level – how do we take patient satisfaction into account?

The second is the collective level, in relation to standards: what is the relationship between what is "regulated" and what is "managed". What spaces of discussion are currently available within MSF?

Finally, again at the collective level: what are the implications for how work is organised? How can a strategy of decentralising some decisions to the field incorporate the relationship with quality?

Brigitte Vasset – Deputy Medical Director
One mechanism that would help us to improve the level of quality we deliver would be to ensure better reporting of medical errors up to head office. We need to avoid the idea that medical errors are immediately synonymous with "sanctions" as we find today. They shouldn't fall within the jurisdiction of the HR or legal department, as we currently find.

These errors would help us improve our processes, procedures and working methods so that we can avoid making the same mistakes in the future. Being able to talk about them would be advantageous for the field teams, but also for other missions, by sharing information and improving our organisation.

It isn't easy, because we need to move away from the idea of sanctions, unless the error is deliberate. But in that case, it's called a "fault". We all make errors, so it's essential that they help us to learn, so that we don't make them again. It's the same as what we do for the morbidity-mortality reviews that we have in our surgical programmes.

Rony Brauman
Indeed, we all make errors, every day. The best way of avoiding them in the future is not sanctions, but talking about them.

And I would add that one of the ways of ensuring an organisation functions properly is making time for discussions, whether that's at head office or in the field. Collectively and institutionally, it should be a normal part of the way any group of people working together operates. The discussion groups should be an opportunity to talk about problems, obstacles, queries and questions. They are not necessarily followed up with practical actions, but can be if necessary. It seems to me to be a simple way of working that would help us adjust our actions and address problems more effectively.

Michèle Beck
To build on that, I would add that the right to make a mistake, but above all, analysing what happened through discussions within the team, would help people to identify all the factors that came into play in the mechanism that led to the error. We also need to look at this more broadly and not just from a medical point of view. A process that doesn't work or not achieving the results expected has an impact right across the board.

Xavier Lassalle gave me the example of a mortality review in the operating theatre. The team realised that mortality was high because the patients who were sent to them were already dying. The problem was not how they were treated in the operating theatre, but the triage system in the emergency room.

Omari Beth – Field coordinator
There's one question we haven't answered today, namely how do we measure quality and what are the indicators that should be systematically used in our programmes?

Whatever project you are setting up, you have to set yourself objectives and decide on indicators so that you can evaluate and monitor the programme. If the indicators are not the right ones, you can change them. But we don't have a more formalised process for managing missions.

Carine Tesse – Field coordinator
A lot of people already complain about the paperwork and I'm not keen on the idea of more indicators.

Above all, we need visibility. We produce an enormous amount of data but they

are never discussed in the team and we never know what the purpose of collecting all this information is. Even discussing the data with the coordination teams and the desks would help us explain what's happening on our project.

Alfatih Osman Suliman – Medical coordinator
The issue is knowing whether they're the right indicators or not. They should be aligned with our objectives so that after a period of time, we know whether they've been achieved or not.

Do we have an external quality control mechanism? If you look at the size of MSF, I think it's time to have a dedicated quality department, which would supervise and assess the quality of our programmes. Some organisations do it with quality control teams that carry out surveys.

Rony Brauman
I don't think it's a good idea. One of the reasons is that, compared with a bank or the automotive industry, we don't have any clear products to offer. There are different assessments, different ideas about what one can expect from a quality assessment: the quality of a programme, care or processes, patient satisfaction, our capacity to improve over time or adjust to unforeseen events, or assessing the unplanned side effects of projects. All of that is part of what we have to call "quality". It is more or less pertinent depending on the timing of a project, or the part of a project one is examining.

The idea of this workshop is not to come up with ideas for quality indicators. The bureaucratic burden is already quite significant, so adding more summary or partial indicators is not the right solution. Conversely, the aim is to encourage more reflection among the operational staff who are involved in taking decisions on a day-to-day basis, by shedding light on the problems associated with quality and the different levels at which we understand quality.

Maya Fehling – OCG and OCA quality adviser
Indicators are useful only if we share them with the whole team, i.e. logistics, the hygiene committee, etc. We all want to improve the quality of care for patients and the whole team is involved. It must therefore get a return for its efforts.

I also don't believe one can assess oneself. It needs an external perspective with an objective examination of methods. An MSF operational centre could call on another centre. It could be done between sections, provided it didn't involve pointing the finger at our failings: we all have them and we all face the same difficulties in the challenging conditions we operate in. It would be

another opportunity to learn from each other and save us from making the same mistakes.

Fabrice Weissman
One of the problems of assessing quality is knowing which benchmark to use. And the question of benchmarks is essential, because an audit measures deviation from the norm. The whole problem we face is which standard to follow and what degree of deviation can be tolerated. An assessment-based approach is inappropriate for responding to the quality problems MSF faces.

Conversely, an approach based on acting in uncertainty, as we saw in the radiotherapy groups and other professions, seems to me much more pertinent. The Swedish air-traffic controllers talk about putting under scrutiny events people can learn from. That immediately broadens the field and means there's no need to wait for an accident before we ask ourselves questions.

Moreover, who can judge the quality of a project? The medical department? The operations department, bearing in mind that they each have different benchmarks? Or the patient too?

We have completely ignored the patient's point of view in our discussions. We ourselves make a judgement, on the patient's behalf, as to whether the caring relationship is good, whether the waiting time is acceptable or whether the therapeutic aims are appropriate. It's an area that still has a lot of room for improvement.

David Olson – Deputy Medical Director
The best point of view for assessing quality is out in the field. It's the people in the field who can see whether things are going well or not. They're the ones who should be given the tools so that they can assess quality and make improvements. And it's down to us to make sure we offer them the support they need to gather the right data, so that they can draw the right conclusions and act accordingly.

Michèle Beck
To conclude, and to pick up on what David has just said, in all the literature on quality, the conclusion is that the best people for assessing quality are those closest to the action. Today, that effectively means the people in the field. It's probably at that level that this whole system of continuous quality improvement should be taking place.

In the MSF library we have a book in PDF format[17] that turns all top-down assessments and indicators on their head. It advocates continuous quality improvement based on a fast, time-limited method, in which the main actors are the people in the field. Problems are identified and indicators – often subjective indicators – are defined by the group. Improvement initiatives are then implemented. Moreover, the author comments that the simple fact of monitoring a situation often led to spontaneous improvement. But it does imply very little standardisation between different areas and little control from head office.

17. Maguerez, G. (2005), *L'amélioration rapide de la qualité dans les établissements sanitaires et médico-sociaux.* Presses de l'EHESP

IV. Summary

To conclude, here is a summary of some avenues to explore that came up during the workshop but were not explored in more depth.

A. AT THE PATIENT LEVEL

Taking the patient and their perspective into account came up regularly during the workshop, both during the interviews carried out before the day and during the discussions. We want to put the patient back at the heart of our concerns.

Some initiatives try to put this desire into practice, for example by allowing fathers to enter neonatal units; or by working more on the relationship of trust with mothers in nutritional programmes, where they act as home relays for the care team; or finally, by discussing treatment options with the patient.

This repositioning underpins an approach to treatment focused on the patient as a person, who has social interactions, lives a certain distance from the project, has family obligations, etc. Our focus should not be on one organ or limb, but the patient as a whole, not split into different specialisms, which should help us to move away from working in silos.

In the article "Treatment objectives: sharing with patients"[18], the journal Prescrire offers a number of "thoughts on creating a better dialogue between carers and patients and better consideration of patients' needs." According to the authors, it is important to share treatment objectives with patients before any evaluation of the benefits and risks of the treatment concerned.

To support this position, they refer back to the main objectives of carers and doctors, such as "cure, prevent a recurrence or subsequent complication, etc." They then link these to non-medical objectives expressed by the patient, which may be connected to "a patient's personal and social situation." These objectives,

18. Prescrire (July 2012). *Concepts et méthodes: Objectifs des traitements : à partager avec les patients.* (Page 544) Vol. 32 no. 345

for example preventing pain, appearance or sexual problems, or maintaining their income from work, will be a major concern for the patient. There is also a question of ethics, when the patient is not the main beneficiary of the treatment. The expected effects of treatment are for the indirect beneficiaries; the article gives the example of preventing carers from becoming exhausted by hospitalising the patient, even if there is no medical justification for it. Finally, the authors advocate talking to the patient to clarify all these objectives and rank them in order of importance, in order to make the best choice together.

In terms of our own practice, this prompts us to reflect on the following questions:

- What benefits does the patient expect from treatment?
In general terms, the main benefit we think about is curing the patient. But in the case of amputation, the medical aim is not to lose the patient because of gangrene or septicaemia. What benefit do the patients get? Some are ready to risk their lives, because losing an arm or leg is not acceptable to them. Hence the importance attached to obtaining surgical consent for amputation combined with information for patients, carried out by our teams working with patients following the earthquake in Port-au-Prince in 2010.

Another example could be the migrants in the Balkans, for whom the benefit of passing through our OPD[19] was to have somewhere out of the crush where they could stay for a while. In addition, they could get relief from certain symptoms, but without seeking a cure.

- What are the objectives a patient has set for their treatment?
Again, in the case of migrants, their objective was to be able to finish their journey, while keeping their family together and not getting blocked at the border.

- Which of them do they see as the priority?
In all the conversations we have been able to have with migrants, their main objective was to keep their family together. So, if hospitalisation was necessary, it was not automatically accepted if the rest of the family was still waiting in the transit camps, afraid of losing sight of the person in hospital. For many of them, health problems were a secondary consideration and could be treated on arrival.

- Is the main beneficiary of the planned treatment the patient? If not, are they or their representatives aware of this?

19. Out Patient Department

These questions are typically those we should be asking ourselves in response to the Ebola epidemic, where the primary objective was to isolate contagious patients from the population, in order to reduce the spread of the disease. Similar questions also need to be asked in the context of clinical trials.

These questions point to the importance of keeping not only patients but also their families informed, for example when there are children involved. Information will cover not only the patient's situation and case management, but also therapeutic choices. The palliative care mentioned during the workshop is a good illustration of the value of dialogue with patients and their families in making therapeutic choices.

B. AT THE GROUP LEVEL: RELATIONSHIP TO STANDARDS AND ORGANISATION OF WORK

As we have seen during the workshop, issues of quality are closely linked to the way work is organised. The main problem identified in the first chapter is a decision-making process that is both confused and remote from the field.

This results in a vicious circle, where the teams have the impression that they are simply operatives and disengage from the processes of reflecting and making suggestions from the field. Their sense of responsibility is removed by *a priori* control and by all the various validation processes, for example for cash requests or pharmacy orders. Medical advisers can block a decision even if this has been taken according to the procedure, and as a result short-circuit Operations, which creates confusion for the teams in the field.

The other problem associated with the organisation of work is the difficulty of maintaining quality as the teams are replaced, either because of turnover, gaps, handover difficulties, a somewhat fatalistic attitude among the teams or information that fails to get through to the field.

In response to these problems, and as we have seen many times during the workshop, ergonomics experts advocate the right to make a mistake and above all, the analysis of these errors by those closest to the action.

The environment must be supportive of these kinds of practices, and trust is the linchpin. The underlying assumption is that most people who commit to

working for MSF want to produce high-quality work. Trust is the main condition for giving the teams the room for manoeuvre they need to do their work. This can be manifested by *a posteriori* control, which would help to give people a sense of responsibility, unlike the infantilisation produced by *a priori* control. Without doubt, it will result in new errors, but the aim is not to remove errors, which would be a utopian view, but to use them as the basis for collective reflection. Not everything can be "regulated" or standardised, hence the importance of space in which the teams can "tinker", i.e. adapt their ways of working to the context, set priorities for quality improvements, makes suggestions, etc.

"Being able to cope (…) is a quality that is recognised as essential [in the humanitarian field]. It means that an expatriate who is caught up in an unusual situation is capable of reinventing and managing new situations."[20]

Even so, autonomy and trust have to work within a framework in order to avoid undesirable deviations. Once again, the work of ergonomics experts and the presentations by Adélaïde Nascimento and Christine Fassert offered us insights into possible methods. Creating spaces of discussion, for example, to define acceptable and unacceptable practices seems to be an interesting avenue. Particularly as they involve conversations within the teams, i.e. encouraging dialogue between peers who are all part of the same work group[21]. The importance of work groups in creating this framework has been studied by Sandrine Caroly:

"The work group (…) has a protective function in terms of the individual's subjectivity in their relationship to action. This protective function works primarily through the group's ability to develop (…) norms and rules to frame the action, in conjunction with quality criteria for the work, to manage potential conflicts in working relationships and ultimately make the work meaningful. It allows each of its members to access this meaning and the quality criteria for "work done well", based on a set of occupational standards. (…).

The work group emerges as a resource for developing health in its broadest sense. It allows the individual to "take care" of their work and from this point of view, it contributes to individual health. Moreover, it encourages learning and skills development."[22]

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20. Dauvin, P. & Siméant, J., (2002). *Le travail humanitaire. Les acteurs des ONG, du siège au terrain.* Presses de Sciences Po (P.E.N.S.P.) (P.323-324)
21. A group that comes together around a particular topic at a specific time. A department is not a work group, but an administrative division
22. Caroly, S., Barcellini, F. (2013). *Le développement de l'activité collective.* In P. Falzon (Coord.) Ergonomie Constructive (pp. 33-46), Paris, France: PUF

It is also important not to confuse team autonomy with suppressing managerial posts. Discussion groups cannot operate without the presence of a "local manager" who comes from the same professional background and understands the constraints of the job. In an article in Santé et Travail[23] examining the various factors that have a positive impact on well-being at work, Matthieu Detchassahar emphasises the importance of this framework:

"There has to be a discussion about the quality of the work (…). But it presupposes engineering spaces of discussion. Our research shows that health at work is better in set-ups where these sapces are well thought through and the manager is present. The problem today is less about the pressure exerted by the manager than their absence. It is no longer about regulating the work but about reporting and meetings."

The importance of local managers lies in valuing occupational skills and recognising work that is well done, but also in recognising the difficulties faced by the teams, by being there alongside them.

"Ultimately, employees suffer more from a lack of management than too much of it.[24]"

23. Mahiou, I. (July 2010). *Le management redécouvre le travail.* Santé & Travail. no. 071
24. Detchassahar, M., Grevin, A. (2009). *Un organisme de santé… malade de « gestionnite »*. Annales des Mines – Gérer et comprendre (No. 9