Thesis for Ph.D. Degree in Medical Law & Ethics

"Developing governance to foster healthcare quality in Kurdistan Semi-Autonomous Region of North-Iraq"

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This paper does not exceed the word limit.

LIST OF ABREVIATIONS

AHRQ: Agency for Healthcare Research and Quality
ALPHA: Agenda for leadership in Programs for Healthcare Accreditation
APSF: Australian Patient Safety Foundation
COHSA: Council of Health Service Accreditation
CREC: College Research Ethics Committees
ECHR: European Convention on the Protection of Human Rights
ECtHR: European Court of Human Rights
ECHRB: European Convention on Human Rights and Biomedicine
EHR: Electronic Health Records
EHRS: Electronic Health Record System
FTPP: Fitness to Practice Process
IAPO: International Alliance of Patients' Organization
IAPO: International Alliance of Patients' Organizations
IHR: International Health Regulations
ISCAS: Independent Healthcare Sector Complaints Adjudication Service
ISIS: Islamic State of Iraq and Syria
ISQUA: International Society for Quality in Healthcare
KDP: Kurdistan Democratic Party
KRI: Kurdistan Region in Iraq
KRG: Kurdistan Regional Government
MGI: Medicina General Integral
MPS: Medical Protection Society
NCSC: National Cyber Security Centre
NFCS: no fault" compensation scheme
NICE: National Institute for Health and Care Excellence
NIHR: National Institute for Health Research
OECD: Organisation for Economic Co-operation and Development
OWAM: UK Organisation with a Memory
PAHO: Pan-American Health Organisation
PATH: Performance Assessment Tool for Hospital
PIS: Participant Information Sheet
PMRA: Professional Medical Regulatory Authority
PSFHI: Patient Safety Friendly Hospital Initiatives
PUK: Patriotic Union of Kurdistan
QALY: Quality-adjusted Life Year
RAND: Research And Development
RTHHC: Right to Health and Healthcare campaign
TFEU: Treaty on the Functioning of the European Union
UK: United Kingdom
UNDP: United Nation Development Program
WHO: World Health Organisation?
WMA: World Medical Association

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ABSTRACT

The governance of healthcare quality is a global priority In many countries and regions, including the Kurdistan Region of Iraq (KRI), it is also a vital development issue. Given the decreasing threat of ISIS in the region, it is opportune to consider how the nettle of its improvement might now be seriously grasped.

In this thesis, I aim to develop of system of benchmarks for the governance of healthcare quality and measure the KRI system of governance in theory and practice in their light thesis. In order to understand the actuality of the KRI system for this end, I have both drawn systematically on the existing literature and conducted a significant programme of empirical research, which consists of 32 semi structured interviews conducted with KRI health policy makers, hospital directors, and healthcare practitioners. Whilst the benchmarks have been a critical lens through which to examine the actuality of the KRI system it is also true that, to some extent, they have been refined by the examination of the actuality of the KRI system. A good example is how the empirical evidence of significant clientelism that I found in the KRI system influenced me to emphasise clientelism amelioration measures significantly in my system of benchmarks. This has meant that to some extent the benchmarks are specifically tailored to the KRI situation, though I am confident that most or all of them would at least be largely pertinent as tools for the critical examination of the governance of healthcare quality in other jurisdictions.

Whilst there is growing evidence of healthcare quality issues in the KRI primary care, this thesis adds very significantly to the existing knowledge and shines a particular light on the role of governing authorities in supporting healthcare quality and ultimately also of the role of law under the KRI healthcare system. The key finding is that the KRI system of health governance falls significantly below the benchmarks of best practice. More specifically, in law and governance have not been properly effective in combating clientelism and its consequences and serious problems exist with risk management the provision of sufficient resource and the provision of patient-centred care. In this light, at the end of the thesis, I thesis make a range of recommendations for reform and put forward an action plan founded partly on the development of a Professional *Medical Regulatory Authority (PMRA)*. To foster the use value of the thesis I will be communicating this plan to KRI health policy makers.

Chapter 1: Introduction

1.1 Overall Scope of the Research

The concept 'health' has been defined as *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."*[1] Given that well-being is affected by all aspects of life, it is evident that efforts to improve it need to be targeted at all sectors of society. However, the question of how to do so as a whole is beyond the scope of this thesis, as it focuses more specifically on health system governance. Although it is evident that the thesis will ultimately bear significantly on the well-being of the population as the objectives are to develop governance and enhance the quality of healthcare in the Kurdistan Region of Iraq (KRI).

Governance of healthcare quality is a global concern. The KRI is one of a significant number of jurisdictions in which it has been suggested to be ineffective[2] Through this thesis I aim to test the extent and ways in which this holds true. I start by providing a brief contextual overview of the key features of Kurdistan region, including the political history, the legal system, and the healthcare system. Subsequently, it outlines the nature and relevance of governance both generally and in the healthcare context. It then critically analyses the key components of governance - namely: strategic direction of policy development and implementation; regulation of healthcare practice; improvement of healthcare quality; and patient-centred care. Upon this analysis I build out a set of benchmarks in relation to the components, which are then measured the benchmarks against the KRI healthcare standards. Finally, I proffer recommendations for potential solutions.

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[1] WHO, *What is the WHO definition of health? Preamble to the Constitution of WHO as adopted by the International Health Conference, (1946)* https://www.who.int/about/who-we-are/frequently-asked-questions#:~:text=What%20is%20the%20WHO%20definition,absence%20of%20disease%20or%20infirmity.

[2] WHO, *10 facts on patient safety* (2018) <http://www.who.int/features/factfiles/patient_safety/en/> 20 March 201; Ali Towfik-Shukur, Hiro Khoshnaw, *The impact of health system governance and policy processes on*
health services in Iraqi Kurdistan (2010) 1 BMC International Health and Human Rights http://www.biomedcentral.com/1472-698X/10/14/ 1 December 2013.

1.2 Key features of Kurdistan Region of Iraq (KRI)

Figure 1: Kurdistan Region

Kurds are one of the largest ethnic groups in the world without a state as they are about 25 million people and they represent 15% of the overall population in the Middle East.[3] The total Kurdish territories consist of 230,000 square miles, which is equal to the territories of UK and Germany combined.[4] As it can be found on figure 1, Kurdish population are living in different countries.[5] About 43% of Kurdish populations are living in Turkey, 31 % in Iran, 18% in Iraq, 6% in Syria, and 2% in countries that used to be part of Soviet Union (including Armenia, Azerbaijan and Georgia).[6] Nevertheless, the thesis is focusing on Kurdistan Region in Iraq, which is formally recognized as an autonomous region under Iraqi's constitution (2005). KRI is governed by the Kurdish Regional Government (KRG) and officially has autonomy over its politics and economy.[7] Iraqi Kurds speak Sorani and Bahdinany, which is fundamentally different from Arabic language.[8]

The native religion of the Kurds is Yazidanism, although nowadays only a small proportion of Kurds follow this, as the majority of Kurds are Muslims (usually Sunni but some Shia) and some Kurds are identified as Jews, Christian, and Baha.[9] Approximately, six million Kurds are living in the North of Iraq; nevertheless, this number is increasing as refugees are fleeing war from other parts of Iraq and Syria.[10] Particularly, KRI attracts billions in investments from around the globe, as Iraqi Kurds territories are rich in natural sources such as oil.[11] The existence of natural resources in the region have made the area

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[3] Anonymous, *Kurds and Kurdistan: Facts and Figures* (1995) (8) 161 International of Kurdish Studies.
[4] Kurdish heritage Foundation of America, Kurds and Kurdistan: *KURDS AND KURDISTAN: FACTS AND FIGURES* (1992) Kurdish Studies: International Journal <https://www.oswego.edu/~baloglou/anatolia/kurds.html> 21 August 2017.
[5] Michelle Ainsworth, Herald Sun, *Kurdish people have a history of persecution across the 'Kurdistan' region*, (2010) Ekurd Daily <http://ekurd.net/mismas/articles/misc2010/8/turkey2884.htm> 21 August 2017.
[6] Anonymous (n 3) 160; WHO, *Patient safety: Safer Primary Care* (2014) <https://www.who.int/patientsafety/safer_primary_care/en/> 19 April 2019.
[7] Kurdish Project, *Kurdistan Oil: The Past, Present and Future* (2015) <https://thekurdishproject.org/kurdistan-news/kurdistan-oil/> 21 August 2017; Elizabeth Miller, Charles Buker, *Legal Education in Iraqi Kurdistan* (2015) SLS <https://law.stanford.edu/stanford-lawyer/articles/legal-education-in-iraqi-kurdistan/> 20 July 2017
[8] Anonymous (n 2) 162.
[9] Ibid p162.
[10] Miller and Buker (n 7).
[11] Michael Rubin, *Kurdistan Rising? Considerations for Kurds, Their Neighbours, and the Region*, American Enterprise Institute (79, Washington, 2016); Anonymous (n 3) 161; Rand Khalid, *No longer*

more desirable to outsiders and as the result, Kurdish populations have been subject to genocide, displacements and assimilations.[12] A brief overview of the historical injustice against the Kurds will be described below.

1.2.1 Political History of Kurdistan Region

The earliest evidence of Kurdish existence and political history dates back to about 8000 years ago when the Kurds were fighting for their survival in the mountains.[13] In 1695, Ahmed Khani called for Kurdish state and the Treaty of Sevres (in 1921) anticipated an independent Kurdish state.[14] Nevertheless, the Treaty of Lausanne (in 1923) formalised the division of Kurdistan population between Turkey, Syria, Iran and Iraq; and as the result Kurds are restricted in exercising their freedom.[15] Subsequently, in 1970, Soviet Union pressurised the Iraqi government to announce a peace plan with the Kurds which had the effect of providing an autonomous status to Kurdish region in the north of Iraq.

Nevertheless, the existence of an official autonomous status (since 1970) did not mean an end of torture and genocide of the Kurdish population.[16] For instance, during the Iran/Iraq war in 1988, approximately 182.000 Kurds were killed.[17] As the result, the Iraqi Kurds rose up against Saddam regime and they became independent from Iraq by the end of 1991.[18] Since then the KRI is governed by Kurdistan Democratic Party (KDP) and Patriotic Union of Kurdistan (PUK). From 1994 to 1998, a military conflict took place between these parties.[19] Nevertheless, presently both KDP and PUK collaborate and strive for independence to gain territorial integrity in the North of Iraq.[20] Furthermore, in

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forgotten: a Kurdish view of the Iraq war (2013) The Guardian <https://www.theguardian.com/world/2013/mar/11/not-forgotten-kurd-perspective-on-iraq-war> 15 August 2017.

[12] Towfik-Shukur (n 2) 14; The Law Library of Congress *Iraq: Legal History and Traditions* (2004) 1 Global Research Centre.

[13] Anonymous (n 3) 163.

[14] Ibid p162.

[15] .

[16] Anonymous (n 3) p163.

[17] F. M. Hasan, *A quantitative analysis about the prevalence of PTSD after the chemical attack I Halabja/Kurdistan*, Iraq (2010) 344 European Psychiatry; BBC News, *Iraqi Kurdistan Profile* (2017) <http://www.bbc.co.uk/news/world-middle-east-28147263> 21 August 2017

[18] Lourie Maylroie, *The Kurdish Uprising, Part I: 25th Anniversary* (2016) Kurdistan24.net <http://www.kurdistan24.net/en/Analysis/ad973e42-b6db-4170-ab87-f5ebdad891aa/The-Kurdish-Uprising--Part-I--25th-Anniversary> 15 August 2017; Anonymous, *Kurds and Kurdistan: Facts and Figures* (1995) (8) 163 The International of Kurdish Studies.

[19] Anonymous (n 3) 163; Tawfik-Shukor (n 2) 1.

[20] Saeedpour (n 15) 5.

2005 the autonomous status of KRI was formalized and this region is now officially recognized as a Federal Kurdistan Territory under the constitution of Iraq.[21]

1.2.2 KRI Legal System

The KRI legal system is based on Iraqi civil law tradition, which is originally modelled on the Egyptian and French civil law system.[22] Under the KRI civil law system, the judiciary have limited roles as they are not developing the law and instead the courts are following legislations (including Islamic rules), customs and civil legal codes.[23] Similar to the UK legal system, under the Kurdish legal system, the separation of powers is a fundamental principle of the constitution. The law is to keep the judiciary within the Kurdistan regional courts independent from Kurdistan Regional Government (KRG) and KRI Parliament.[24] In 1996, under the Provisional Constitution of the Federal Republic of Kurdistan, a unicameral parliament with a single legislative chamber and 111 seats was established.[25] The Kurdistan Parliament is based in the capital city of KRI, Erbil. It has passed several landmark pieces of legislations relating to investments, presidency and terrorism laws.[26]

The legal system of KRI is developing gradually as the KRG prime minister had initially requested to enhance the rule of law for the purpose of protecting the human rights of the Kurdish population; [27] through which the fundamental international norms and international human right are recognized as a principle of law.[28] In order to build capacity for judges and public prosecutors, the United Nation Development Program (UNDP) was implemented under the KRI legal system and this program includes case management systems; legal research units; legal database and free legal assistance services. [29]

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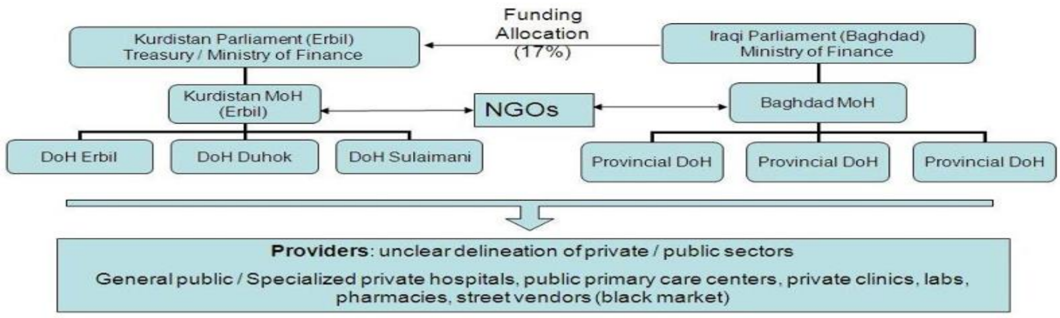
[21] Hiwa Perdawood, *Kurdish Legal System and UK Legal System*, Academia (2017) 1. <http://www.academia.edu/4258098/Kurdistan_legal_system_and_UK_legal_system> 20 July 2017; Anonymous, *Timeline: Iraq War* (2016) BBC News <http://www.bbc.co.uk/news/magazine-36702957> 15 August 2017.
[22] Perdawood (n21) 1.
[23] Miller & Buker (n 7) 1.
[24] Global Justice Project, *The Judiciary and the law in the Kurdistan Region of Iraq* (2009) <http://gjpi.org/2009/08/14/the-judiciary-and-the-law-in-the-kurdistan-region-of-iraq/> 20 July 2017; Perdawood (n 21) 2.
[25] Kurdish Project, *KRG: Kurdistan Regional Government* (2015) <https://thekurdishproject.org/history-and-culture/kurdish-democracy/krg-kurdistan-regional-government/> 19 April 2019.
[26] Khalid Abdullah Rashid, *About the Kurdistan Parliament*, Kurdistan Parliament, (2014) 1. <http://www.kurdistan-parliament.org/uploads/About-the-Parliament.pdf> 25 August 2017.
[27] Shawqi Younis, *United Nation Development Programme Iraq: Promoting the rule of law in the Kurdistan Region of Iraq*, (2013) 4 Annual progress report.
[28] Perdawood (n 21) 2.
[29] Younis (n 27) 5, 9.

Additionally, three independent arbitration centres in the provinces of Erbil, Duhok and Sulaymaniyah have been established for the purposes of resolving disputes outside the courts and decreasing the number of claims in the courts.[30] The recent progress in relation to governance in the KRI has the potential of further improving the management system within the healthcare providers. Alternative dispute resolution (ADR) could be used as a way of resolving issues and compensating victims.

1.2.3 KRI Healthcare System Structure

The Iraqi healthcare system is in operation since 1920, which is one of the middle-income countries that have developed health infrastructure.[31] Following the uprising of 1990's, the KRI hospitals are governed by the Kurdistan Ministry of Health, which is based in the KRI capital city (Erbil).[32] Under the KRI healthcare system, the Minister of Health is being assisted and advised by Parliamentary Health Committee.[33] As illustrated under figure 2, the provinces of *Sulaymaniyah*, *Erbil* and *Duhok* have their own Department of Health to ensure local management of the health services and access to the healthcare. [34]

Figure 2: KRI Health System Framework



Although, figure 2 indicates that independent non-governmental organisations exist to ensure effective collaboration between KRI and Baghdad (central government's) Ministry of Health, there is an unclear delineation of public and private sectors in the

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[30] Ibid p8-9.

[31] WHO, *Report on the Regional Consultation on improving quality of care and patient safety in the Eastern Mediterranean Region, Jeddah Saudi Arabia* (2014)11,12. <file:///C:/Users/MEDION/Desktop/WHO%20quality%20in%20Middle%20East.pdf> 20 May 2017

[32] Nazar P Shabila et al, *Iraqi Health System in Kurdistan Region: medical professionals' perspectives on challenges and priorities for improvements* (2010) Conflict and Health <http://www.conflictandhealth.com/content/4/1/19> 25 March 2014; Tawfik-Shukor (n 2) 1

[33] Tawfik-Shukor (n 2) 1

[34] Ibid 1.

KRI. This is also known as the phenomenon of 'dual healthcare practice,' whereby physicians are working under both public and private sector sectors.[35] The potential impact of such practice on the KRI healthcare quality is discussed under chapter 6.1.3.

Similar to the UK healthcare system, in the KRI the healthcare system is financed through a percentage of national budget whereby the government acts as health service provider and is under a duty to provide health services.[36] Due to the existence of *National Health Service*, the provision of medical intervention is free of charge, except admission charges which is 250 to 3000 Iraqi dinars[37] (£0.20 to £2.00).[38] KRI has over 1300 hospital beds and over 1600 healthcare practitioners.[39] Each province has dozens of primary care specialists including diagnostics laboratory, pharmacy and maternity care units.[40] In the KRI, patients have access to medical intervention in public primary care centres (local), private clinics; emergency departments of both public and private hospitals.[41] As figure 3 illustrates, the first avenue for receiving medical care in the KRI is either primary care centres or private clinics. Depending on patient's medical condition, patients are sometimes being transferred to hospitals.

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[35] C. Ross Anthony et al, *Health Sector Reform in the Kurdistan Region — Iraq: Financing Reform* (2014) Primary Care, and Patient Safety.

[36] Melinda Moore et al, *The Future of Health Care in the Kurdistan Region—Iraq: Toward an Effective, High-Quality System with an Emphasis on Primary Care* (2014) xvii RAND Health https://www.rand.org/content/dam/rand/pubs/monographs/MG1100/MG1148-1/RAND_MG1148-1.pdf 4 September 2017.

[37] The currency that is used in KRI is Iraqi Dinars and KRG currency does not exist; Rubin (n 11) 87

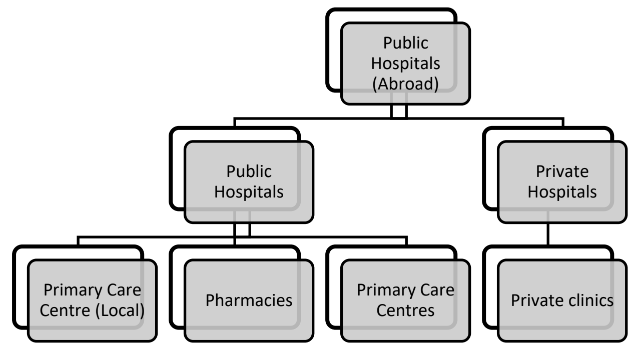
[38] John Quinn, *Health Security in Kurdistan*, Journal of Human Security, (2011) (7) 47-53, p49; Tawfik-Shukor (n 2) 4.

[39] Melina Moore (n 36) 19.

[40] Tawfik-Shukor (n 2) 4

[41] Salih Waladbagi, *Private Hospitals are the New Face of Medical Services*, (2011) Kurdish Globe <http://www.kurdishglobe.net/article/10661BE451F2B75B803F7302F234BE77/Private-hospitals-are-the-new-face-of-medical-services.html> 3 April 2018

Figure3: Avenues for Medical Intervention



Nevertheless, due to the political instabilities, KRI is receiving less than 17% of the Iraq's annual budget and this is regarded as a significant barrier for further improvements in the health system.[42] Furthermore, the pressure from about 2 million refugees has resulted in many issues including access to limited resources within the healthcare providers.[43] As the result, scarce resources and limited budget have contributed significantly to the healthcare quality issues within the healthcare providers of KRI.[44] Although Kurdistan region in North of Iraq has been subject to persistent terror attacks by militant group known as ISIS (Islamic State of Iraq and Syria), given the progressive weakening of the threat posed, it is clearly the time to undertake strategic analysis of the KRI healthcare system.[45]

1.3 Research Questions, Aims and Objectives

The thesis aims to innovate a set of benchmarks for health system governance. In the light of these benchmarks, this research seeks to explore the KRI healthcare standards and identify options for reform. To achieve these aims, this research involves the following objectives:

- Innovating benchmarks of best practice by critically discussing the key components of governance and drawing on knowledge gleaned from the operation of systems under different jurisdictions.

[42] Miller and Buker (n 7) 1; Quinn (n 38) 51.
[43] Miller and Buker (n 7) 1.
[44] Towfik-Shukur (n 2) 1.
[45] Ali Towfik-Shukur, Hiro Khoshnaw, *The impact of health system governance and policy processes on health services in Iraqi Kurdistan* (2010) 1 BMC International Health and Human Rights <http://www.biomedcentral.com/1472-698X/10/14/> 1 December 2013.

- Providing an overview of the KRI governance by reviewing the existing literature, conducting empirical qualitative research in the KRI, and measuring the findings against the benchmarks of best practice.
- Identifying options for reform by recommending a framework of Professional Medical Regulatory Authority to develop governance and improve quality of healthcare in the KRI.

As such, the thesis seeks is to answer the following research questions:

- What are the benchmarks of best practice for health system governance?
- What is the role of the KRI health system governance?
- What is the impact of the KRI health system governance on the quality of healthcare? What are the KRI healthcare standards? What are the areas for improvements?
- How can the KRI healthcare standards reach the benchmarks of best practice? What are the recommendations for improving health system governance in KRI?

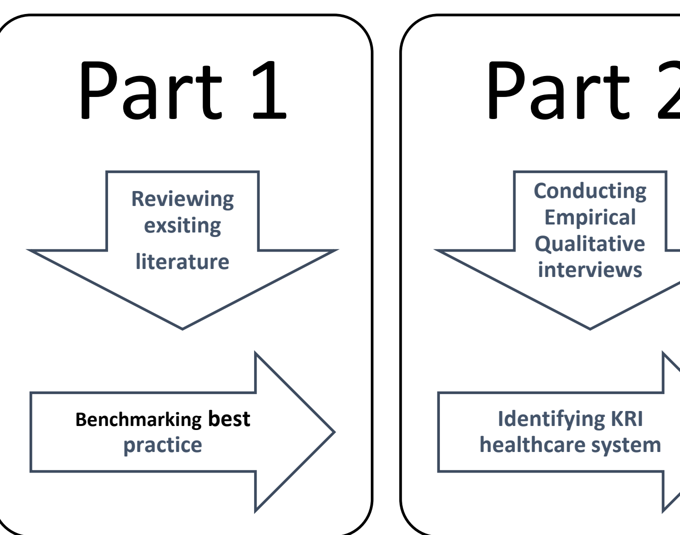
1.4 Research Methodology and Method

The specific processes that is followed under the thesis consists of three parts:
Part one focuses on the benchmarks health system governance. By looking critically at existing scholarly work and based on own thinking, this chapter aims to innovate a set of benchmarks of best practice for health system governance. This part is multi-disciplinary as it draws on health laws; statistical data on existing medical practices; and relevant ethical principles. Relevant sources relied on include legislation, cases, reports by national and international health organisations, journals, books, statistics and regulations.

Part two explores the KRI health system governance and its impact on healthcare quality. To provide an overview of the KRI health system governance, this part involves the process of reviewing the existing literature and conducting semi-structured interviews with the KRI health policy makers, hospital directors, and healthcare practitioners. The empirical data, obtained from the semi-structured interview, is codified using NVIVO software and analysed through Thematic Data Analysis process. This part also involves the presentation and the synthesis of the emerging findings.

Part Three of the thesis measures the identified KRI healthcare system against the benchmarks of best practice to identify the gap between the benchmarks of best practice and the KRI healthcare standards. This is then followed by recommendations for potential solutions, whereby an action plan is produced to remedy the gap between the KRI healthcare system and the benchmarks of best practice. The methodological basis of the thesis is further illustrated under figure 4 below:

Figure 4: Research Method & Methodology



1.5 Significance and Original Contribution to Knowledge

Although, due to political instabilities, research and improving healthcare quality is not a priority, in 2010 the *Kurdistan Regional Government (KRG)* funded *RAND International Research Corporation* to conduct a research on the KRI quality of primary care and this is regarded as one of the most significant existing research on the KRI healthcare system. [46] Whilst the RAND report provides growing evidence of healthcare quality in the KRI primary care, the thesis adds to such findings and emphasises the role of health system governance and its impact on the quality of healthcare in the KRI. More specifically, the thesis is not only assessing the impact of the KRI health system governance, it also provides a comprehensive overview of the role of law under the KRI health system.

[46] Melina Moore (n 36) 19.

Building significantly on the existing scholarly analysis by RAND Corporation, the thesis demonstrates originality as it draws on a system of benchmarking derived from a critical examination of healthcare standards across different jurisdictions. Predominantly, the thesis illuminates in its findings not just by a robust use of existing work, but also a significant programme of original empirical research consisting of a total of 32 semi-structed interviews with KRI policy makers, health service leaders and healthcare practitioners. Furthermore, the increased knowledge provides the KRI health policy makers with additional information and there is a scope of broader impact as a produced action plan will be communicated to the KRI health policy makers.

1.6 Organisation of this Thesis

The organisation of the chapters are as follows:

Chapter 2: Literature Review on Benchmarking Health System Governance

Following the process of reviewing the existing literature, chapter two develops through critical analysis, the benchmarks of best practice for health system governance. It starts with benchmarking best practice for the component of developing and implementing professional regulatory laws. The second part focuses on the process of regulating healthcare practice through effective accountability mechanisms, leadership, and professional regulatory authorities. The third part focuses on the benchmarks of best practice for improving healthcare quality through patient safety and risk management initiatives; professionalisation; and the development of health technology. The final part of chapter two critically discusses the component of getting patients involved through patient-centred approach.

Chapter 3: Research Methodology and Method

To provide an overview of the dependability and the credibility of the empirical data, chapter three briefly describes the empirical research procedure. It elucidates the underlying rationale for conducting empirical qualitative research, research strategies and techniques. This chapter demonstrates how an appropriate research strategy is developed and discusses the rationale for conducting qualitative empirical research with semi structured interviews in this instance and describes and reflect on my specific process within a consideration of relevant strategies and techniques – including

discussion of: the process complying with intensity; homogeneous and snowball sampling; the consideration of ethics; and the use of a pilot study. Finally, it provides detailed information on the step-by-step process I drew on for analysing the empirical data – including a six phase thematic data analysis process.

Chapter 4: Empirical Findings and Discussions: The Role of Health Law in KRI

Chapter four provides an overview the role of health law under the KRI health system by critically discussing the empirical data relating to the role of law and regulations. The main focus is on the three emerging themes, including: KRI health law; lack of awareness of regulations and guidelines; and implications on team performance. Each of these emerging themes under chapter four are followed by synthesis and discussions, whereby the findings are measured against the benchmarks of best practice for developing and implementing health laws.

Chapter 5: Empirical Findings and Discussions: KRI Healthcare System Leadership and Accountability

This chapter focuses on the participant’s perspectives relating to the functions of the KRI clinical leaders and their role under a system of accountability. Similar to chapter four, this chapter presents three emerging themes, including: KRI health service leaders, holding to account, and clientelism. The first theme emerged from the empirical data concern with the role of the KRI Ministry of Health, Department of Health, Professional Syndicate, and hospital management teams. The second theme emerged from the data, relates to professional and institutional accountabilities under the KRI healthcare system. The third emerging theme focuses on the existence of political interference under the KRI healthcare system. Subsequently, the emerging themes are followed by synthesis and discussions whereby the findings are measured against the benchmarks of best practice for regulating healthcare practice.

Chapter 6: Empirical Findings and Discussions: The Quality of Healthcare in KRI

This chapter presents the empirical findings relating to the KRI healthcare quality and risk management measures. It focuses on healthcare practitioner's perspectives about the existing tools for managing risks under the KRI healthcare system. The aim of this chapter is to provide an overview of the implications if ineffective governance on the KRI healthcare quality. The emerging themes under this chapter include patient safety practices, patient-centred care, and risk-management measures. Eventually, under this

chapter, each theme is followed by discussions and synthesis, whereby the empirical findings are related back of to the existing literature and are measured against the benchmarks of best practice.

Chapter 7: Recommendations for Potential Solutions

Following the discussion of the KRI healthcare system, chapter seven concludes the thesis and makes recommendations for potential solutions. The aim of this chapter is to remedy the gap between the KRI healthcare standards and the benchmarks of best practice. More specifically, this chapter produces an action plan for introducing *Professional Medical Regulatory Authority* under the KRI health service sector. During this process, the social, political, economic and cultural aspects of KRI are taken into account to ensure the applicability of such authority in the KRI.

PART 1

BENCHMARKS OF BEST PRACTICE

Chapter Two: Benchmarking Health System Governance

2.1 Introduction

The purpose of an ideal healthcare system is to facilitate good health in the population. Effective governance helps to maximise the fulfilment of this purpose. One of the issues addressed in this chapter is what effective governance means in general and in the specific context of a health system. Looking critically at scholarly work in the existing literature and based on own thinking, this chapter aims to develop a set of benchmarks of best practice for health system governance. More specifically, under this chapter various recommended health governance measures by national and international organisations; government authorities; and academics are critically discussed to develop benchmarks of best practice. Predominantly, the focus of this chapter will be on the key components of governance, including: the development and the implementation of professional regulatory laws; the regulation of healthcare practice; the improvement of the quality of healthcare; and patient-centred care.[47]

2.2 Governance and Benchmarking

2.2.1 Defining Governance

The term of governance has been subject to academic and philosophical scrutiny for years. For instance, in the 20th century, *Michel Foucault*, combined the principle of rationality and governance to develop the concept of governmentality. This concept discusses both internal (self) and external (policing) form of governance. It provides that power not only resides in the state and political institutions, but power also resides internally that is influenced by social relations, discourses and practices.[48] More specifically, *Foucault* characterises modern society as disciplinary society in which

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[47] NHS Leadership Academy, *Inspiring shared purposes* (2013) https://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/nine-leadership-dimensions/inspiring-shared-purpose/ 8 August 2019

[48] Michel Foucault, *Security, Territory, Population* (Pelgrave McMillan 1977); Graham Burchell, Colin Gouden, Peter Miller, *The Foucault effe: studies in Governmentality* (Hemel Hampstead 1991) 87-104; *Nicholas J. Fox*, *Postmodernism, Sociology and Health* (University of Toronto Press, Toronto, 1994); Caroline Fusco, *Inscribing healthification: governance, risk, surveillance andthe subjects and spaces of fitness and health* (2006) Health and Place, 68.

surveillance becomes routinised in every aspect of institutional practice and social life.[49] Such approach of governmentality was subject to detailed observation by *Flynn,* who attempted to refine governmentality. According to Flynn governmentality is about "*the disciplining and regulation of the population without director oppressive intervention*."[50] It can be argued that such approach by Flynn is more lenient and promotes humane intervention which contrasts with the 'structuralism theory' adopted by *Max Weber*. The latter focuses on top-down approach, whereby government oversees both institutional practices and social lives.[51]

Whilst the concept of governance was further discussed by a number of academics, according to *Rosenau "…governance emerges when those who would control an activity ('sources of authority') achieve a degree of compliance from those who are to be controlled, thereby establishing a 'system of rule' that regularises activity …"* [52] Nevertheless, such exposition by *Rosenau*, excludes the governance of activities that do not necessarily need to be regularised. In contrast to such exposition, *Leeuw* is from the opinion that there are three main types of governance, including '*constitutive governance*' which is concerned with policy coordination; *'directive governance'* which focuses on the regulation of facilities and distribution of essential sources; and finally, *'operational governance'* of redistribution and communications across different sectors.[53]

Further, *Leeuw* summarizes governance within the healthcare context as "*the expressed intent of government to allocate resources and capacities across relevant actors to resolve an expressly identified (health)issue within a certain timeframe*"[54] It can be

[49] Rob Flynn, *Clinical governance and governmentality* (2002) Health, Risk & Society 163
[50] Ibid 163
[51] Max Weber, *The Protestant Ethic and the Spirit of Capitalism* (Routledge, 2001) 154 https://is.muni.cz/el/1423/podzim2013/SOC571E/um/_Routledge_Classics___Max_Weber-The_Protestant_Ethic_and_the_Spirit_of_Capitalism__Routledge_Classics_-Routledge__2001_.pdf 16 December 2019; Patty Mulder, Bureaucratic Theory by Max Weber (2017) https://www.toolshero.com/management/bureaucratic-theory-weber/ 16 December 2019
[52] James N. Rosenau, *Along the domestic-foreign frontier: Exploring governance in a turbulent world* (1997) 34
[53] De Leeuw,E. *Engagement of Sectors Other than Health in Integrated Health Governance, Policy, and Action* (2017) Annual Review of Public Health, 338; WHO, *Health Systems Governance for Universal Health Coverage: Action Plan* (2014) 8, https://www.who.int/universal_health_coverage/plan_action-hsgov_uhc.pdf 6 February 2020;
[54] De Leeuw,E., (2017) 337.

argued that such definition of governance reflects mostly on the second type of governance (directive governance) as it is concerned with the distribution of healthcare resources. The concept of governance was broadly defined by the *World Health Organisation (WHO)*. According to the *WHO Department of Health Systems Governance and Financing,* the broader definition of governance:

> *"encompass politics, policy, public administration, the interaction of these with civil society and the private sector, and the effects the various institutions have on socio-economic outcomes. These definitions encompass many functions, activities and interventions that apply to, and cut across, all sectors"* [55]

Enhancing policies, under the broader definition, is paramount to the process of developing health system governance.[56] This broader definition of governance is applicable to the thesis, as the main focus is on developing governance through the process of enhancing policies to improve the overall health service performance under both public and private health sector. Chapters 2, 5 and 7 of the thesis centres around politics, policies, and health system leadership. In addition to this broader definition, the WHO provides that the narrow definition of governance involves:

> "*the oversight, control and incentive mechanisms that are used to hold any particular institution accountable to its owners or founders, and to align the objectives and interests of the institution's management with the objectives of its owners or founders."*[57]

The narrow definition of governance is also relevant to the thesis, as in addition to the broader aspects of governance, chapters 2, 5 and 6 of the thesis are also concerned with the management of the clinical processes. As such, under the thesis both broader and narrow concepts of governance are taken into consideration whilst innovating the benchmarks of best practice for health system governance.

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[55] WHO, *Health Systems Governance for Universal Health Coverage: Action Plan* (2014) 9 https://www.who.int/universal_health_coverage/plan_action-hsgov_uhc.pdf 30 July 2019
[56] Ibid.
[57] WHO, *Health Systems Governance for Universal Health Coverage: Action Plan* (2014) 9 https://www.who.int/universal_health_coverage/plan_action-hsgov_uhc.pdf 30 July 2019

2.2.2 Benchmarking Methods

The concept of benchmark consists of different types and its definition has attracted both national and international organisations. According to the WHO, a benchmark denotes:

> *"a standard or point of reference for the capacity. Setting benchmarks facilitates the development of plans to increase capacity levels (limited, developed, demonstrated and sustainable) and adopt best practices with a target of reaching sustainable capacity for each benchmark."*[58]

Whilst the definition by the WHO concerns general aspects of health system, the definition provided by the *UK Department of Health* is more specific to healthcare practice. As the department defines benchmarks as *'a systematic process in which current practice and care are compared to, and amended to attain, best practice and care.'* [59] There are various methods of benchmarking, including *Competitive Benchmarking; Comparative Benchmarking; Clinical Practice Benchmarking; and the Essence of Care Benchmarking*. Whilst *Competitive Benchmarking* is concerned with the comparison of costs and prices of competing organisations, *Comparative Benchmarking* aims to compare functions of different organisations and *Clinical Practice Benchmarking* involves the comparison of clinical process. Nevertheless, the *Essence of Care Benchmarking* is a sophisticated approach to clinical practice benchmarking as it involves the process of comparing best practices across healthcare organisations.[60]

2.2.3 Key Components of Health System of Governance

The present chapter relies mostly on the *Essence of Care Benchmarking,* as it involves a systematic evaluation of the key components of health system governance initiated from different jurisdictions. Health system governance was defined by the WHO as:

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[58] WHO, *Benchmarks for International Health Regulations (IHR) Capacities* (2019). https://apps.who.int/iris/bitstream/handle/10665/311158/9789241515429-eng.pdf?sequence=1 16 Feb. 20.

[59] Department of Health, *Essence of Care 2010 Benchmarks for the fundamental aspects of care* (2010) 9 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216691/dh_119978.pdf 4 December 2018.

[60] J FL Kay, *Healthcare Benchmarking* (2007) 12 Medical Bulletin 22; Amina Ettorchi-Tardy et al, *Benchmarking: A Method for Continuous Quality Improvement in Health* (2012) 7(4) Health Policy.

> *"a wide range of steering and rule-making related functions carried out by governments/decisions makers as they seek to achieve national health policy objectives that are conducive to universal health coverage."*[61]

As such it can be argued that rule-making functions of the government to achieve national objectives correspond to the wider definition of governance (discussed above). Health system governance in the context of the KRI system should centrally focus on fostering healthcare quality. To aid the critical analysis, I have developed a system of benchmarks which is grounded substantially both in the relevant literature and on a number of existing suggested governance of healthcare quality frameworks, including those established by the *World Health Organisation (WHO)*, the *NHS Leadership Academy,* and *the Royal College of Nursing*:[62]

Figure 5: The Key Components of Health System Governance

Despite the fact that there are various components to draw on, the present chapter attempts to justify the underlying rationale for selecting the above components of health system governance.

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[61] WHO, *Health Systems: Governance* (2020) https://www.who.int/healthsystems/topics/stewardship/en/ 8 February 2020.

[62] NHS Leadership Academy, *Healthcare Leadership Model: the nine dimensions of leadership behaviour* (2013) <http://www.leadershipacademy.nhs.uk/wp-content/uploads/dlm_uploads/2014/10/NHSLeadership-LeadershipModel-colour.pdf> Accessed 4 October 2016; Royal College of Nursing, *A key part of patient centred care is allowing people to engage in their own health and help design health systems. Learn about the four areas where patients are getting involved* (2020) https://www.rcn.org.uk/clinical-topics/clinical-governance/patient-focus 9 February 2020.

2.3 Benchmarks of Best Practice for Developing and Implementing Professional Regulatory Laws

Hard Law / Soft Law: Hard laws are rules that are recognized by a domestic court as having binding force. Such rules in a system grounded on the concept of Parliamentary sovereignty means at least any rules directly created by Acts of Parliament and any rules generated under authority created by Act of Parliament. Examples of the latter includes elements of EU law; any rules created by *Quasi-Autonomous Non-Governmental Organisations (QANGOS)* acting under authority granted by Act of Parliament (and/or delegated legislation); and rules created under the common law. Within the context of healthcare, hard laws have vital role in enhancing health outcomes as it can have the impact of regulating the operation of healthcare system; protecting the health of population by setting up standards and imposing duties on the state/government to make essential care available.[63]

Promoting wellbeing and protecting health through policies was further emphasised by the *WHO Regional Office for European* in a proposed philosophical framework known as 'Health 2020.'[64] As one of the initial goals under such framework provides that the aim is to *"improve people's health by strengthening health system, whilst acknowledging social, cultural and economic diversity.*"[65] Although, introducing laws to strengthen health systems can have the effect of improving health system, such initiative by the WHO Regional office implies responsive measure, it fails to provide sufficient consideration to preventative measures. As such, it can be averred that under the benchmarks of best practice, hard laws are not only aimed at responsive measures within the healthcare providers, but such laws are also aimed at preventative measures such as public health (further discussion on public health are found under chapter 2.2.3 /2.6.2) .

A distinction is often made between hard and soft law. Unlike hard laws, soft laws are often introduced by non-state actors, assemblies, national and international organisations.

[63] WHO, *Health Laws* (2020) https://www.who.int/health-laws/legal-systems/health-laws/en/ 23 Feb. 20; NHS Leadership Academy, *Leading with care* (2013). https://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/nine-leadership-dimensions/leading-with-care/ 8 August 2019.

[64] WHO Regional Office for Europe, *Health System for Health and Wealth* (2008) 1. André Den Exter, *European Health Law* (Maklu Publisher; 1 edn 2017) 29.

[65] Ibid (WHO) 1.

Regulations, treaties, guidelines, policies, resolutions and codes of conduct are examples of soft laws. Although, the failure to comply with hard laws can lead to legal actions in the courts, soft laws are not strictly and legally binding and often the failure to comply leads to internal disciplinary procedures within an organisation.

Nevertheless, not every law is regarded to be a good law as some do not hold legal weight. Although the purposes of health laws are to bring more accountabilities, due to financial issues, not everyone is qualified for legal aid and have access to justice. To initiate the enforcements and values of introduced laws, it is paramount to contemplate a number of points, namely the reason why the law was introduced; the benefit and the validity of the law; and whether such laws are oppressive and causing injustice. To develop a set of benchmarks of best practice, this part of the thesis critically discusses the role of laws within the process of developing health system governance.

Soft Laws: Soft laws are regulations/rules, which are potentially significant in terms of rights and obligations but do not have a binding status in the Courts. Thus, the rigid dichotomy between hard laws and soft laws are the enforceability in the courts. Essentially, the concept of regulation is not explicitly defined, as it can be defined in two ways: regulation as a form of law, and regulation as the process of overseeing practice.[66] According to the WHO the concept of regulations involve "*…the promulgation of rules by government accompanied by mechanisms for monitoring and enforcement (usually assumed to be performed through a specialist public agency)…"*[67] Nevertheless, to ensure promulgation, it is essential for the government authority to establish rules (professional regulations) in the first place.

Within the context of healthcare, the main purpose of professional regulations is setting up standards of professional conduct to clarify duties and responsibilities; manage and respond to risks of harm and ensure evidence-based practice.[68] Typically, professional regulations are established at both national and international level.[69] The *International*

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[66] Christel Koop, Martin Lodge, *What is regulation? An interdisciplinary concept analysis* (2015) 3 LSE Research Online http://eprints.lse.ac.uk/62135/ 31 July 2019

[67] WHO, *Law, regulation and strategizing for health* (2016) vii https://apps.who.int/iris/bitstream/handle/10665/250221/9789241549745-chapter10-eng.pdf;jsessionid=E74A0518EC91B9866A0048A75362A19F?sequence=1 7 September 2019.

[68] Angela Yu. et al, *Patient Safety 2030* (2016) National Institute for Health Research 23.

[69] World Medical Association, *Health Systems* (2017) https://www.wma.net/what-we-do/health-systems/ 26 July 2017; Chris Newdick, Judith Smith, *The structure and organisation of the NHS* (2010) 15

Health Regulations (IHR) is an example of professional regulations at international level.[70] The *IHR* was established by the *WHO* as an international agreement between 196 member states to impose a duty on member states to report international disease to the *WHO* and prevent any threat on global health.[71]

2.3.1 Developing Professional Regulatory Laws

Unlike the process of introducing hard laws, no legislative means are required to develop professional regulatory law. Although regulations are often state-enacted legal rules, nowadays non-state actors are becoming increasingly involved in the process of introducing health laws.[72] Under the benchmarks of best practice, the process of developing professional regulations does not only involve three stages,[73] it also involves the consideration of several distinct characteristics of professional regulations.[74] The three stages and the characteristics are discussed below.

Stage 1: Setting-up Policy Agenda: The first stage of setting up the agenda does not only involve the deliberation of health service failures, but it also involves the development of existing regulations. In other words, this stage also involves the elaboration of the existing rules, whereby two approaches can be taken: developing more specific rules from the existing general rules; or developing general rules from specific rules.[75] The development of existing rules complies with the essential characteristic of proportionality, which aims to avoid overregulation by limiting excessive amount of regulation.[76] Over-regulation have the potential of causing complications in the course of providing medical treatment. The key advantage of such initiative is not only avoiding overregulation, but it can also be more cost-effective as professional regulators are only

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http://www.midstaffspublicinquiry.com/sites/default/files/evidence/Expert_report_-_Structure_and_Organisation_of_the_NHS_0.pdf 8 July 2014.

[70] WHO, *The International Health Regulations* (2005). http://www.who.int/ihr/publications/ihrbrief1en.pdf?ua=1 Accessed 15 December 2016.

[71] WHO, Health laws and universal health coverage (2019) http://www.who.int/health-laws/legal-systems/health-laws/en/ Accessed 24 June 2019.

[72] Bronwen Morgan, Karen Yeung, and William Twinning*, An introduction to Law and Regulation* (Cambridge, 2007) 17.

[73] John Tingle, Charles Foster, *Clinical Guidelines: Law Policy and Practice* (Routledge 2002) 27-29.

[74] Angela Yu. et al, *Patient Safety 2030* (2016) 23.

[75] John Dickson, *Legal Rules: their application and elaborations* (1931) American Law Register, 1058.

[76] Ibid; WHO, *Guidance for developing national patient safety policy and strategic plan* (2014) 11.

required to interfere in exceptional circumstances. This could save costs and time for introducing and implementing regulations.

Stage 2: Formulation of the Agenda: this stage involves the process of refining the proposed regulations, whereby only those rules which respond to the failures under the existing regulations are selected for further considerations. One major drawback from this initiative is that the emphasis is on letters and words rather than root causes of failures. To respond to root causes of the failures at the level of patient's care, it is essential to ensure that the proposed regulations are also in compliance with the characteristic of 'focus,' meaning that they address both failures under existing regulations and failures at the level of patient's care.

Responding to the failures at the level of practice is also known as the bottom-up approach, whereby professional regulatory authorities and healthcare practitioners are involved in the process of developing regulations.[77] As recommended by the *Organisation for Economic Co-operation and Development (OECD)* such initiative is even more effective when citizens, in this context patients and families with first-hand experience, are involved in the process of developing laws.[78] As such, it can be argued that under the benchmarks of best practice, not only professional regulators, but also healthcare practitioners and even citizens are involved in the process of developing laws.

Evidence indicates that the bottom-up approach is successfully applied in *Cuba*, whereby the citizens in the local communities are working with the government representatives to develop strategies for addressing health service priorities. Further, Iran is one of those Middle Eastern countries with almost similar health system development status as Kurdistan region. Although, Iran started with the process of improving their health systems since 1974, attempts for enhancing health system governance in Iran has not always been successful. According to *Tabrizi*, the main reason for such failure is due to lack of attention on a bottom-up approach. The way in which Iran has attempted to deal

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[77] Shannon de Ryhove, *Primary health care implementation: A brief review* (2012). http://www.polity.org.za/article/primary-health-care-implementation-a-brief-review-2012-08-21 4 July 2017.

[78] Marc Gramberger, *Citizens as Partners: OECD Handbook on Information, Consultation and Public Participation in Policy-Making* (2001) OECD.

with such failure is through research studies on root causes of system failures.[79] As such it can be argued that under the benchmarks of best practice, a bottom-up approach is taken through the exploration and research studies on the root causes of system failures.

In addition to the above, the characteristic of 'transparency' is also applicable to the second stage of formulating the agenda, as it focuses on the process of streamlining regulatory framework. Under such process, the introduced rules and its objectives are simplified by way of presentation of a conceptual framework. [80] Transparent regulations are absolutely paramount, as clarifying the objectives of the proposed regulation is not only about the elimination of complications, but it can also avoid over-regulations.[81]

Stage 3: Designing and Submitting the Rules: As suggested by *European Observatory on Health Systems and Policies*, during this stage it is essential to take cultural and the socio-economic factors into account. [82] Within the context of healthcare, the consideration of such factors can lead to effective regulations, as otherwise policy makers can face issues of competing interests of health service organisation and general public. For instance, setting high standards under proposed regulations in a developing country with economic issues, can lead to a situation whereby the general population will have high expectation of a health services that the health organisation cannot fund.

Nevertheless, balancing competing interests by taking economic factors into account and setting reasonable standards can lead to the development of effective regulations. Additionally, balancing competing interests is also in accordance to the characteristic of 'agility.' As under such characteristic policy makers are not only focusing on the existing failures within the healthcare providers, but they also anticipate future changes by taking socioeconomic factors and general public interests into account.[83] Overall, it can be argued that under the benchmarks of best practice, over-regulation should be avoided and there should be an effective process of developing professional regulations with distinct characteristics of proportionality, transparency, focus, and agility being followed.

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[79] Jafar Sadegh Tabrizi et al., *Governance of Iranian Primary Health Care System: Perceptions of Experts* (2019) Iran Journal of Public Health 541 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6570813/ 24 March 2020
[80] Angela Yu (n74) 23.
[81] Charles Vincent, *Clinical Risk Management: Enhancing Patient Safety* (Blackwell 2001) 88.
[82] Helena Legido-Quigley et al, Assuring the Quality of the Health Care in the European Union (2008) European Observatory on Health Systems and Policies 5, 9.
[83] Angela Yu (n 74) 23

2.3.2 Implementing Professional Regulatory Laws

Following the introduction and following the development of professional regulations, under the benchmarks of best practice, regulations are not bureaucratic but are successfully implemented at the level of patient's care. Nevertheless, the general proposition about bureaucratic laws undermine the integral role of bureaucrats in complying with the procedural requirements including the administration and the communication of essential data information. As such it can be averred that under the benchmarks of best practice, bureaucracy of laws are the initial stages of implementations. The most prevalent types of implementations are discussed below.

Vertical and Horizontal Implementation: According to the *National Institute for Health Research (NIHR),* regulations can be implemented vertically and horizontally.[84] Within the healthcare context, vertical implementation involves the process of imposing responsibilities on healthcare leaders to ensure the implementation of the proposed rules by overseeing the functions of healthcare practitioners. Whereas, the method of horizontal implementation is concerned with the process of peer review whereby the process of applying emerging laws are monitored by fellow healthcare practitioners.[85]

Whilst it is evident that vertical implementation is concerned with hierarchies and the functions managing authorities, horizontal implementation it is debatable. As the process of overseeing the functions by healthcare practitioners alone is inadequate. The power healthcare practitioners to monitor the process of implementation is often provided by managing authorities. Thus, it is paramount to specify the role of managing authorities within the process of horizontal implementation. Besides, such distinction also fails to give sufficient consideration on whether leaders should adhere to the proposed rules. As such, it can be averred that distinguishing between vertical and horizontal implementation is almost meaningless. Whether such practice is within the definition of horizontal or vertical implementation, the crucial stratagem is successful execution of the proposed laws at the level of patient's care.[86]

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[84] Angela Yu (n74) 23.
[85] Newdick (n69) 15.
[86] David Clarke, *Strategizing national health in the 21st century: a handbook on Law, regulation and strategizing for health* (2016) WHO, <http://apps.who.int/iris/bitstream/10665/250221/1/9789241549745-chapter10-eng.pdf> 19 March 2018

Stages of Implementing Professional Regulations: The process of implementing emerging rules is not straightforward and involves various stages. The initial stages of implementation involve the consideration of local conditions.[87] This is in compliance with the approach by *Matland,* as he argued that "*success depended greatly on the local implementer's ability to adapt to local conditions*"[88] Such approach complies with *'Public Interest Theory'* as it provides that the adaptation of local conditions increases the chances of successful implementation of regulations.[89] Therefore, it can be averred that under the benchmarks of practice, not only national socio-economic backgrounds are taken into account but also the local conditions such the number of people in need to medical care are taken into account.

The subsequent stage of the implementation involves the process of communicating the proposed professional regulations to the healthcare practitioners. Often emerging law and guidance are communicated via subject-specific medical journals, workshops, seminars, and training courses. According to the *National Institute for Health Research (NIHR)* consistency is paramount within the process of communicating professional regulations, as it can increase standardised rules across all healthcare providers.[90] Predominantly, the aforementioned initiatives are not only applicable to the implementation of national law, but also to international health regulations. Although *Sperling* and *Fattal* are suggesting that international regulations are successfully implemented at national level through the consideration of specific characteristics of national health systems,[91] there should also be an emphasis on national socio-economic backgrounds and local conditions.

[87] Richard E Matland, *Synthesizing the Implementation Literature: The Ambiguity-Conflict Model of Policy Implementation* (1995) 148 Journal of Public Administration Research and Theory http://orion.luc.edu/~rmatlan/pdf/1995SynthesizingtheImplementationLiterature.pdf 4 July 2017.
[88] Ibid 149.
[89] Morgan, Yeung, and Twinning (n72) 17.
[90] Angela Yu (n74) 23.
[91] Marcos von Sperling and Badri Fattal, *Implementation of guidelines: some practical aspects* (WHO 2001) 361 http://www.who.int/water_sanitation_health/dwq/iwachap16.pdf 24 June 2019

2.3.3 Supplementary Statutory Instruments and Non-legal Rules

In addition to professional regulations, clinical guidelines, protocols, and code of practices can also have an essential role in clarifying roles and responsibilities of healthcare practitioners.

Guidelines: Unlike regulations (which is often established by government authorities), guidelines are mostly developed by non-state actors, such as *National Institutions*, *National Guideline Centre*s, *National Collaborating Centres*, *Professional bodies*, *Medical Colleges, and International Health Organisations*.[92] Guidelines are described as *"a broad statement of principle giving practical guidance … to achieve acceptable outcomes."*[93]*Medicines Practice Guidelines*, *National Institute for Clinical Excellence* and *Public Health Guidelines* are examples of clinical guidelines. For instance, *Medicines Practice Guidelines* aim to develop clinical governance and support health service managers during the execution of their duties. Additionally, the *National Institute for Clinical Excellence* provide guidance on cost-effective treatment and assists healthcare practitioners in complying with the expected professional standards.[94] Nevertheless, having excessive number of clinical guidelines by different institutions can cause complications for healthcare practitioners. To avoid or at least ameliorate this issue, the best approach is to review the existing guidelines and update them on a regular basis in a way that maintains the normative value .[95]

Clinical Protocols and Codes of Conduct: A protocol is a document containing the background, the rationale, and the objectives[96] of subject specific clinical process.[97] As indicated by the WHO, protocols supplement the process of the implementation and the standardisation of emerging laws.[98] Subject specific examples include clinical trial

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[92] NICE, *Types of Guidelines* (2018) < https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/types-of-guideline> 28 February 2018
[93] Tingle and Foster (n73) 2
[94] Patient Trusted Medical Information and Support, *UK Clinical Guidelines* (2015) http://patient.info/guidelines.asp Accessed 7 July 2015
[95] Johan Legemaate, *Exploring patient participation in reducing health-care-related safety risks: Patient Rights and Patient Safety* (WHO 2013) 12; Judith Allsop, Mike Saks, Regulating the Health Professions, (Sage, 2002) 48.
[96] Clinical Research Resource Hup*, Clinical Trial Protocol Development* (2018) https://hub.ucsf.edu/protocol-development
[97] Fuss MA, Pasquale MD, *Clinical management protocols: the bedside answer to clinical practice guidelines* (1998) J Trauma Nurs 4-11
[98] WHO, Protocols and guidelines (2018) http://www.who.int/tobacco/surveillance/guide/en/

protocols which aims to provide an action plan for medical research processes.[99] Another example is the *Clinical Management Protocols* which can play a vital role in the process of clarifying the interactions between healthcare managers and healthcare practitioners. In addition to protocols, the aim of codes of conducts is to clarify the expected practice by setting up a number of codes in the form of practical steps that is intended to be followed during the provision of medical intervention.[100] Generally, codes of conduct are related to the protection of confidential information; the process of obtaining informed consent; and the compliance with ethical standards.[101]

Health Codes of Ethics: to give a shape and structure of moral environment, ethical codes summarise ethical principles and aim to guide practitioners in critical situations.[102] The key ethical principles in healthcare are generally considered to be autonomy, beneficence, non-malfeasance, and justice. [103] Whilst the ethical principle of autonomy aim to protect patients' rights of self-determination, the principle of beneficence imposes a duty on healthcare practitioners to act in the best interests of patients; the principle of non-malfeasance imposes a duty not to harm patients; and the principle of justice imposes a duty to treat patients equally.[104] Although according to *Miller*[105], health codes of ethics cannot provide guidance to unpredictable dilemmas, as suggested by *Global Alliance Code of Ethics*, emphasising the importance of honesty and transparency during unpredictable situations can minimise ethical dilemmas.[106]

In addition to the above codes for health professionals, the *World Health Organisation/Pan-American Health Organisation (WHO/PAHO)* proposed and prepared

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[99] Azzam Al-Jundi, Salah Sakka, *Protocol Writing in Clinical Research* (2016) J Clin Diagn Res 10(11) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5198475/pdf/jcdr-10-ZE10.pdf> 2 May 2019

[100] Social Institute for Excellence, Legislation – Understanding the Legal Framework (2013) <https://www.scie.org.uk/publications/guides/guide15/legislation/legalframework.asp> 5 March 2018

[101] WHO, *Health Policy* (2018) <http://www.who.int/topics/health_policy/en/> 28 February 2018

[102] Alexander E Limentani, *An ethical code for everybody in health care: The role and limitations of such a code need to be recognised* (1998) 1456 GMJ https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1113129/ 4 August 2019

[103] Jim Summers, *Principles of Healthcare Ethics*: in Morrison Eileen E., *Health care ethics : critical issues for the 21st century* (Sedbury, 2nd edn, 2014) 41.

[104] Ibid (Jim Summers) 41.

[105] Saul Miller, *Three crucial limitations need to be considered* (1998) BMJ 1458 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1113129/ 4 August 2019

[106] Global Alliance Code of Ethics, Benchmarking of codes of ethics In Public Relations- Phase 2 (2002) https://static1.squarespace.com/static/561d0274e4b0601b7c814ca9/t/56c20345c2ea510748cb2768/1455555401036/ethics-Benchmarking.pdf 4 August 2019

e-Health Code of Ethics for general public to raise awareness about the potential risks involved in managing own health via internet.[107] To ensure the publication of reliable data online, the primary focus of such codes centres around "*candour; honesty; quality; informed consent; privacy; professionalism in online health care; responsible partnering; and accountability*." [108] Although, such codes are directed at those releasing health-related information over the internet, no specific guidelines are provided for those who suffer harm as the result of negligent information or substandard medications.

Non-legal Rules: In addition to legal rules, non-legal rules such as (norms, religious values, and moral obligations) have also an impact on the behaviours of healthcare practitioners. Non-legal rules can vary from one place to another as it usually applies to a group in a particular place. Within the healthcare context, the non-legal rules that exist in developed countries of Europe differs substantially with non-legal rules that exist in developing countries in the Middle East. The existence of non-legal rules within the healthcare providers can have a number of advantages as it is not entrenched, it can be amended, which is more flexible to adapt to particular circumstances. Moreover, the application of non-legal rules can be used as a teaching tool to pilot new knowledge, which can subsequently be codified into legal rules and can ensure common standards across healthcare providers. Although the failure to comply with non-legal rules has no legally actionable consequences, it can have other serious consequences of both a formal nature (such as being formally sanctioned at work or dismissed from it) and an informal one (such as being isolated within a particular team[109] or looked upon less favourably by an employer when opportunities for employees arise).

Self-governance: In Foucaldian terms self-governance can be seen as the internalisation of governance[110] However, it is also a philosophical position taken by thinkers and bodies who want to maximise the extent to which a particular area of activity is free of regulation. This is sometimes captured in simplistic pleases or demands such as the

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[107] Helga Rippen, MD et al, *e-Health Code of Ethics* (2000) J Med Internet Res https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1761853/ 4 August 2019
[108] Ibid (Helga Rippen).
[109] John W. Davis, *Contemporary Issues in Biomedical Ethics* (The Humana Press Inc, New Jersey, 1978)
[110] Michel Foucault, *Discipline and Punish: The Birth of the Prison* (Vintage Books, New York, 1977) 104.

slogan for sport that 'the law should be left at the touchline' or the notion in the context of healthcare that professionals should be able to practice free of the fear of the 'dagger in their back.' However, there are also serious attempts to make such arguments more cogently. For example, the *European Chambers of Physicians*, has argued that allowing doctors and medical professionals to regulate themselves is the most effective means of governance and enhances professional integrity, which ultimately has the effect of internalising rules.[111] I would argue for a more nuanced balance where legal tools of action are left largely intact but consideration is given to supplanting some general legal norms with other forms of regulation where these can be shown to be more effective.

Critical analysis: Having considered various sources of rules (including Acts of Parliament, regulations, guidelines, protocols, codes of conduct, norms, religious values, moral obligations and self-governance), it can be argued that different sources of rules could cause complexities for health service leaders and healthcare practitioners. To avoid such issue, under the benchmarks of best practice, healthcare practitioners and health service leaders are aware about the hierarchies of such sources and the consequences for breaching such rules. Thus, the ideal system involves the process of clarifying roles and responsibilities through the implementation of rules by means of supplementary statutory instruments and non-legal rules.

2.4 Benchmarks of Best Practice for Regulating Healthcare Practice

Having considered the benchmarks of best practice for developing and implementing professional regulations, this part of chapter 2 focuses on the benchmarks of best practice for regulating healthcare practice. Within the healthcare context, the process of regulation involves the act of overseeing the functions of healthcare practitioners rather than on the actual rule that is followed by professionals. According to *Selznick* the process of regulation is generally conceived as *"sustained and focused control exercised by a public agency over activities that are valued by the community"*[112] In the context of the present research, the activities are not necessarily to be valued by the community, as often the occurrence of certain activities generates some risks for the public that would

[111] European Chambers of Physicians, *About Physicians' self-governance* (2018) http://www.medical-chambers.org/about_self_governance.html 18 Dec. 19

112 Selznick, Philip, *Focusing organizational research on regulation* (1985) 383 in Regulatory Policy and the Social Sciences, Berkeley: University of California Press.

warrant regulation. More specifically, although the process of regulation is more a sociological issue, healthcare practice involves some risks of medical misadventure. Such issue necessitates the formation of medical professional bodies to regulate the process of medical intervention and achieve a special status in the eyes of public, government and themselves. As such *Baldwin* has divided the definition of professional regulations into three main conceptions:

> (1) *"the promulgation of an authoritative set of rules, accompanied by some mechanism [...] for monitoring and promoting compliance with these rules";*
>
> (2) *"all the efforts of state agencies to steer the economy"; and*
>
> (3) *"all mechanisms of social control – including unintentional and non-state processes"*[113]

Whilst such attempt of broadly defining professional regulations covers both the rules and the acts of regulating, it also centres around regulating professionals via non-legal rules under social controls and non-state processes. Nevertheless, the first conception by *Baldwin* is equally paramount as it concerns the process of overseeing the implementation of rules. To identify the benchmarks of best practice for regulating healthcare practice, this part of chapter 2 critically discusses the functions of health service leaders, professional regulatory authorities, and accountability mechanisms.

2.4.1 Health Service Leadership

Heath service leadership can be regarded as an essential tool for health service governance as it involves the process of setting up objectives, distributing resources, observing performances, and holding practitioners to account. The *National Institute for Health Research* provides that *"organisational leadership helps to achieve system-level objectives by translating them into the values and goals of a health service organisation."*[114] Nevertheless, according to *Donaldson LJ,* system-level objectives are

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[113] Baldwin et al, *Understanding Regulation: Theory, Strategy, and Practice* (Oxford: Oxford University Press, 2nd edn 2012) Ch1.
[114] Angela Yu (n 74) 24

achieved through the process of overseeing the functions of healthcare practitioners.[115] Such approach is supported further by *Cowper:*

> *"Leaders have got to walk the floors in their organisations, and know and be known by their staff, and ... ask them where care could be safer; ask them what's preventing them from delivering safer care now, today."*[116]

Whilst closely engaging with healthcare practice is only a preliminary step and will not amount to the improvement of healthcare quality, subsequent attempts of empowering leaders to speak up can lead to innovative measures and reforms for improvements. Predominantly, the empowerment of health service leaders is not effective without the collaboration with healthcare practitioners under collective leadership.

Collective Leadership: In contrast to a hierarchical structure of power, the component of collective leadership aims to ensure collaboration between leaders. According to the *UK National Audit Office,* clinical governance is successful when appropriate organisational structure and sufficient arrangements are in place to inspire shared purposes.[117] The organisational arrangements include collective leadership through communication strategies and effective team working.[118] As it can be seen below, under the Medical Leadership Competency Framework collective leadership is also an important sub-domain of *'working with others'*.[119] According to *Matt Green*, collective leadership has the effect of sharing best practices and learning from other institutions/jurisdictions.

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[115] Donaldson LJ, Scally G, *Clinical management and the drive for quality improvement in the NHS in England* (1998) British Medical Journal 61-65

[116] Andy Cowper, *The case for patient safety: Financially, professionally and ethically* (2015) Health Service Journal https://www.hsj.co.uk/Journals/2015/07/13/r/y/h/Patient-Safety-Case-full-report-.pdf Accessed 14 December 2016

[117] National Audit Office*, Improving quality and safety – Progress in implementing clinical governance in primary care: Lessons for the new Primary Care Trusts* (2007) https://www.nao.org.uk/report/improving-quality-and-safety-progress-in-implementing-clinical-governance-in-primary-care-lessons-for-the-new-primary-care-trusts/ Accessed 24 June 2019

[118] Bruce Keogh, *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report* (2013)22-25; John Tingle et al, *Regulating Healthcare Quality: Legal and professional issues*, (Butterworth 2004) 19

[119] Matt Green, Lynne Gell, *Effective medical leadership for consultants: personal qualities and working with others* (2012) BMJ 345

Figure 6: Medical Leadership Competency Framework

Nevertheless, collective leadership is not only about the relationship between leaders, but it is also about the relationship between leaders and healthcare staff. As such it can be argued that under the benchmarks of best practice, effective leadership is ensured through the process of working closely with healthcare practitioners at the level of patient's care; and developing individual capability by engaging healthcare practitioners with the traditional approach of '*collective leadership*.' Effective leadership through collaboration with healthcare practitioners has the potential of increasing productivity and operational improvements. In a report entitled as *"healthcare advisory for the Middle East"*, it is found that in the Middle East (in countries with low/middle income) that health service leaders can increase productivity in a cost-effective way through the process of effective planning and effective distribution of health service resources.[120]

2.4.2 Professional Medical Regulatory Authority (PMRA)

According to the *International Association of the Medical Regulatory Authorities*, medical regulatory authority is

> *"an organization recognized by the government of a country, state, province etc., as being responsible for: the registration/licensure of physicians, whereby such physicians are entitled to practice the profession of medicine; and/or the standards of practice of registered/licensed physicians within that jurisdiction."*[121]

[120] PWC, *Healthcare Advisory Middle East* (2019) https://www.pwc.com/m1/en/industries/healthcare/healthcare-advisory-me-v5.pdf Accessed 28 June 2020

[121] International Association of the Medical Regulatory Authorities, *What is a medical regulatory authority?* (2020) https://www.iamra.com/What-is-a-Medical-Regulatory-Authority 19 Feb. 20

Whilst the above definition suggest that a medical regulatory authority can be responsible for both the registration of medical professionals and the implementation of expected standards, the words ‘and/or’ also suggest that different authorities can be responsible for different areas of health professional practice. Under multitudinous jurisdictions, healthcare systems consist of different types of health professional regulators including: *General Medical Council*, *General Dental Council*, *General Optical Council, nursing and midwifery council*.[122]

Even though, the existence of numerous professional regulatory authorities can cause complication and overregulation, a single regulator may not necessarily respond to the needs of specific areas of medical practice. To avoid complications, the functions of such authorities are indistinguishable as the common duties involve promoting continuous improvements by setting up standards; overseeing and scrutinising the functions of healthcare professionals; regulating disciplinary processes; and investigating failures to learn from mistakes. [123] The distinct characteristics and the functions of professional regulatory authorities are critically discussed below.

Registration/licensure of Physicians: To maintain a good medical practice, and to identify personal and professional development, [124] under a number of jurisdictions, the PMPRA oversees the *Fitness to Practice Process (FTPP)*.[125] Under the FTTP, medical practitioners are registered on the medical register and competent doctors are awarded with a *Fitness to Practice Licence (FTPL)*.[126] The registration of healthcare professionals and the provision of fitness to practice licence enable healthcare practitioners to practice

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[122] Professional Standards Authority, *A closer look at each regulator* (2018) https://www.professionalstandards.org.uk/what-we-do/our-work-with-regulators/find-a-regulator 10 September 2018.

[123] Department of Health, *The New NHS: Modern, Dependable* (1997) Cmnd 3807, London, HMSO http://www.archive.official-documents.co.uk/document/doh/newnhs/contents.htm 15 December 2013]; Judith Allsop (n95) 22; John Tingle (n118) p78.

[124] Department of Health, *Professional accountability - clinical governance, performance and appraisal* (2017) https://www.healthknowledge.org.uk/public-health-textbook/organisation-management/5a-understanding-itd/accountabililty 1 August 2019

[125] WHO, *Do lifelong learning and revalidation ensure that physicians are fit to practice?* (2008)1 http://www.euro.who.int/__data/assets/pdf_file/0005/75434/E93412.pdf?ua=1 Accessed 12 October 2016

[126] GMC, *Licencing and Fitness to Practice* (2014) http://www.gmc-uk.org/GMC_FTP_Factsheet_Licensing_and_fitness_to_practise.pdf_56010555.pdf Accessed 12 October 2016

within the healthcare providers.[127] In order to maintain the safety of the public and promote competency of healthcare professionals,[128] the FTPL is subject to revalidation through a formal appraisal process.[129] Under the benchmarks of best practice, the FTPL is only awarded to those practitioners who are acting in accordance to the highest standards of care by being aware of most recent developments.[130]

Regulating Healthcare Practice: The notion that professional regulatory authorities are absolutely self-regulated, is a fallacy. Realistically, the powers of regulating healthcare practice derive from an Act of Parliament and PMRA cannot be seen as entirely self-regulated. Nonetheless, under a number of jurisdictions (including the UK), professional regulatory authorities are regarded as self-regulatory. This is mainly because such authorities are often formed by healthcare practitioners, whereby the existing healthcare practitioners are actively engaged in the process of improving health outcome and are regulating the functions of fellow practitioners.[131]

It is undisputed that the existence of self-regulatory authorities within healthcare providers have multiple advantages. First being the application of bottom-up-approach, whereby those healthcare practitioners who are members of the regulatory authorities and who have in-depth expertise in the area of healthcare practice, are more likely to decipher health service failures. As such, this process also reconciles the process of horizontal implementation of regulations as members of the regulatory authorities are medical practitioners who are involved in the process of medical care as well as enforcing the regulations. The second advantage of self-regulatory authority is known as ‘quality circles’ whereby the functions of healthcare practitioners are reviewed by their peers/fellow healthcare practitioners.[132] As such, self-regulatory authorities / peer review practices are widely recognised under a number of jurisdictions including *Austria,*

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[127] Ibid.

[128] GMC (n126).

[129] Spencer-Lane, *Creating a single statute for the regulatory councils: the law Commission’s review of health and social care professional regulation* (2013) Journal of Professional Negligence 182.

[130] Department of Health, *Delivering the NHS Plan: The Next Steps* (2002); John Tingle (n118) 77.

[131] Andrew Grubb, Judith Laing, and Jean McHale, *Principles of Medical Law*, Oxford University Press (2010).

[132] WHO, *Do lifelong learning and revalidation ensure that physicians are fit to practice?* (2008) 2 WHO, *Guidance for developing national patient safety policy and strategic plan* (2014) 28.

Belgium, Denmark, Germany, Ireland, the Netherlands, Norway, Sweden, and Switzerland.[133]

Biopower: Peer review can be related to Foucault's concept of bio-power.[134] The existence of peer review can be considered as a self-disciplinary practice, whereby a top-down approach is avoided as the power does not only derive from a dominant group but rather from doctors themselves. The concept of 'Biopower' is known as *"[A] power that exerts a positive influence on life ..."*[135] To avoid a repressive practice and support best practice, such as where power is exercised to foster desire and sharing of knowledge.[136] Aligned with the premise by *Foucault*, occasionally the exercise of powers necessitates disciplinary actions, as he provides *"a well-governed society requires the disciplining and organization of space..."*[137] As such, it can be attested that the concept of biopower is not only about a productive power excreted by fellow practitioners, it is also about the power exerted by external agencies including government authorities and political parties.

Clientelism: Although, self-regulatory authority without governmental interferences can lead to the domination of healthcare practitioners, excessive governmental interferences can increase issues of political clientelism.[138] Clientelism has been defined by *Stokes* as "*proffering of material goods in return for electoral support, where the criterion if distribution that the patron uses is simply: did you (will you) support me*?"[139] Proffering is not only about inducements, but it also takes the form of threats whereby healthcare

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[133] Beyer M et al, *The development of Quality circles/ peer review groups as a method of quality improvement in Europe*, Family Practice (2003) 443-451
[134] Ibid 21-23.
[135] Michael Foucault, *The Will to Knowledge: The History of Sexuality* (1998); Rachel Adams, *Michel Foucault: Biopolitics and Biopower* (2017) Critical Thinking: Law and Politics http://criticallegalthinking.com/2017/05/10/michel-foucault-biopolitics-biopower/#fnref-22546-11 Accessed 17 July 2017.
[136] Jen Pylypa, *Power and Bodily Practice: Applying the Work of Foucault to an Anthropology of the Body* (1998) Journal of Health and Politic 21 https://journals.uair.arizona.edu/index.php/arizanthro/article/viewFile/18504/18155 Accessed 5 July 2017
[137] Foucault (n110) 135
[138] Sylvia R. Cruess, MD and Richard L. Cruess, MD, *The Medical Profession and Self-Regulation: A Current Challenge* (2005) AMA Journal of Ethics https://journalofethics.ama-assn.org/article/medical-profession-and-self-regulation-current-challenge/2005-04 1 August 2019; Judith Allsop (n95) 51
[139] Susan C. Stokes, *Clientelism* (2009) The Oxford Handbook of Comparative Politics 4 http://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780199566020.001.0001/oxfordhb-9780199566020-e-25 Accessed 3 January 2016.

professionals can lose their job if they do not act in accordance to the political parties' preferred method.[140]

Clientelist social order (which is more common in developing countries) is known to be dependent on relations of patronage, whereby organisations are financially dependent on political parties.[141] As evidence, *Kitschelt* concluded that "*poor and uneducated criticizes discount the future; rely on short casual chains, and prize instant advantages ... clientelistic exchanges always trumps that of indirect*."[142] Often healthcare practitioners, in developing countries, are most likely to experience a high level of pressures from political actors. As such, in most developing countries the line between health systems and politics is a blurred one. Due to health systems being at least indirectly financially dependent on political parties, political party ideologies and objectives can often (mis) shape the way health systems are formally structured and, more particularly, the way they operate in practice.

As a matter of best practice methods should be established to maximise the independence of the healthcare system from political party influence. One way to support this is to have regulated independent bodies organising the macro governance and operation of health services According to *Judith Allsop,* the existence of regulated authorities in a democratic society with non-interventionist ideologies is more effective.[143] Avoiding political clientelism and having state's power in the background enables the members of regulatory authorities to speak up and bring changes. Overall, it can be averred that the ideal system involves the process of establishing non-excessive, but diverse self-regulatory authorities with non-political interventionist and non-repressive powers by governmental bodies. More specifically, under an ideal health system clientelism is avoided through a transparent and effective accountability system by regulatory authorities with non-political interventionist.

[140] Ibid 5.
[141] Ibid 13.
[142] Kitschelt, H, *Linkages between citizens and politicians in democratic politics* (2000) Comparative Political Studies 857.
[143] Judith Allsop (n95) 22

2.4.3 Transparent and Effective Accountability Mechanisms

Accountability has increasingly become an important mechanism and has received global attention over the last years. As evidence, under a framework developed by the *NHS Leadership Academy*, accountability is regarded as an important component of health system governance.[144] Moreover, the *United Nation: General Assembly* regarded accountability as one of the main goals of the *2030 Agenda for Sustainable Developments*.[145] As evidence, the main target under goal 16 is to develop accountability at both institutional and practitioners level.[146] As such, under the benchmarks of best practice, effective accountability mechanism does not only operate at practitioners level, but responsibilities are also imposed on health service leaders at institutional level.[147]

Accountability at Institutional Level: the overall definition of accountability involves a high degree of complexity. Such phenomenon consists of different components, namely, accountability of health service leaders and of individual healthcare professionals. There are a number of attempts for defining accountability. According to *Ezekiel*, health service leaders are accountable for "*professional competence, legal and ethical conduct, financial performance, adequacy of access, public health promotion, and community benefit*."[148] Nevertheless, such definition would have been far more persuasive if it distinguished between the accountabilities of leader within the healthcare providers and health system leaders at ministerial level. Although at institutional level health service leaders are accountable for professional competence, ethical conduct and access to healthcare, at ministerial level leaders are more likely to be accountable for public health promotion and community benefits.

In contrast to the above work by *Ezekiel*, *Yahagi*'s focus is only on clinical leaders as he provider that leaders within the healthcare providers are to be responsible for both inputs

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[144] NHS Leadership Academy, *Healthcare Leadership Model: the nine dimensions of leadership behaviour* (2013).
[145] UN Department of Economic and Social Affairs, *Envision2030: 17 goals to transform the world for persons with disabilities* (2016) https://www.un.org/development/desa/disabilities/envision2030.html 10 May 2019.
[146] Ibid.
[147] NHS Leadership Academy, *Holding to account* (2013) https://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/nine-leadership-dimensions/holding-to-account/ 8 August 2019.
[148] Ezekiel J. Emanuel, Linda L. Emanuel, *What is accountability in healthcare?* (American College of Physician 2004) 41.

and outputs.[149] According to *Yahagi*, under the inputs, leaders are responsible for the allocation of sufficient and efficient personnel, resources, and information relating to healthcare performance. Under the outputs, leader is responsible for assessing performance outcomes, whereby the focus is not only on quantity (the number of patients treated) but also on quality (the outcome of medical intervention).[150] As such, it is arguable that the imposition of responsibilities on health service leaders can lead to continuous improvements of healthcare quality and the reduction of medical misadventure.[151]

Accountability at practitioners' level: In addition to the above accountabilities of healthcare leaders, under the benchmarks of best practice, healthcare practitioners are equally accountable for a high quality of health services. At practitioner's level, *Maybin* defines accountability as a *"relationship involving answerability, an obligation to report, to give an account of, actions and non-actions.*"[152] Under such broader definition of accountability, the focus is not only on actions but also on omissions and on the process of reporting failures to learn from mistakes. Although *Moloney* argues that accountability is usually based on the hierarchy of the authorities,[153] under the benchmarks of best practice, professionals are held accountable at every level of their practice.

To ensure transparent and effective accountability mechanism, duties and responsibilities need to be clarified, communicated, and agreed in advance. As Such, *Moloney* is of the opinion that accountability at practitioners' level is about *"answerability to an account holder in accordance with agreed performance criteria."* [154] In the healthcare context, the account holders are healthcare leaders and professional regulatory authorities, who have the power to oversee the functions of healthcare practitioners.[155] Predominantly, the expected standards are enforced via *FTTP*, whereby unfit practitioners are subject to

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[149] Yahagi S., *Management Resource input/output strategy and its applications*, Journal of Strategic Change (1994) p227
[150] Ibid; Department of Health (n130).
[151] Department of Health (n130).
[152] Jo Maybin et al, *Accountability in the NHS: Implications of the government's reform programme* (2011) https://www.kingsfund.org.uk/sites/default/files/Accountability-in-the-NHS-June-Kings-Fund-2011.pdf 5 December 2018
[153] Susan Moloney, *Medical misadventure: compensation, accountability and regulating standards of practice* (2000) Medico-Legal Journal of Ireland 2.
[154] Ibid.
[155] Donaldson (n115) 61-65.

disciplinary processes if they fail to take responsibilities for their actions.[156] The disciplinary process includes suspending or removing healthcare practitioner's name from the medical register.[157]

Advantages of Disciplinary Proceedings: The existence of disciplinary proceedings within the healthcare providers has certain advantages, including: the imposition of deterrent effect on healthcare practitioners, whereby the threat from disciplinary processes leads to better note-keeping and longer consultations with patients.[158] Essentially, the absence of disciplinary processes can lead to the misuse of limited resources and abuse of powers, which ultimately can result into serious failures in healthcare. As evidence, *the Institute of Medicine* provides that ''*individuals must sometimes be held to account for their actions – in particular if there is evidence of gross negligence or recklessness, or of criminal behaviour*.''[159] This illuminates that professional accountability is necessary to ensure a high quality of healthcare.[160]

Panopticon: Notwithstanding, under the concept of 'panopticon', which according to *Foucault* is about a system of control, the exertion of powers can lead to a strict internal surveillance by a group of people.[161] Within the context of healthcare, internal surveillance by healthcare practitioners can materialize, whereby practitioners become defensive. To avoid blame, under defensive medicine, practitioners are undertaking additional tests, which are often not in the patient's best interests.[162] As evidence, *Cowper* is of the opinion that a blame-culture in the healthcare is not in the public interest, as he argued ''*point the finger' blame response is cheap, easy, quick and ... so is deadly to patient safety*."[163] Blame response, in the absence of listening to the needs of individual practitioners and learning from errors, is deadly to patient safety.[164] Without

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[156] WHO, *Guidance for developing national patient safety policy and strategic plan* (2014) 28.
[157] Emily Jackson, *Medical Law*, Second Edition (Oxford University Press 2010) 153; Shaun D. Pattinson, *Medical Law* (Oxford University Press 2011)144; GMC, *Annual Statistics: Fitness to Practise* (2009) 9 http://www.gmc-uk.org/2009_Annual_Statistics.pdf_33097340.pdf Accessed 26 November 2013.
[158] Oliver Quick, *Regulating Patient Safety: The End of Professional Dominance?* Cambridge University Press (2012) 84,124
[159] IOM, *To Err is Human Error: building a safer health system* (1999) 1
[160] Charles Vincent (n81) 285
[161] Michel Foucault, *Discipline & Punishment: The birth of the prison* (New York: Vintage Books 1977) 195
[162] This process will be considered later under chapter *2.3.1*
[163] Andy Cowper (n116).
[164] Ibid.

appropriate support for healthcare practitioners, the chances of losing self-confidence increases, which ultimately can lead to further adverse events. [165] Overall, under an ideal system transparent and effective accountability mechanisms at both leaders and practitioners' level is assured through the avoidance of a blame culture and defensive medicine.

2.5 Benchmarks of best practice for Improving the Quality of Healthcare

Quality of Healthcare: The *Institute of Medicine* defined healthcare quality as "*the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge*." [166] In order to achieve the desired outcomes and update professional knowledge, continuous improvement is regarded as one of the initiates under the process benchmarking healthcare quality. The *European Observatory on Health System and Policies* identified a number of healthcare quality dimensions including *patient safety, effectiveness, efficiency, access,* and *responsiveness*.[167] Accordingly, the WHO designed *Performance Assessment Tool for Hospital (PATH)* to compare and recommend the best practice of healthcare at international level.[168] The framework below, highlights the six dimensions identified to assess hospital performances. [169] The particular focus of this research is on the dimensions of patient safety and risk management initiatives; professionalization of healthcare practitioners; and the development of health technology.

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[165] Ibid.

[166] Agency of Healthcare Research and Quality, *Understanding quality measurements* (2012) https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/chtoolbx/understand/index.html Accessed 22 June 2017.

[167] Helena Legido-Quigley (n82) 5.

[168] WHO, *PATH – The Performance Assessment tool for quality improvement in hospitals* (2007) 7 http://www.pathqualityproject.eu/what_is_path.html Accessed 19 December 2016

[169] Ibid; J. Veilard et all, *A performance Assessment framework for hospitals: the WHO regional office for Europe PATH project* (2005) 17 Journal for Quality in Healthcare 487.

Figure 7: Performance Assessment Tool

Clinical effectiveness | Efficiency | Staff orientation | Responsive governance

Safety

Patient centerednees

2.5.1 Patient Safety & Risk-management Initiatives

As one of the most important dimensions of healthcare quality,[170] patient safety is defined by the *World Health Organisation*[171] as "*the reduction of risk of unnecessary harm associated with health care*."[172] Accordingly, the *Institute of Medicine* provides that the benchmarks of best practice for patient safety necessitates "*the freedom from accidental injury due to medical care*."[173] Nevertheless, it can be attested that such definition by the IOM is a delusive perception. Due to the complexities in medical practice, it is unfeasible to be free from accidental injuries. Compared to the definition provided by the WHO, it can be argued that the definition by the IOM cannot be entirely accurate for the reason that it is more likely for the risks of unnecessary harm to be reduced.[174]

Medical Errors: The *International Alliance of Patients' Organizations (IAPO)* claim that one in ten patients suffers harm due to medical errors.[175] Consequently, the *Institute of Medicine* claims that at least 44,000 people die as the result of medical errors every

[170] Helena Legido-Quigley (n82) 5,6; Angela Yu (n 74) 6
[171] *The World Health Organisation was established in 1945 and is also known as 'the global guardian of public health' as it is working with 150 countries across the world. The WHO aims to achieve good health for the population and ensure that health services are responsive to the public through the introduction of norms on risk management initiatives.*
[172] WHO, *Definitions of Key Concepts from the WHO Patient Safety Curriculum Guide (2011)*; Kathrin M et al, *Global Research Priorities to Better Understand the Burden of Iatrogenic Harm in Primary Care: An International Delphi Exercise* (2013) 11 PlOS Medicine 2
[173] IOM, *To err is human: building a safer health system* (Washington, DC: National Academy Press; 1999); Helena Legido-Quigley (n82) 5.
[174] Angela Yu (n 74) 6
[175] IAPO, *Patient Safety Toolkit* (2016) https://www.iapo.org.uk/patient-safety-toolkit Accessed 20 December 2016

year.[176] Medical errors are described by the *European Observatory on Healthcare System and Policies* as "*the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim* ..."[177] Adverse drug events, improper transfusions, surgical injuries, and wrong site surgeries are the main examples of the failure of a planned action.[178] Some medical errors, such as adverse drug events including allergic reactions are unavoidable, unless the reaction is known to the healthcare professional.[179] The *Organisation with a Memory* indicate that only in the UK, every year around 10,000 people are experiencing serious adverse reactions to drugs.[180]

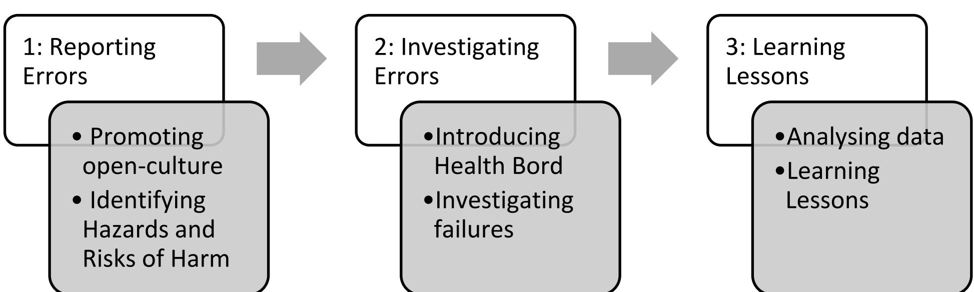
It is arguable that medical errors do not only eventuate from actions but also from omissions. As such, the *Institute of Medicine* recognises three types of medical errors, including: diagnostic error; treatment error; and the omission to provide adequate medical treatment.[181] Unlike diagnostic and treatment errors, which concerns with the provisions of the right quantity of medications at the right time,[182] the final type is not only about the omission to provide adequate treatment, but also about the omission to follow up treatments.[183] Although numerous international patient safety initiatives are undertaken to avoid unnecessary harm to patients,[184] reporting medical errors and risk management through the '*Swiss Cheese Model'* is regarded as the corner stone of patient safety initiatives.[185] The benchmarks of best practice for these initiatives are discussed below.

Reporting System: The importance of the reporting system is recognised globally.[186] This part of the chapter explores the benchmarks of best practice by critically discussing the reporting systems under various jurisdictions. In principle, the reporting system is

[176] IOM, *To Err is Human Error: building a safer health system* (1999) 1
[177] Helena Legido-Quigley (n82) 5.
[178] S O'Mahony, *Medical Nemesis 40 years on: the enduring legacy of Ivan Illich* (2016) J R Coll Physicians Edinb 134.
[179] Basia Kutryba et al, *Patient Safety, Rights and Medication Safety in Primary Care in Poland* (2013) World Health Organisation 77.
[180] Kieran Walshe, Ruth Boaden, *Patient Safety: research into practice* (2006) Open University Press 19
[181] IOM, *To Err is Human Error: building a safer health system* (1999) 2.
[182] Ibid 2; Kieran Walshe, Ruth Boaden (n180) 24.
[183] IOM, *To Err is Human Error: building a safer health system* (1999) 2.
[184] Ellie Rizzo, *100 Patient Safety Benchmarks* (2013) Community Hospital Corporation http://www.beckershospitalreview.com/lists/100-patient-safety-benchmarks.html Accessed 18 September 2016.
[185] Johan Legemaate (n95) 14.
[186] WHO, *Guidance for developing national patient safety policy and strategic plan* (2014) 1.

about encouraging healthcare practitioners to report medical errors for the purposes of learning from mistakes.[187] Accordingly, the WHO provides that "*Intuitive patient safety incident reporting and learning systems, which capture and provide structured learning, are key to improving patient safety and preventing the occurrence of harm.*"[188] Although the WHO provides that the reporting system is a key to improving safety, it does not provide comprehensive explanation and practical guidance. To avoid confusions and to ensure consistencies, under the benchmarks of best practice, the reporting system can be divided into three steps.[189] Each step is presented under the chart below.

Figure 8: Reporting System



Step 1: Reporting Errors: This involves the imposition of a duty of candour on healthcare practitioners to act in an open and honest manner for the purpose of detecting poor practices. [190] The duty of candour does not only apply to the practitioner's own errors but it also applies to the process of raising concerns about workplace and colleagues' failings (which is known also as whistleblowing).[191] Under the benchmark of best practice an effective reporting system is ensured through the promotion of an open-culture, whereby healthcare practitioners are encouraged to actively report medical errors.[192] In order to guarantee an open-culture, the concept of *"safe space"* has been

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[187] Ibid.
[188] WHO, *Reporting and learning systems: Patient safety incident reporting and learning systems* (2006) https://www.who.int/patientsafety/topics/reporting-learning/en/ 12 March 2020.
[189] WHO, *WHO Draft Guidelines for adverse event reporting and learning systems* (2005) 13
[190] GMC, *The new guide: What to expect from your doctor* (2013) recommendations 173; Hannah Blythe, *Regulating the duty of candour*, AvMA (2016) https://www.avma.org.uk/?download_protected_attachment=Regulating-the-duty-of-candour.pdf Accessed 19 December 2016.
[191] Susan Moloney (n153) 2.
[192] Bruce Keogh (n118) 29.

introduced by the *UK Department of Health* to guarantee an open-culture - reported information (and the identity of the person reporting it) is kept confidential.[193]

Although various approaches to the reporting system are taken under different jurisdictions, the best approach is to impose a duty of candour or even a mandatory duty on healthcare practitioners to report medical errors. Evidence indicates that in the USA due to the introduction of mandatory reporting system by *the USA IOM*, the number of deaths is reduced by 50,000.[194] Furthermore, due to the existence of statutory duties to report medical errors, evidence indicates that in *Denmark* practitioners are actively reporting medical errors.[195]

Step 2: Investigating Errors: This step involves the introduction of relevant authorities to oversee the process of reporting medical errors and identify the causes of medical errors.[196] Professional regulatory authorities have an important role within the process of investigating and monitoring the reported failures.[197] In the USA, even if the patient does not take action, risk managers have a duty to investigate patient's file after serious incidents.[198] Under the investigation process, all healthcare professionals involved in the incident are questioned to gain comprehensive information about such failure.[199] In a prominent example, *the UK Organisation with a Memory (OWAM)* [200] and *the Australian Patient Safety Foundation (APSF)* were introduced to ensure the process of monitoring and reporting system.[201] Moreover, in *Africa*, *Patient Safety Information System* was

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[193] Department of Health, *Providing a 'safe space' in healthcare safety investigations* (2016) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/560522/Safe_spaces_cons.pdf Accessed 19 December 2016; Andy Cowper (n116); Bruce Keogh (n118) 29.
[194] IOM, *To Err is Human Error: building a safer health system* (1999) 3; Angela Yu (n 74) 8.
[195] Johan Legemaate (n95) 12
[196] Department of Health, *An organisation with a memory* (2009) The National Archives http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Aboutus/MinistersandDepartmentLeaders/ChiefMedicalOfficer/ProgressOnPolicy/ProgressBrowsableDocument/DH_5016613 Accessed 30 October 2016
[197] IOM, *To Err is Human Error: building a safer health system* (1999) 3; The National Audit Office Press Notice, *A Safer Place for Patients: Learning to improve patient safety* (2005).
[198] WHO, *WHO Draft Guidelines for adverse event reporting and learning systems* (2005) 35.
[199] Ibid.
[200] Department of Health, *Safety First: A report for patients, clinicians and healthcare managers* (2006) http://webarchive.nationalarchives.gov.uk/20130104224441/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_062848 Accessed 12 July 2017.
[201] W B Runciman, *Lessons from the Australian Patient Safety Foundation: setting up a national patient safety surveillance system—is this the right model?* (2002) Qual Saf Health 246.

introduced for the purpose of recoding the information relating to medical misadventure to ensure effective risk management system.[202]

Step 3: Evaluating Information and Learning from Mistakes: Further to the process of recording information and investigating the failures, the third step involves the evaluation the findings to learn from mistakes and prevent medical errors from re-occurring.[203] Under the evaluation process certain factors such as mortality rates; patient's care; safety measures; and workforce on medical practitioners are taken into account.[204] As suggested by Angela, the evaluation of such factors leads to a better clinical oversight and recommendations for potential solutions.[205] For instance, it enables the investigators to identify whether doctors (particularly junior doctors) are managed sufficiently and whether safety equipment checks are adequate in certain departments of healthcare providers. Nevertheless, the process of evaluating information is only effective and the findings are reliable provided that those authorities who are investigating the failures have completed specific training courses on root cause analysis of incidents.

Numerous national and international organizations and foundations are established for the purposes of safeguarding the best practice of healthcare through collaboration and recommendation for potential solutions. In a prominent example, *The Health Foundation* recommended that successful implementation of a reporting system is achieved through the existence of health boards to investigate and evaluate the recorded data.[206] Furthermore, the *Patient Safety Friendly Hospital Initiatives (PSFHI)* was introduced by the WHO which recommended a total 140 of standards on patient safety domains, leadership, management, evidence-based practices, patient and family involvement.[207] Such standards were recommended to minimise risks of medical misadventure. In addition to the PSFHI, the *World Alliance for Patient Safety* had also recommended specific guidelines to trigger and conduct in-depth investigation and

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[202] WHO, *Report on the Regional Consultation on improving quality of care and patient safety in the Eastern Mediterranean Region* (2014) Jeddah Saudi Arabia 14.

[203] John Tingle (n118) 11; Donaldson LJ, Scally G (n115) 1725-1727.

[204] Bruce Keogh (n118).

[205] Angela Yu (n 74) 24.

[206] The Health Foundation, *Culture and Leadership* (2015) http://patientsafety.health.org.uk/area-of-care/safety-management/culture-and-leadership Accessed 2 July 2015

[207] WHO (174) 3; WHO, *The global guardian of public health* (2016); J. Veilard et all, *A performance Assessment framework for hospitals: the WHO regional office for Europe PATH project* (2005) Journal for Quality in Healthcare 487.

evaluation of the reported failures. [208] As suggested by the *WHO*, under the benchmarks of best practice and following the evaluation of reported data, lessons are learned by generating alerts about new hazards and communicating it to the healthcare practitioners for the purpose of learning from mistakes.[209]

The Swiss Cheese Model: In addition to the reporting system, the '*Swiss Cheese Model of Accident Causation'* was proposed by *James Reason [a British psychologist]* which demonstrates the stages between hazard and harm to patients.[210]

Figure 9: Swiss Cheese Model

James Reason, *Human error: models and management*, British Medical Journal, 2000, 320:768–70

As it can be seen on the model above, each slice of cheese is a protective factor which can reduce the likelihood of an incident occurring and the holes in the cheese are the gaps or failures in the expected practice. [211] Under the benchmark of best practice, each protective factor has the effect of preventing hazards to pass through the holes and cause harm to patients. According to *Reason*, the first protective factor relates to effective management of workload to ensure that patients are seen by the relevant healthcare practitioner at the right time. The second protective factor is about information analysis whereby each step of medical interventions is recorded and is accessible to ensure follow-ups. The third protective factor involves comprehensive analysis of potential risks of harm by reviewing the recorded information of medical intervention. Under the fourth protective factor, care planning is updated and completed to reflect the needs of

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[208] WHO, *WHO Draft Guidelines for adverse event reporting and learning systems* (2005) 8-12
[209] WHO, *WHO Draft Guidelines for adverse event reporting and learning systems* (2005)13
[210] Reason J. *Human error: models and management* (2000) British Medical Journal 768–70
[211] Thomas V Perneger, *The Swiss cheese model of safety incidents: are there holes in the metaphor?* (2005) 71 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1298298/ Accessed 05 July 2017.

individual patients. The final protective factor focuses on effective verbal communication between doctors and patients about future plans and follow-ups.[212]

International Legal Provisions: Additionally, the *Council of Europe* imposed a duty on the member states of European Union (under the *European Convention on the Protection of Human Rights and Fundamental Freedoms 1953 (ECHR))* to guarantee the civil rights such as the right to life,[213] the prevention of inhuman or degrading treatment; and the right to private life.[214] It can be argued that patient safety measures are important for compliance with the ECHR in some contexts, not least because it contains a duty to protect life under *Article 2* ,[215] but it also contains a duty to avoid torture and inhuman degrading treatment under Article 3; [216] a duty to safeguard physical and mental integrity;[217] and autonomy via the right to private life within Article 8 ECHR. Safe treatment has also proven to be cost-effective. As evidence, Salford's Chief Executive *(Sir David Dalton)*, concluded that since 2008 his trust saved about £5m and 25,000 beds following the implementation of effective safety measures.[218] This has a positive impact on healthcare quality, as the money saved can be used for the improvements of healthcare quality such as the professionalisation of healthcare practitioners through education and training courses. Overall, it can be averred that an ideal health system involves the process of patient safety measures including reporting failures and learning from mistakes.

2.5.2 Professionalisation of Healthcare Practitioners

Professionalising healthcare practitioners is one of the most important patient safety initiatives as it enhances practitioner's knowledge and develops medical practitioners' capabilities during the process of medical intervention. [219] Medical practitioners are perceived to be the most trusted professions amongst the public and they are expected to

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[212] Ibid.
[213] European Convention on the Protection of Human Rights and Fundamental Freedoms 1953 (ECHR) art 2
[214] Ibid Art 3.
[215] Ilhan v Turkey [2000] (Application no. 22277/93); ECHR art 2.
[216] Jonathan Cohen and Tamar Ezer, *Human rights in patient care: A theoretical and practical framework* (2013)
[217] Andy Cowper (n116). See, for example, *Pentiacova and Others v Moldova (2002)*, *Sentges v Netherlands [2003], and in R (Tracey) v Cambridge University Hospitals [2014].*
[218] Andy Cowper (n116).
[219] Judith Allsop (n95) 91; John Tingle (n118) 11-12.

possess high degree of skills within the process of medical intervention.[220] According to the *Royal College of Physician,* medical professionalism is ''*a set of values, behaviours, and relationships that underpins the trust the public has in doctors*."[221] Although it is absolutely correct that professionalisation underpins public trust in doctors, such a definition fails to acknowledge the potential implications of professionalisation on the confidence of individual practitioners. A more comprehensive definition is provided by the *American Board of Medical Specialty* as they provide that medical professionalism is *"a belief system in which group members ("professionals") declare ("profess") to each other and the public the shared competency standards and ethical values they promise to uphold in their work and what the public and individual patients can and should expect from medical professionals."*[222] As such, it can be argued that the benchmarks of best practice on professionalisation consists of three pillars 1) the expectation of the public in healthcare professionals acting in patient's best interests 2) having the knowledge and skills to act in accordance to the expected standards 3) effective interpersonal skills within doctor-patient relationship. The benchmarks of best practice in relation to each of the aforementioned pillars are discussed below.

Education and training: Medical professionalism through education and training can ensure compliance with the aforementioned pillars. In other words, enhancing medical practitioners' knowledge through education and training can lead to higher quality of care and have the potential of increasing trust public in the health sector. This is broadly the position of the *Medical Protection Society (MPS)* which notes that it can also foster performance, increase the chances of having an effective and modern health system culture, enhance partnerships within healthcare teams and not only heighten knowledge but the patient-centredness of care.[223]

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[220] Judith Allsop (n95) 19.
[221] Royal College of Physicians, *Doctors in Society: Medical Professionalism in a Changing World* (2005).
[222] American Board of Medical Speciality, *ABMS Definition of Medical Professionalism* (2012) https://www.abms.org/media/84742/abms-definition-of-medical-professionalism.pdf 12 July 2020; WHO, *Exploring patient participation in reducing healthcare related safety risks* (2013) 4 file:///C:/Users/MEDION/Downloads/Documents/e96814.pdf Accessed 3 June 2017
[223] Medical Protection Society, *Professionalism - What does it look like?* (2015) http://www.medicalprotection.org/uk/advice-booklets/professionalism-an-mps-guide/chapter-2-professionalism-what-does-it-look-like Accessed 28 June 2015.

Professional self-regulation: Whilst knowledge is important, the extent to which someone can clinically reason when drawing on their own knowledge and consider patient's clinical situation makes for a distinction in the quality of practice. Within this context, health practitioner's ability to control its actions and think through situations before choosing how to react, can also lead to emotional self-control and self-regulation. Health practitioner's potentiality to self-regulate actions have a positive impact on the quality of healthcare as emotional self-regulations enables practitioners to act ethically.

Training and education are critical to professionalisation, as training has the effect of enhancing organisational coherence and it enables healthcare practitioners to demonstrate evidence-based knowledge. Although the provision of training and education is expensive,[224] it keeps healthcare practitioner's knowledge up-to-date,[225] and it leads to the public recognition of healthcare quality within the hospitals.[226] In addition to education and training, healthcare practitioners are professionalised by attending international conferences for the purpose of learning from others and improve medical-related knowledge.[227] Under the benchmarks of best practice, healthcare practitioners are professionalised via web-based e-learning programmes and training courses by councils, associations and unions.[228]

National / International Health Organisations Initiatives: The importance of achieving highest attainable standards through professionalisation are acknowledged at both national and international levels. For instance, in *Ukraine,* educational events are recommended to enhance the skills of healthcare practitioners.[229] Furthermore, a research study conducted in *Uganda* concluded that professionalisation can lead to confidence, self-esteem and better care to patients.[230] Essentially, under *the European Convention on Human Rights and Biomedicine* and under *the International Covenant on Economic,*

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[224] Segouin, Hoges and Brechart, *Globalization in the healthcare: is international standardization of quality a step towards outsourcing?* (2005) International Journal for Quality in the Healthcare 278; Bruce Keogh (n118).
[225] Segouin, Hoges and Brechart (n226) 278; Judith Allsop (n95) 88.
[226] Helena Legido-Quigley (n82) 32.
[227] WHO, *Report on the Regional Consultation on improving quality of care and patient safety in the Eastern Mediterranean Region* (2014) Jeddah Saudi Arabia 9.
[228] Judith Allsop (n95) 154
[229] International Renaissance Foundation, Abridged Report on 2008 Activities (2008) 14. http://www.irf.ua/files/eng/projects_re_1733_en_PR.pdf Accessed 6 December 2013.
[230] Clare I R Chandler et all, *Aspirations for quality health care in Uganda: How do we get there?* (2013) 10 Hum Resour Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3610284/ 16 July 2019

Social and Cultural Rights a legal duty is imposed on the healthcare providers to reach highest attainable standards through professionalising healthcare practitioners.[231] Additionally, the *World Health Organisation* claims that healthcare providers have an important role in ensuring the highest attainable standard of care through the identification of priority needs and the introduction of pragmatic approach for the improvement of healthcare quality.[232] Additionally, under a patient safety and strategy plan the *WHO* acknowledges that training and education decreases chances of medical errors, adverse effects and drug misuse.[233]

Accreditation Programmes: In addition to the education and training courses, certification under accreditation programmes enables healthcare practitioners to set up common principles and share best practices.[234] As the overall aim of accreditation programs is to globalise healthcare by creating international uniformity.[235] Globalisation has been described as "*the circulation of goods and services between countries in response to criteria of efficiency*."[236] Accreditation programs are examples of the circulation of the services whereby healthcare providers under different jurisdictions are working jointly to exchange experiences; share best practices in quality of health; and identify potential solutions.[237] Under an ideal system, accreditation courses are improving clinical outcomes and increasing standards of care by clearly addressing and systematically reviewing the quality of healthcare.[238]

Various international organisations are introduced to formalise accreditation programmes.[239] In a prominent example, the *International Society for Quality in*

[231] European Convention on Human Rights and Biomedicine [1997] art 4; United Nations, *International Covenant on Economic, Social and Cultural Rights 1976* (1996) http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx Accessed 11 December 2016.
[232] WHO, *Safer Primary Care* (2014) http://www.who.int/patientsafety/safer_primary_care/en/ Accessed 20 March 2014; Judith Allsop (n95) 88
[233] WHO, *Guidance for developing national patient safety policy and strategic plan* (2014) 11, 28.
[234] Under the professionalization of healthcare practitioners.
[235] E. Heidemann, *The ALPHA Program* (1999) International Journal for the Quality in Healthcare 275.
[236] Yu-Chuan (Jack) Li, *Globalization in health care: is international standardization of quality a step toward outsourcing?* (2005) International Journal for Quality in Health Care 227.
[237] Joint Commission International, *about JCI* (2016) http://www.jointcommissioninternational.org/about/ Accessed 2 November 2016; Directive 2011/24/EU of the European Parliament and of the Council [2011] art 3 (e); Judith Allsop (n95) 21.
[238] Abdullah Alkhenizan, Charles Shaw, *Impact of Accreditation on the Quality of Healthcare Services: a Systematic Review of the Literature* (2011) Ann Saudi Med 407.
[239] ISQUA, *Who we are?* (2017) http://www.isqua.org/who-we-are/who-we-are Accessed 23 May 2017; WHO, *Guidance for developing national patient safety policy and strategic plan* (2014) 9.

Healthcare (ISQUA) and its agenda known as *Agenda for leadership in Programs for Healthcare Accreditation (ALPHA)* were introduced to establish a Council of Accreditation at international level.[240] Accreditation programs are becoming more common in the Middle East countries. For instance, the healthcare providers of a number of countries such as *Jordan* and *Saudi-Arabia* are accredited by the *ISQUA*.[241] The *Quality Improvement and Patient Safety Organisation* in *Jordan* attained *ISQUA* accreditation and healthcare professionals are certified under his programme.[242] In order to ensure the accreditation of healthcare providers and the certification of healthcare professionals, the *Quality Improvement and Patient Safety Organisation* in *Jordan* consists of two departments including *Surveys and Standards Development Department* and *Education and Consultation Department*.[243] Furthermore, under the African healthcare system, *the Council of Health Service Accreditation (COHSA)* is established to achieve multi-disciplinary standards through web-based information system, whereby practitioners have continuous access to relevant information.[244]

Having discussed the practices under various jurisdictions, it can be argued that under the benchmark of best practice, healthcare practitioners are professionalised not only through education, training courses, regulation, but also through international accreditation initiatives.[245] Additionally, the accreditation programmes are successfully implemented through accreditation policies, courses and healthcare providers are certified for adapting new technological developments.[246] Essentially, accreditation policies aim to clarify the objectives of accreditation programmes, and imposes duties on practitioners to completed the programme.[247]

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[240] E. Heidemann (n236) 275.

[241] WHO, *Report on the Regional Consultation on improving quality of care and patient safety in the Eastern Mediterranean Region* (2014) Jeddah Saudi Arabia 5-9.

[242] Ibid 11.

[243] ISQUA, *Benefits of ISQua's International Accreditation Programme (IAP)* (2017) http://www.isqua.org/accreditation-iap/benefits-of-the-iap Accessed 21 May 2017

[244] WHO, *Report on the Regional Consultation on improving quality of care and patient safety in the Eastern Mediterranean Region* (2014) Jeddah Saudi Arabia 11.

[245] Ibid 9.

[246] Ibid 11.

[247] Ibid 8.

2.5.3 Developing Health Technology

Electronic Health Records (EHR): As a sub-dimension of patient safety, electronic health record plays a critical role within the process of recording patient's medical data and providing an overview of patient's medical history.[248] Over the last years, under a number of jurisdictions, there is increasingly a shift from paper-based health records to electronic health records, whereby patient's medical information is saved on an electronic data system to ensure immediate access to patient's medical data and treat those patients in critical conditions within a reasonable time. As evidence, a research conducted by the *Agency for Healthcare Research and Quality (AHRQ)* concluded that "*computerising and mining patient data increases opportunities for process and performance improvement...*"[249] Although such conclusion fails to specify the obstacles in successfully implementing electronic health records, it correctly suggests that it can improve healthcare and in some cases save patients from serious harm by reducing delay in access to medical information.

Although EHR is more common in developed countries, in the UK external access of electronic medical records between hospitals and clinics are limited and paper-based medical prescriptions are still common practice. By contrast, the Netherlands adopts a digitally advanced approach, including the use of electronic medical prescriptions (e-prescription).[250] Under the benchmark of best practice, EHR programme is introduced without the need to follow complex steps. Furthermore, the imposition of a duty to attend relevant staff development sessions and training courses enables the healthcare practitioners to detect errors under electronic health reports.[251] Although the imposition of a duty to attend relevant training can be costly and time-consuming, it aims to minimise errors by ensuring the process of storing accurate information on computer databases.[252] Additionally, under an ideal system, in-patient and out-patient medical

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[248] Priyadarshini R. Pennathur et al, *Provider workforce and patient care: impact of electronic health information systems* (2015) 996.
[249] Handel, D. A., Wears, R. L., Nathanson, L. A., & Pines, J. M. *Using information technology to improve the quality and safety of emergency care* (2011) Academic Emergency Medicine.
[250] Dutch Healthcare, *Electronic Prescribing* (2011) https://dutchhealthcare.wordpress.com/2011/06/22/electronic-prescribing/ [accessed 10/10/16]
[251] Priyadarshini R. Pennathur (n249) 996
[252] Ibid.

records are merged in one comprehensive medical record to allow effective cross communication and are reviewed on regular bases to avoid errors.[253]

Protection of confidential information: To protect patient's confidential information, measures should not just be taken to train staff in relevant ethics standards but also to ensure that robust data security defences are in place. It has been argued that these measures should extend to draw on the support of special security agencies such as the *National Cyber Security Centre (NCSC)* to defend against cyber attacks carried out by individuals, groups and states.[254] The protection of patient's confidential information is required as a matter of human rights. In the European context, for example, it is protected not just by specific national and European rules but also under Art.8 ECHR. [255] Confidentiality also relies on the appropriate organisation and utilization of health spaces, such as provision for private consultation rooms and other privacy measures necessary for both actually protecting private information and fostering open communication on matters of concern.

Design-based regulation: Having considered the increasing role of health technology in promoting safe practice and protecting confidential information in healthcare, it is crucial to emphasise that technology has now become a regulatory strategy.[256] As suggested by *Yeung and Dixon-wood*, design-based regulations can discourage certain behaviour through the use of technical constraints to stop actions.[257] More specifically, design-based regulatory strategy is about a process whereby technological devices are used as a mode of regulation, whereby specific rules in the form of step-to-step guidance are followed by healthcare professionals whilst using medical devices. For instance, decontamination devices or single use devices are regulating healthcare practice by preventing other options of healthcare practice for the purpose of ensuring a safe environment for patients.

Essentially, *Karen Yeung* adds that 'algorithmic accountability' can lead to successful implementation of such rules by healthcare practitioners as she argues *"Although*

[253] Kathrin M Cresswell, David W Bates, Aziz Sheikh, *Ten key considerations for the successful optimization of large-scale health information technology* (2017) J Am Med Inform Assoc.
[254] Krishna Chinthapalli, *The hackers holding hospitals to ransom* (2017) British Medical Journal 357
[255] CSOMA v. ROMANIA (Application no. 8759/05) [2013].
[256] Karen Yeung, Mary Dixon-Woods, *Design-based regulation and patient safety: A regulatory studies perspective* (2010) Social Science and Medicine, 503
[257] Ibid 503

algorithms need not be implemented in software, computers are fundamentally algorithm machines, designed to store and read data, apply mathematical procedures to data in a controlled fashion, and offer new information as the output."[258] This method accountability is relevant in the context of the thesis as it is about imposing responsibilities on practitioners to follow a set of rules relating to technological devices.

2.6 Benchmarks of Best Practice for Patient-centred Care

Getting Patients Involved: This key component of health system governance, aims to respond to the patient's needs by not only allowing patients to engage with clinical processes but under this process patients are also allowed to be engaged in managing their own health.[259] Patient-centred care is acknowledged from the historical times of the "Hippocratic Oath," whereby healthcare practitioners are required to undertake an oath that they uphold ethical standards by acting in their patient's best interests.[260] Nowadays, the importance of Hippocratic oath is further highlighted and adopted by the *World Medical Association (WMA)*.[261] The concept of best interest can be understood in two ways: long-term and short term understanding. *Trau* and *McCartney* have described such understanding in the following way:

> *"The long-term understanding of best interest refers to the balance of benefits and burdens with respect to the ultimate goals or purposes of a community within which an individual is situated; short-term best interest refers to that balance with respect to a specific healthcare decision, without reference to the overall situation."*[262]

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[258] Karen Yeung, *Algorithmic regulation: A critical interrogation* (2018) Regulation & Governance 506.
[259] Robert Francis, *The report of Mid Staffordshire NHS Trust Public Inquiry: Executive Summary* (2013) http://webarchive.nationalarchives.gov.uk/20150407084231/http://www.midstaffspublicinquiry.com/report Accessed 18 July 2017; Helena Legido-Quigley (n82); Royal College of Nursing, *A key part of patient centred care is allowing people to engage in their own health and help design health systems. Learn about the four areas where patients are getting involved* (2020) https://www.rcn.org.uk/clinical-topics/clinical-governance/patient-focus 9 February 2020
[260] WHO, *Exploring patient participation in reducing healthcare related safety risks* (2013) 1
[261] Michael Cook, *World Medical Association to revise 'Hippocratic Oath"* (2016) BioEdge https://www.bioedge.org/bioethics/world-medical-association-to-revise-hippocratic-oath/11760 Accessed 26 June 2017; WHO, *Health Systems*, 2017 https://www.wma.net/what-we-do/health-systems/ Accessed 26 July 2017.
[262] Trau JM1, McCartney JJ. *In the best interest of the patient. Applying this standard to healthcare decision making must be done in a community context* (1993) 74(3) 50 Health Progress.

Balancing the benefits and burdens of patients whilst taking the goals and purposes of a community into account can lead to decisions that would not be preferable to patients at times. Nevertheless, it will have the potential long-term benefits, which sheds the light of the benchmarks of best practice for a patient-centred care. Although when it comes to the conflicts of institutional and patients' interests, the pragmatic approach under patient centred care is to allow the patients best interests to have priority over any other interests. Additionally, various international organisations such as the *International Alliance of Patients' Organization (IAPO)* (with 276 member organizations from 71 countries) is claiming that cross-sector alliances and collaborative working have a critical impact on better care for patients.[263] According to the *IAPO*, global patient's congress raises awareness relating to the latest developments on patient-centred care through effective interpersonal connections between doctors and patients.[264] This part of chapter two will consider the benchmarks of best practice for the sub-quality component of patient-centred care, including: effective interpersonal connections; access to the healthcare; and patient's right to request redress.

2.6.1 Effective interpersonal connections

Nowadays, effective doctor-patient become the focus of attention by numerous national and international organisations. For instance, the *American Institute for Healthcare* has provided guidelines to healthcare professionals to take patient's educational back-grounds, skills and belief into account during the process of medical intervention.[265] Further, the *IAPO* and the *Royal College of Surgeons* are emphasising the importance of communicating medical information in a clear and understanding manner to those patients who lack competency or health literacy.[266] The *WHO* provides that health literacy is about "*the cognitive and social skills that determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote*

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[263] IAPO, *Who we are?* (2016) https://www.iapo.org.uk/who-we-are 20 December 2016.
[264] Ibid; Judith Allsop (n95) 20-21; Yu-Chuan (Jack) Li (n236) 227.
[265] American Institute for Healthcare, *Guide to Patient and Family Engagement* (2012) https://www.ahrq.gov/research/findings/final-reports/ptfamilyscan/ptfamilyex1.html Accessed 26 June 2017.
[266] IAPO, Addressing Global Patient Safety Issues: an Advocacy Toolkit for Patient Organizations (London 2008) 28-29 https://www.iapo.org.uk/sites/default/files/files/IAPO%20Patient%20Safety%20Toolkit%20Main.pdf Accessed 22 December 2016; Royal college of surgeons, *consent: Supported Decision-Making, a guide to good practice* (2016) 20.

and maintain good health"[267] As such it is arguable that often the population in developing countries do not have access to public health education, thus, such class of people need sufficient clarification of medical information. Nevertheless, due to lack of essential resources under most jurisdictions, the imposition of duties on healthcare practitioners to make more time and provide further clarification can be impossible and unrealistic. Predominantly, a number of initiatives are taken to promote patient-centred case and ensure effective relationship between doctors and patients. Examples of such initiatives are discussed below.

International Legal Provisions: An abundance of measures is taken globally to increase the involvement of patients and their families within the decision-making process. Such measures include the imposition of duties under the international legal provision to get patients and their families involved within the process of medical decisions.[268] For instance, *Article 5 ECHB* imposes a legal duty on healthcare practitioners to obtain informed consent from the patients prior to medical intervention.[269] Further, Article 8 ECHR aims to protect individuals right to private life by imposing a duty on relevant authorities of member states to respect individuals rights of self-determination.[270] These legal provisions imply that the failure to disclose relevant information can lead to legal actions against healthcare practitioners. In this context, the disclosure of medical information includes the process of making patients are aware of alternative treatment choices,[271] and providing the opportunity to choose which of the recommended and available options the patient prefers.[272]

Shared Decision-making (SDM): Taking the literal meaning of SDM would indicate that clinical decisions are shared between healthcare practitioners and patients including their families. Nevertheless, due to the acquired medical knowledge by healthcare

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[267] WHO, *Health promotion glossary* (1998).
[268] Council of Europe, *Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine* (1997) European Treaty Series 3 https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=090000168007cf98 Accessed 13 December 2016.
[269] European Convention on Human Rights and Biomedicine [1997] Art 5; Vahan Bournazian et al, *Human Rights in Patient's Care: A Practitioner Guide* (2016) http://www.healthrights.am/docs/pg_eng.pdf Accessed 26 June 2017.
[270] European Convention of Human Rights, Article 8; Jonathan Cohen and Tamar Ezer (n216).
[271] Montgomery v Lanarkshire Health Board [2015] UKSC 11
[272] Catherine Hambley, *Six Keys to Effective Physician-Patient Interactions* (2015) Physicians practice http://www.physicianspractice.com/patient-relations/six-keys-effective-physician-patient-interactions Accessed 19 October 2016.

practitioners, it is almost impossible to equally share one decision between doctors and patients. Though, such shared approach is not realistic, it has nevertheless become the centre for discussion in recent times. A number of non-state actors, including the *Health Foundation,* the *Informed Medical Decisions Organisations* and the *IAPO* claim that under the approach of *SDM* practitioners are actively engaging patients and their families in the process of decision making by guiding them to the best treatment available.[273] More specifically, according to the *IAPO*, such shared approach encourages collaborative process, whereby healthcare practitioners are working side-by-side. In other words, under this process healthcare practitioners are routinely engaging patients and their families in the decision-making process.[274] Notwithstanding, the above explanation makes no attempt to address the level of knowledge by practitioners and fails to distinguish between shared and supportive decision-making. As suggested by *Garwood-Gowers,* working side-by-side and engaging healthcare practitioners into clinical decision-making process do not imply equal shared decision-making and appear to fall within the definition of supportive decision-making.[275]

Supportive Decision-making: Further to the limitation relating to *"shared decision-making,"* the *Royal College of Surgeons* introduced "s*upported decision-making."*[276] Instead of sharing clinical decisions, which is realistically impracticable, supportive decision-making shows alignment with the legal duties of healthcare practitioners to obtain informed consent from patients and their families.[277] The key steps underpinning the consent process under *"supported decision-making"* are the disclosure of relevant information; the understanding patient's views and values; the explaining of material risks of each medical option; recording patient's decisions to ensure evidence-based practice.[278] More specifically, the *Royal College of Surgeons* is claiming that patients are

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[273] IAPO (n266) 28-29; The Health Foundation, *Shared Decision Making* (2015) http://personcentredcare.health.org.uk/person-centred-care/shared-decision-making/?gclid=CPzovvGNx8cCFSUOwwodsycNBQ Accessed 26 August 2015; Johan Legemaate (n95) 24.

[274] IAPO (n266) 28-29; The Health Foundation, *Shared Decision Making* (2015) http://personcentredcare.health.org.uk/person-centred-care/shared-decision-making/?gclid=CPzovvGNx8cCFSUOwwodsycNBQ Accessed 26 August 2015.

[275] Austen Garwood-Gowers and S. Olsena, *Informed Consent,* European Compendium of Health Law (A. den Exter ed. Maklu 2017) 67.

[276] Royal college of surgeons (n266) 4.

[277] Royal college of surgeons (n266) 4; M. B. Simmons, and P. M. Gooding, *Spot the difference: shared decision-making and supported decision-making in mental health,* Irish Journal of Psychological Medicine (2017) 283.

[278] Simmons and Gooding (n278) 283.

sufficiently informed through the explanation of the nature of their medical condition; possible side-effects of the proposed treatment; alternative treatments; and potential implications of no medical treatments.[279] In cases concerning incompetent patients, healthcare practitioners are expected to engage with the patient's representatives including family members to obtain informed consent and comply with legal duties.[280]

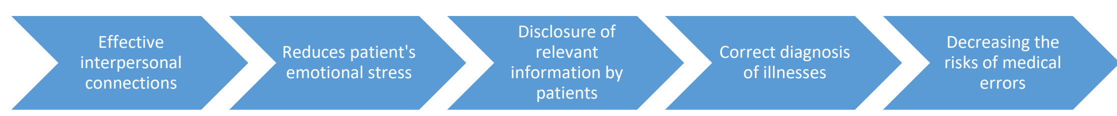
Overall, it can be argued that supportive decision-making is more applicable within the healthcare context. Under the benchmarks of best practice, the existence of collaborative and supportive relationship increases the chances of communicating relevant information; explaining potential side effects; respecting patient's preferences; giving emotional support, and physical comfort.[281] Particularly, collaborative and supportive relationship help healthcare practitioners to identify key behaviours, culminate greater satisfaction by patients, and ensure better overall experiences and outcomes.

Impact of Effective Doctor-Patient Relationship: It can be averred that effective doctor-patient relationship can lead to the reduction of medical errors within the healthcare providers. As indicated under figure 10, proficient doctor-patient interactions can reduce patient's emotional stress, which can ultimately lead to trust and the disclose relevant information.[282] The disclosure of relevant information by patients aid open communication which can increase chances of correct diagnosis of patient's medical condition and can minimise risks of medical errors.[283] As evidence, a study conducted in *China* concluded that "*Better doctor patient communication was shown to be associated with better emotional and physical health, higher symptom resolution, and better control of chronic diseases*."[284] This has further been confirmed by the WHO as it was concluded that patient's involvement within the decision-making process have a positive impact on health outcome.[285] As evidence indicates that those patients who are made aware of the potential risks through consultations, they are more likely to adopt the recommended

[279] Ibid.
[280] WHO, *Exploring patient participation in reducing healthcare related safety risks* (2013) 21; Charles Foster, Jonathan Herring, *Human Thriving and the Law* (Springerbriefs, 2018) 2.
[281] Robert Francis (n260); Helena Legido-Quigley (n82) 7; Catherine Hambley (n273).
[282] Clare I R Chandler (n231) 9.
[283] Samuel YS Wong, Albert Lee, *Communication Skills and Doctor Patient Relationship* (2006) 7 http://www.fmshk.org/database/articles/607.pdf Accessed 19 October 2016.
[284] Ibid.
[285] WHO, *Exploring patient participation in reducing healthcare related safety risks* (2013) 4, 18.

behaviours and deal better with unexpected events.[286] The impact of effective interpersonal connections on medical errors has illustrated below under figure 10.

Figure 10: Impact of Patient's involvement in Decision-making



The ethical implications: within the context of effective interpersonal connection between doctors and patients, the most relevant ethical principles are autonomy and paternalism. Following the Nuremberg Trials (in the Mid-twentieth century), patient's autonomy became a fundamental part of patient-centric approach, which is originally designed to shift away from a paternalistic approach.[287] The aim of patient's autonomy is to ensure patients' rights of self-determination is described as ''*allowing or enabling patients to make their own decisions about which health care interventions they will or will not receive*.''[288] Although, enabling patients to make their own decisions complies with the discourse of paternalism, due to medical knowledge it is eventually for health practitioners to decide whether or not to allow patients to make decisions.

Accordingly, due to the involvement of medical professionals within the decision-making process, the ethical principle of autonomy does not outweigh paternalism. Contestably, the latter is lightened as nowadays under a number of jurisdictions (including the UK), the majority of patients are no longer putting a blind trust into healthcare practitioner's knowledge to make decisions on their behalf. Due to the existence of 'supportive decision-making' and due to the imposition of a legal and an ethical duty to seek informed consent, patient's or their families are increasingly engaged within the process of decision making prior to the proposed medical intervention.

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[286] Kathrin M (n254) 2.

[287] Suhas Chandran, MD, *Paternalism vs autonomy: Why watching our words is important* (2019) https://mdedge-files-live.s3.us-east-2.amazonaws.com/files/s3fs-public/CP01805e3.PDF 5 August 2019; Medical Protection Society, *The end of Paternalism* (2017) http://www.medicalprotection.org/uk/advice-booklets/mps-guide-to-ethics---a-map-for-the-moral-maze/chapter-1---ethics-values-and-the-law/the-end-of-paternalism Accessed 2 June 2017.

[288] Vikki A. Entwistle et al, *Supporting Patient Autonomy: The Importance of Clinician-patient Relationships* (2010) J Gen Intern Med. 741–745.

2.6.2 Access to Healthcare

In addition to effective inter-personal connections, patients' rights to access healthcare is also known as an essential sub-component for patient-centred approach. Access to the healthcare has been described by the *WHO Regional Office for Europe* as "*the proportion of a given population in need of health services that can obtain them.*"[289] Due to the existence of limited resources within healthcare providers, the proportion of a given population cannot unfailingly obtain healthcare services.[290]

Measures to ensure access to the healthcare: The *WHO* is claiming that an ideal healthcare system is accessible and citizens are entitled to healthcare depending on various factors including the availability of resources.[291] In agreement with *Andre Den Exter*, although patients are unable to claim the right to be healthy, the recognition of healthcare as a right creates state obligations to provide access to healthcare as a basic human right.[292] Such rights to healthcare is globally recognised as under International and European Union Laws, including *Universal Declaration of Human Rights (Art.25); International Covenant on Economic, Social and Cultural Rights (ICESCR); Council of Europe: European Social Charter (Art.11); Convention on Human Rights and Biomedicine (Art.3),* and *the European Union's Human Rights Charter (Article 35)*.[293] Notwithstanding, due to issues relating to limited resources, the formal recognition of individuals right to healthcare, does not provide patients the right to demand medical treatment.[294]

To address the issues relating to limited resources and ensure that the proportion of a given population can obtain health services, various initiatives have been taken under different jurisdictions. For instance, in the UK, the *Secretary of State* has a legal duty to

[289] WHO Regional Office for Europe, *Terminology – A glossary of technical terms on the economics and finance of health services* (Copenhagen 1998).
[290] Doctors of the World, *Access to healthcare in the UK* (2015) https://www.doctorsoftheworld.org.uk/files/2015-09-18_DOTW_Access_to_healthcare_final.pdf Accessed 15 October 2017.
[291] WHO, *Exploring patient participation in reducing healthcare related safety risks* (2013) 16
[292] André den Exter, *The Right to Healthcare undr European Law* (2017) Diametros 174 http://bazhum.muzhp.pl/media//files/Diametros/Diametros-r2017-t-n51/Diametros-r2017-t-n51-s173-195/Diametros-r2017-t-n51-s173-195.pdf 21 Feb. 2020; Doctors of the World (n291).
[293] Andre den Exter (n293) 176.
[294] Gulliford, M., *Availability of primary care doctors and population health in England: is there an association?* (2002) Journal of Public Health Medicine 252-254.

make basic medical care available to the given population in need of health services.[295] Nevertheless, due to limited resources, in certain cases such duty does not extend to the provisions of preferred medical treatment requested by individual patients.

To increase access to healthcare, under the healthcare system of *USA* and the *Netherlands,* health insurance is recognised as one of the fundamental factors.[296] One of the reasons for introducing health insurance in the USA and the Netherlands was to impose a duty on patients to make monthly payments and utilise the income to enhance the quality of healthcare and ensure access to healthcare. Additionally, *People Health Movement* as an international organisation is promoting patient's right to health through the *Right to Health and Healthcare campaign (RTHHC)* whereby a global action plan on the right to healthcare is drafted to allocate priorities and resources.[297] Health insurance policies are not only implemented in Western countries but also many others. A Middle East example is the *United Arab Emirates,* as insurance authorities were established in the *United Arab Emirates* under the *Federal Law No. 6 of 2007* and mandatory health insurance was fully implemented since 2013.[298] Interestingly, health insurers in the UAE are exerting an increasing influence on the shape of healthcare services, adjusting health insurance policy terms towards the end of better access to primary care services. Mandatory health insurance has been empirically shown to improve access to health services in low- and middle-income countries.[299]

Limited resources: Whilst budget is a contributing factor for ensuring a better access to the healthcare, limited budged is not a justification for a low quality of healthcare.[300]

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[295] National Health Service Act [2006] Section 3(1); Doctors of the World, *Access to healthcare in the UK* (2015).
[296] National Health Service, *Country-by-country guide: Accessing healthcare in the Netherlands* (2015) http://www.nhs.uk/NHSEngland/Healthcareabroad/countryguide/Pages/healthcareintheNetherlands.aspx Accessed 16 October 2016; Mark Fendrick, Michael E. Chernew, *Value-Based Insurance Design: A "Clinically Sensitive" Approach to Preserve Quality of Care and Contain Costs* (2006) The American Journal of Managed Care 18.
[297] People's Health Movement, *The PHM Right to Health and Health Care Campaign* (2017) http://www.phmovement.org/en/node/134 Accessed 16 July 2017.
[298] Andrea Tithecott, *United Arab Emirates* (2019) The Healthcare Law Review https://thelawreviews.co.uk/edition/the-healthcare-law-review-edition-3/1197545/united-arab-emirates
[299] Darious Erlangga et al, *The impact of public health insurance on health care utilisation, financial protection and health status in low- and middle-income countries: A systematic review* (2019) 14(8).

[300] Ruth Robertson, *Six ways in which NHS financial pressures can affect patient care* (2016) http://www.kingsfund.org.uk/projects/impact-nhs-financial-pressures-patient-care/six-ways?gclid=COiThrfh3M8CFc8K0wod2JUNSA Accessed 15 October 2017

Despite limited resources, *Cuba* is known for having the world-class healthcare system, whereby life-expectancy in Cuba is around 78 years and hundreds of countries are learning from the Cuban healthcare system.[301] As such according to Fiona Hill "*Cubans live like the poor, and die like the rich.*"[302] Cuba has achieved this success through *Medicina General Integral (MGI)* whereby preventative measures are undertaken to safeguard a healthy life for the population at large.[303] Such measures include broadening individual's knowledge about health problems; providing compulsory health checks to detect early signs of ill health; and implementing successful vaccination programmes for the purposes of preventing infectious deceases.[304]

Broadening individual's knowledge through public health education programmes promotes healthy living which can be cost-effective as healthy living has the potential of decreasing heart attack, stroke and cancer rates. According to the WHO, public health is about the "*the art of applying science in the context of politics so as to reduce inequalities in health while ensuring the best health for the greatest number*"[305] Through public health education, the population is made aware of nutrition, hygiene, diet and exercise. Such an approach fits with the ideal of individuals, families and communities taking a measure of responsibility for their health, bringing with it benefits for the control of health budgets[306] and also acting as a bulwark against tendencies toward medicalization.

In addition to the Cuban healthcare system, the unique approach taken under the Chinese healthcare system as a preventative measure is the use of traditional medicines by community health workers.[307] Moreover, due to the issues relating to the importation of substandard medications and poor-quality food from other countries, economic blockade and the use of traditional medications and food could be in the best interest of general public. As such, under a recent report, the WHO recommended the incorporation of

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[301] Don Fitz, *Why Is Cuba's Health Care System the Best Model for Poor Countries* (2016) http://www.ratb.org.uk/news/cuba/321-why-is-cubas-healthcare-system-the-best-model Accessed 21 November 2016

[302] Fiona Hill, *Prevention better than cure in Cuban healthcare system* (2015) http://www.bbc.co.uk/news/health-35073966 Accessed 21 November 2016.

[303] Don Fitz, *Why Is Cuba's Health Care System the Best Model for Poor Countries* (2016).

[304] Royal College of Surgeons (n266) 20.

[305] WHO, Strengthening public health function in the UAE and EMR of the WHO (2001) London, Royal Colleges of Physicians of the United Kingdom.

[306] Buyx AM, *Personal responsibility for health as a rationing criterion: why we don't like it and why maybe we should* (2008) Journal of Medical Ethics 871.

[307] WHO, *China's village doctors take great strides* (2008) 909-988 http://www.who.int/bulletin/volumes/86/12/08-021208/en/ Accessed 13 December 2016.

traditional medicines into the healthcare systems.[308] Overall, it can be argued that under the benchmarks of best practice, the existence of preventative measures such as the promotion of healthy life style through public health education can have a positive impact on the limited resources within the healthcare providers.[309] In other words, the focus is not only on responding to medical misadventures but also on implementing preventative measures to limit the number of hospital admissions.

Cost-effective treatment: to minimise issues relating to limited sources, numerous national institutions have established guidelines on the allocation of limited resources in a cost-effective way.[310] For instance, the *UK National Institute for Health and Care Excellence (NICE)* established 'clinical guidelines' for healthcare practitioners to assess the cost-effectiveness of the proposed medical intervention.[311] In addition to clinical standards, NICE have also established 'Service Guidelines', whereby a duty is imposed to make use of particular services (such as cancer services[312]) in a cost-effective way.[313] Although, due to the complicated nature of medicine assessing cost-effectiveness of medical services is in itself onerous process, under the benchmarks of best practice, patients best interests outweigh the interests of the healthcare providers.[314] In other words, healthcare practitioners are guided in a way to make decisions on cost-effective treatment that is in the best interests of the healthcare providers. For instance, NICE recommends cost-effectiveness analysis also known as the "Quality-adjusted Life Year" (QALY) whereby health effects are measured against monetary outcomes by taking the life expectancy of the patient into account.[315]

International Legal provisions: In addition to systematic measures, treaties by European Union, conventions by the Council of Europe, and decisions by European

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[308] WHO, *Equitable Access to Quality Services* (2019) http://www.searo.who.int/entity/primary_health_care/en/ 21 June 2019.
[309] WHO, *Report on the Regional Consultation on improving quality of care and patient safety in the Eastern Mediterranean Region* (2014) Jeddah Saudi Arabia 12.
[310] Zsuzzanna Jakab, *Exploring patient participation in reducing health-care-related safety risks* (2013) World Health Organisation.
[311] NICE, *The guidelines manual: Nice Clinical guidelines* (2012) https://www.nice.org.uk/process/pmg6/chapter/introduction#nice-clinical-guidelines Accessed 16 July 2017.
[312] NICE, *Cancer Service Guidance* (2019) https://www.nice.org.uk/guidance/published?type=csg 21 June 2019
[313] NICE (n311).
[314] NICE, *Response to the error of the Bristol Royal Infirmary Inquiry* (2001).
[315] NICE, *The guidelines manual: assessing cost-effectiveness* (2012) https://www.nice.org.uk/process/pmg6/chapter/assessing-cost-effectiveness 21 June 2019.

Court of Human Rights (ECHR) have an important role in safeguarding utmost access to the healthcare and to protect patient's rights through the provision of essential/basic healthcare services.[316] For instance, under one of the EU primary treaties known as the *Treaty on the Functioning of the European Union (TFEU)* a legal duty is imposed on the EU member states to protect and improve human health.[317]

Moreover, *the European Convention on Human Rights and Biomedicine (ECHRB)* provides that "*Parties, taking into account health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality.*"[318] Whilst the ECHRB, acknowledges that due to the lack of medical resources patient's access to healthcare can be limited, it imposes a duty to make essential care available. Such approach is further supported by the ECHR in the case of *McGlinchey and others v UK (2003)* as it was confirmed that states have an absolute duty to make essential care available.[319] Moreover, the provision of essential medical care is also compatible with the *European Convention of Human Rights* as in certain circumstances it can prevent inhuman and degrading treatment.[320]

Equitable Access to Healthcare: Further to article 3 of ECHRB (above) the duty is not only providing healthcare but also ensuring equitable access to the healthcare.[321] Such approach is further endorsed by WHO as it provides:

> *"Universal health coverage means that there is equitable access and use of quality services by all those that need it, be it preventive, curative or palliative care."*[322]

Overall, cost-effective treatments are the bedrock of making access to healthcare more equal. However, access can also be hindered by other forms of discrimination. There are

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[316] Essential or basic healthcare services include emergency, inpatient/outpatient, and preventative health services; WHO, *Primary health care* (2019) https://www.who.int/news-room/fact-sheets/detail/primary-health-care 21 June 2019.
[317] Treaty on the Functioning of the European Union (TFEU) art 168 (1).
[318] European Convention on Human Rights and Biomedicine [1997] Art 3.
[319] McGlinchey and Others v. The UK [2003] (Application no. 50390/99).
[320] European Convention of Human Rights 1950 (ECHR) art 3; Francoise Girard, *Stop torture in the healthcare, Open Society Foundation* (2011) https://www.opensocietyfoundations.org/voices/stop-torture-health-care-0 Accessed 13 December 2016.
[321] European Convention on Human Rights and Biomedicine [1997] Art 3.
[322] WHO, *Equitable Access to Quality Services* (2019) http://www.searo.who.int/entity/primary_health_care/en/ 21 June 2019.

various normative standards designed to protect against these too. For example, *Article 11ECHRB* prohibits any form of discrimination against a person on grounds of genetic heritage in the delivery of healthcare.[323] The objective should be to ensure that individual patients in equal needs are assessed irrespective of discrimination whether that relates to genetic heritage or other factors such as race, age, or sex.[324]

2.6.3 Patient's right to Request Redress

Complaint Process: It is unfortunate that at times negligent treatment, due to ineffective doctor-patient relationship or due to limited resources, can result into serious harm to patients. In cases of medical misadventure, patient's right to request redress is regarded as an essential sub-component of patient-centred care. This process involves different stages such as local resolution and complaints review stage, whereby patients are lodging complaints to hospital management teams.[325] Numerous organizations are established to support patients and guide healthcare providers during complaint procedures. For instance, in the UK, the *Independent Healthcare Sector Complaints Adjudication Service (ISCAS)* provides guidelines (and *Complaint Code of Practice*).[326] According to *ISCAS* under the complaint procedure, healthcare providers need to acknowledge that things may have gone wrong and provide remedies (including compensation / an apology).

Legal Actions: In cases where the complaint process does not provide patients with a satisfactory result, patients need to exercise their rights by taking a legal action and request redress through clinical negligence system or criminal law. Whilst in cases of gross negligent healthcare patients are required to take action under criminal law, in cases of less serious negligent treatment, patients can take legal actions under medical negligent system. Nevertheless, it is not a straightforward process for patients to succeed claim under the negligent system as often patients are required to establish the elements of duty of care, breach of duty, damage, causation, and remoteness. Each of these

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[323] Council of Europe, *Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine* (1997) European Treaty Series 3; Jonathan Cohen and Tamar Ezer (n215).

[324] Ruth Robertson (272).

[325] ISCAS, *Making a complaint in the independent health sector: a guide for patients* (2014) 6 file:///C:/Users/N0187407/Downloads/iscas-patient-guide-for-making-complaints.pdf Accessed 29 June 2017.

[326] Ibid 1-2.

elements are often regarded as an obstacle for patients or their families within the process requesting redress. Under the benchmarks of best practice, such obstacles are avoided through a scheme currently operating in New Zealand, which is known as "*no fault" compensation scheme (NFCS)*.[327] Such scheme has numerous advantages, including the circumvention of a blame-culture, as this scheme enables claimants to succeed in their claim, irrespective of blaming individual healthcare practitioners to prove fault.[328]

The *NFCS* is deemed to have a positive impact on healthcare quality as the shift from a blame-culture enable practitioners to report failures, which ultimately leads to prompt investigation of the causes of medical errors.[329] As the result, according to *Gaine* "*the no-fault system would increase compliance with the mandatory reporting of adverse clinical events and would facilitate the culture of openness demanded by clinical governance*"[330] The shift from a culture of cover-up leads to an open-culture, which can enhance the process of reporting errors to learn from mistakes, although to protect professional reputation, some practitioners may still be reluctant to report failures.[331]

To advocate the revelation of failures, under the benchmark of best practice, the approach of 'safe space' is applied to strictly anonymise and protect professional reputation.[332] Additionally, to prevent the protection of offending doctors and avoid high burden on compensation costs, under an ideal healthcare system, the NFCS is limited to only certain cases with high chances of medical errors (such as birth injury cases and brain damaged cases).[333] Moreover, under the benchmarks of best practice, the organisational attributes and hierarchical structures are critically assessed and a '*commitment based management philosophy'* is taken into account to progress from a blame-culture to a just-culture whereby practitioners are not held liable for system failures.[334]

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[327] William J Gaine, *No-fault compensation systems* (2003) British Medical Journal 998 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1125962/ Accessed 29 June 2017.
[328] Ibid p997.
[329] Ibid.
[330] William J Gaine, (n327) 998.
[331] Susan Moloney (n153) 1.
[332] Department of Health, *Providing a 'safe space' in healthcare safety investigations* (2016) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/560522/Safe_spaces_cons.pdf 5 August 2019
[333] Clare Looker, Heath Kelly, *No-fault compensation following adverse events attributed to vaccination: a review of international programmes* (2011) Bulletin of the World Health Organization 371 http://www.who.int/bulletin/volumes/89/5/10-081901/en/ 30 June 2017
[334] Khatri N, Brown GD, Hicks LL., *From a blame culture to a just culture in health care* (2009) Health Care Manage Rev.

Learning from Complaints / Legal Actions: The *WHO* is claiming that patient's rights to complaint has a positive impact on healthcare quality as the information from complaints can provide comprehensive data about serious failures and this can be regarded as important source for patient safety management system.[335] As evidence, it has been stated that "*complaints lodged by patients or their family can be used as indicators to evaluate and – if necessary – improve the safety and quality of care.*"[336] This clearly indicates that under an ideal healthcare system, lessons are not only learned from reported adverse events (chapter 2.5.1), but also from the complaint system.[337] As the result, ISCAS imposes duties on healthcare providers to take actions to put things right following complaints by patients.[338] According to the *WHO* following the consideration of patients complaints, under an ideal healthcare system, the information is recorded; the causes of the complaints are identified through the analysis of the information; lessons are learned by taking actions to resolve the problem and prevent it from reoccurring; publishing a report to raise awareness about such issues and the solutions.[339]

Overall, it can be attested that under the benchmarks of best practice, patients or their families are entitled to request redress under a number of avenues including local complaint procedures, Criminal Law, Medical Negligent system, and NFCS. In order to identify areas of improvement, special units are put in place with trained staff to investigate complaints and to respond to the need of complainant with patience.[340] Under such processes, patient's dissatisfactions are dealt with by accessible patient advocates or complaint officials such as independent ombudsman.[341] Predominantly, under an ideal system, such process are not only benefitting patients but also the overall health system performance, whereby the information from complaint are taken into consideration for the purposes of learning from failures.

[335] WHO, *Exploring patient participation in reducing healthcare related safety risks* (2013) 19.
[336] Ibid.
[337] World Health Organisation, *WHO Draft Guidelines for adverse event reporting and learning systems* (2005) 35
[338] ISCAS, *Patient complaints adjudication service for independent healthcare* (2017)
[339] WHO, *Exploring patient participation in reducing healthcare related safety risks* (2013) 19.
[340] WHO, *Standardizing national health in the 21st century: a handbook* (2016) 65 file:///C:/Users/N0187407/Downloads/9789241549745-eng(1).pdf Accessed 29 June 2017.
[341] WHO, *Exploring patient participation in reducing healthcare related safety risks* (2013) 20.

2.7 Summary

Chapter 2 aimed to innovate the benchmarks of best practice through the use of *Essence of Care Benchmarking* whereby the key components of health system governance are compared and critically analysed for the purposes of identifying benchmarks of best practice.[342]

Introducing and implementing regulations: This chapter started by benchmarking the process of introducing professional regulations through the bottom-up approach, whereby the rules are introduced to respond to failures. Conclusively, it can be argued that the characteristics (including proportionality, transparency, focus and agility) established by the *NIHR* have essential role in ensuring a clear and transparent rules which could elude excessive and complicated regulations.[343] Although this chapter considered different methods of implementation including vertical, horizontal, bottom-up and top-down approach, it was found that under an ideal system, successful implementation of regulations is assured through the intervention of governing authorities.[344] In other words, the existence of professional regulatory authorities can lead to the process of overseeing the function of healthcare professionals to assess whether practitioners are following the rules at the level of patient's care.

Health Service Leadership: The analysis of the existing literature on health system governance has allowed the discussion of the role of sub-quality dimension relating to professional regulatory authority in the healthcare. I have concluded that the existence of professional regulatory authorities has a number of advantages including the process of promoting continuous improvements; setting up standards; implementing professional regulations; and overseeing the functions of the healthcare practitioners through the disciplinary processes.[345] Although, according to a number of academics the existence of disciplinary processes can lead to issues relating to defensive medicine and blame culture, the benchmark of best practice for health system governance provides that healthcare professionals are only subject to disciplinary proceedings in cases concerning

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[342] Amina Ettorchi-Tardy et al, *Benchmarking: A Method for Continuous Quality Improvement in Health*, Health Policy (2012) 7(4) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3359088/ Accessed 15 December 2016

[343] Angela Yu (n 74) 23

[344] David Clarke (n86). <http://apps.who.int/iris/bitstream/10665/250221/1/9789241549745-chapter10-eng.pdf> 19 March 2018

[345] National Audit Office Press Notice (n196).

serious harm to patients, gross negligence and criminal behaviour. Finally, it can be averred that the existence of an independent regulatory authority minimises the chances of interventionist political ideologies, which is also known as 'Clientelism'.

Continuous improvement of healthcare quality: The third part of this chapter aimed to identify benchmarks of best practice for measures to continuously improve the quality of healthcare. This chapter focused on three sub-quality dimensions including the revelation of medical errors; professionalising healthcare practitioners; and development of health technology. This chapter attempted to identify different ways of promoting disclosure of medical errors and it has been found that under the benchmarks of best practice, that national and international organisations such as the *WHO* and *Health Foundation* have an important role in providing guidance to advocate an open culture by encouraging healthcare practitioners to report medical errors and learn from mistakes. In order to encourage healthcare practitioners to report medical errors, under this chapter it has been found that it is important to impose a duty of candour and to make healthcare practitioners aware that no disciplinary actions will be followed.[346] Furthermore, professionalisation of healthcare staff through web-based learning and accreditation courses also has an important impact on healthcare quality as the confidence and self-esteem through professionalisation contributes to a better quality of healthcare.

Patient-centred Care: the fourth part of the present chapter aimed to identify the impact of effective interpersonal connections on quality of healthcare. Further to the analysis above, it can be concluded that interpersonal connections between doctors and patients has the effect of reducing patient's emotional distress, which ultimately leads to the revelation of additional information relating to patient's condition. The more relevant information is disclosed to healthcare practitioners, the more likely for the illness to be diagnosed correctly thus less chances of medical errors. As a result, it can be argued that effective interpersonal connections between doctors and patients have a positive impact on healthcare quality. Under this part of chapter two, it has also been found that although the existence of *Shared Decision Making* between doctors and patients have shown to be associated with better diagnosis of physical and mental illnesses, due to the lack of health education, *Supported Decision Making* has been identified to be more effective within

[346] Department of Health, *An organisation with a memory* (2009) The National Archives.

the healthcare providers.[347] Therefore, the combination of public health education (currently operating in Cuba) and SDM does not only have a positive impact on the effective interpersonal connections between doctors and patients, but also on the quality of healthcare.

Additionally, effective public health education by community health workers has a positive impact on limited resources. As the promotion of healthy living leads to the reduction of illness and less demand of treatments within the healthcare providers. The final part of this chapter evaluated the impact of complaint system and litigations on healthcare quality. Aligned with the premise by the WHO, the existence of a complaint system does not only protect patient's rights but it has also a positive impact on healthcare quality as the data from complaints can provide rich and comprehensive information about quality issues within the healthcare providers.[348] As a result, it can be argued that under an ideal healthcare system, the information from complaints, alongside with the information from reported medical errors, are used to learn lessons and allude the reoccurrence of such failures. Appendix 1 illustrates a summary of the benchmarks discussed under this chapter.

Having identified the benchmarks of best practice for the components of health system governance, the next step under the thesis is to measure the benchmarks against the KRI healthcare system under chapters of 4, 5 and 6. Nevertheless, the hypothesis is that not all best practice identified under this chapter can be applicable to the KRI healthcare system. Following the presentation of the empirical findings, under chapter 7 of the present thesis, the initiatives under the KRI healthcare system are then measures against the benchmarks of best practice to identify areas for improvements and make recommendations for potential solution.

Although the aim of this chapter was to critically discuss international benchmarks of health system governance, on the whole, it can be contended that the focus of chapter 2 was on the European benchmarks of best practice for the components of health system governance. As evidence, reference was made to the best practices recommended by numerous health organisations, including the WHO. The rationale for drawing on European benchmarks were to achieve the overall aim of the thesis, which was to

[347] Royal College of Surgeons (n265) 4.
[348] WHO, *Exploring patient participation in reducing healthcare related safety risks* (2013) 19.

critically explore the KRI health system governance. Drawing on the benchmarks of developed countries is arguably higher standards when it comes to the recommended measures of developing countries. As such, measuring the KRI healthcare standards against European benchmarks of best practice would allow detailed critical discussion of existing healthcare practices in the KRI.

Essentially, receptivity towards European Benchmarks in the KRI is not only based on the high standards, but also the historical and contemporary political conflicts that Kurds have endured with many Middle East countries. In other words, given the hostility towards the Kurds by the neighbouring countries in the Middle East, European benchmarks are mostly favoured by the KRI health policy makers. Furthermore, due to the existing collaborative initiatives between the WHO and the KRI, benchmarks based on recommendations by the WHO would essentially contribute to the existing initiatives in the KRI. Examples of such initiatives includes successfully funding projects by the WHO. Strengthening primary health care system in Iraq ($37,363,516); medical equipment management and maintenance system ($1,718,281); and strengthening non-communicable diseases in the KRG ($1,833,333) are examples of the projects funded by the WHO.[349]

Whilst accepting that the focus of this chapter was mainly on European benchmarks, it is also worth to note that references were made to the health system governance of some Middle East countries. For instance, the accreditation programmes of Jordan and Saudi Arabia (Chapter 2.5.2); insurance system of United Arab Emirates (Chapter 2.6.2); the recommended measures for effective leadership by health advisory for Middle East (Chapter 2.4.1); and Iran's health system governance (Chapter 2.3.1) were discussed in addition to the European Benchmarks. Essentially, not only lessons can be learned from the aforementioned countries on what they perceive to be best practices, Middle East countries such as Iran share similar development issues in terms of health system governance. As indicated above (Chapter 2.3.1) the Iranian attempts of improving health

[349] United Nations, *UN Agencies, Funds and Programmes: Support to KRG 2008-2010* (2010) http://www.mop.gov.krd/resources/MoP%20Files/PDF%20Files/DCC/Studies/UN%20Activities%20in%20KRG_2008-2010%20_17%20Jan_1_.pdf Accessed 27 June 2020

system governance by focusing on bottom-up approach has been added to the benchmarks of best practice for health system governance.

PART 2: EXPLORING KRI HEALTHCARE SYSTEM

Chapter 3: The Methodology and Method of the Empirical Research Programme

3.1 Introduction

This chapter focuses on the methodology and the method of the empirical research programme. Whilst research methodology is about the overall theoretical approach to the empirical research, the research method focuses on the tools used to conduct the empirical study. The purpose of the present empirical research programme is to examine the role of governance under the healthcare system of Kurdistan; ascertain healthcare quality issues; and identify the priorities for improvements.

This chapter starts with the research methodology which focuses on the critical realism paradigm as the overall theoretical approach to the empirical research. The second part of this chapter focuses on empirical qualitative research method as an essential tool for conducting the empirical study. Detailed information on the step-by-step process of designing the empirical study, collecting qualitative data, selecting the samples, conducting the interviews, and analysing the data through thematic data analysis are considered below.

3.2 Research Methodology

Critical Realism: The paradigm of critical realism emerged in the 1970s through the work of the philosopher *Roy Bhaskar*.[350] Critical realism is distinguishable from interpretivism, epistemology and positivism. Whilst, the paradigm of interpretivism is about objectively testing a hypothesis through empirical studies; epistemology concerns the method of acquiring knowledge; and the paradigm of positivism involves standardised and uniform structure of knowledge.[351] Nevertheless, the paradigm of critical realism aims to distinguish between the 'real' and the 'observable' world as

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[350] Bhaskar, R., *Scientific Realism and Human Emancipation* (2009) London: Routledge;

[351] Archer et al. (2016) *What Is Critical Realism? American Sociology Association*, [online] http://www.asatheory.org/current-newsletter-online/what-is-critical-realism 25 December 2019; Ancher M., *Critical Realism and Research Methodology* (1999) Alethia, 12

according to *Bhaskar* the real world exists independent from human perceptions.[352] More specifically, critical realists are from the opinion that the world is layered between three levels of reality including empirical, actual and real levels. Whilst the 'empirical' level focuses on experienced or observed events, which are often explained through common sense perspectives; the 'actual' level is concerned with the actual occurrence of events without being filtered through human experiences. Finally, the 'real' level events are independent from human conceptions, whereby the knowledge exist and are facts without the need for human conception.[353]

Applicability of Critical Realism: Amongst the above paradigms, critical realism is regarded to be more suitable to design, conduct and analyse empirical data within the context of this thesis. This is partly because the goal is to the actual role of KRI health system governance and the true occurrence of the KRI healthcare quality issues under the 'actual' and the 'real' level of reality referred to within critical realism. To confirm the validity of the empirical finding and to avoid sensory experiences or mistaken belief of the participants, the findings of the thesis are subject to critical scrutiny. More specifically, the pictures presented by interviewees are cross examined against one another and also what is known from elsewhere about the KRI situation, such as via. Under the present research aimed efforts were made to obtain data about the objective state of healthcare in the KRI through the process of reviewing government reports (KRG Cabinet Reports), WHO and other KRI NGO's reports. Although, the WHO briefly discussed the KRI child mortality rates in its reports (such as the indication of KRI child mortality rates),[354] no comprehensive data is presented about the KRI incident reports and litigation data. With regards to NGO reports, I make reference to the *International Medical Corps* (a global non-governmental organisation), which recommended the increase of competent professionals and health service providers under the KRI healthcare system. Although no statistical data was provided under the report, it is

[352] Bhaskar, R. A Realist Theory of Science (London: Verso, 1975)
[353] Amber J Fletcher, *Applying critical realism in qualitative research: methodology meets method* (2016) International Journal of Social Research Methodology, 181

[354] Ala'din Alwan, *Health in Kurdistan* (2004) 22, WHO.
https://www.who.int/hac/crises/irq/background/Iraq_Health_in_Iraq_second_edition.pdf?ua=1 12 July 2020.

indicated that there is evidence of dramatic improvements in Iraqi emergency hospitals.[355]

In terms of limitations of this approach it should be noted that whilst many states have very good statistical data to draw on to appraise healthcare quality and its governance, pertinent KRI websites are not kept properly updated . As an example, the Kurds NGO website only provides information about the projects funded prior to the year of 2013.[356] Further, the Ministry of Planning website was accessed to obtain data on the causes of the mortality rates and systematic failures under the KRI health sector, however, the website was not updated since 2008 and the listed reports were not accessible.[357] Equally, it was not possible to obtain reliable data on the KRI medical negligence claims. Although, *United Nation* reported that only 2% of negligence cases are considered in the Iraqi courts, such data was not specific to the KRI medical negligence claims.[358]

One of the ways in which I sought to address this limitation was to approach senior members of the *KRI Department of Health* with a view to obtaining more data. Whilst members of the Department have generally been very supportive of my project, they were concerned not to release further data in order to maintain public trust and confidence in the health service. Whilst this objective is understandable and important, I would humbly suggest that being more open informationally will ultimately secure public trust and confidence on a sounder footing than it currently is if it is packaged as part of a national conversation and political commitment to reformative action on healthcare quality. This is particularly the case, given that healthcare professionals are both experientially and informationally aware of the general degree and nature of healthcare quality failures, and the fact that patients also often are to a lesser but still significant degree. This view stands notwithstanding the fact that producing extensive up to date

[355] International Medical Corps, *International Medical Corps Assists the Iraqi Ministry of Health in Developing Comprehensive Emergency Medical System for Iraq* (2009) https://internationalmedicalcorps.org/press-release/international-medical-corps-assists-the-iraqi-ministry-of-health-in-developing-a-comprehensive-emergency-medical-system-for-iraq/ 12 July 2020

[356] Kurds NGO, *Sulaimani Projects* (2020) http://www.kurdsngo.org/we-work/sulaimani-projects 16 July 2020

[357] Ministry of Planning, *Kurdistan Region: Statistics by Sector* (2012) http://www.mop.gov.krd/index.jsp?sid=1&id=146&pid=105 12 July 2020

[358] United Nation Development Programme, *Corruption and Integrity Challenges in the Public Sector of Iraq* (2012) 62 http://www.krso.net/files/articles/040814110655.pdf

information can be a challenging process practically and in terms of scarce resources, particularly in a developing country.

Despite the inaccessibility of incident data, according to a study conducted in 2008, the health sector consists of only 11 physicians per 10.000 populations. Although this has proven to be higher than the South of Iraq (only 5 physicians per 10.000 populations), the allocation of 11 physicians in the KRI is substantially low when compared to European standards (which requires the allocation of 33 physicians per 10.000 population).[359] Not only the number of the KRI physicians are significantly below the expected standards, but the number of health service providers are also proven to be substantially low. As evidence, the *Kurdistan Statistic Office* provides that only 121 public and private hospitals exist in the KRI to accommodate the healthcare needs of about 6 million Kurds in the North of Iraq.[360]

Taking a pragmatic approach, the thesis could have benefitted from the use of statistical data on reported incidents in as it would potentially have provided an overview of the objective state of the KRI healthcare system and would have illustrated the probabilities of health system failures. Nevertheless, it can be attested that statistical data cannot always provide an accurate overview of the KRI healthcare quality. As often statistical data are criticised for lack of clarity and accuracy. In other words, due to ineffective systematic measures of recoding incidents reports in the KRI, it is highly unlikely to obtain access to reliable statistical data.

In the light of these challenges, I used a *Thematic Data Analysis Method* to ensure the validity and the reliability of the qualitative data gathered via the semi-structured interviews. This method led to the process of identifying consistencies within the entire data set, whereby under each theme that was emerged from the empirical data, the number of those participants who shared similar views are clearly presented under chapters 4, 5, and 6 of the thesis. The more discussion there was on a particular theme within the interviews as a whole, the more likely the issue would reflect the real situation

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[359] http://www.mop.gov.krd/resources/MoP%20Files/Newsletter/KRG_2020_last_english.pdf
[360] Kurdistan Region Statistic Office, *Health and Education* (2015) http://www.krso.net/Default.aspx?page=article&id=899&l=1&#krso1

under the KRI healthcare system. For instance, it is indicated under chapter 5.4 about 53% of the participants are confirming the existence of clientelism, which suggest that such issue could relate to the real situation. Further, to confirm the validity of the empirical data, under the synthesis and discussion part of the above chapters, the findings are related back to the issues reported RAND Corporation and other relevant literature.

3.3 Research Method

Interdisciplinary Research: The present empirical research can be regarded as an ethnographic case study as it aims to explore the KRI health system governance which is ultimately influenced by the KRI culture, and socio-economic background. To achieve this aim, I combined a number of disciplines including medical practice, law, and social science principles. It focuses on the discipline of law, as it assesses governance from legal perspective; medical practice as it assesses healthcare practice; and social science perspective as it provides a comprehensive overview of the KRI healthcare system through the process of conducting empirical qualitative study and the application of social science theory and data analysis method.

Empirical Qualitative Study: The predominant technique adopted to accumulate and collect the empirical data under the thesis is empirical qualitative research study. The importance of the empirical study is driven by the pragmatic needs to clarify the role of health system governance and its impact on healthcare quality under the KRI healthcare system. Given the problematic nature of data generated on healthcare governance of KRI, it was agreed that this research would benefit from collecting qualitative data, which has been described as "non-numeric data or data that have not been quantified."[361] Of course, there are many reasons to include empirical qualitative research method as such method provides an in-depth understanding on how participants make sense about their personal experiences relating to the role of governance and its impact on the quality of healthcare in the KRI.[362] The nature of the inquiry is qualitative, as ideally the aim of this empirical study is to obtain rich data about the status, nature, and inherent limitations of health system governance under the KRI healthcare system. In other words, the aim is to

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[361] Mark Saunders, Philip Lewis, and Adrian Thornhill, *Research Methods for Business Students: Analysing Qualitative Data* (Pearson Education, London, 2007) 4th ed. 470

[362] Roger J. Gagnon, *Empirical Research: The Burdens and the Benefits* (1982) Department if Management 30602.

explore the underlying reasons behind healthcare quality issues of KRI, which cannot be achieved under quantitative research method by way of quantifying the issues through generating data and statistics.[363]

3.4 Empirical Research Strategies and Techniques

Semi-structured interviews: to achieve the overall aim of the present empirical study, the strategy that is used to collect the primary data is individual semi-structured interviews. Semi-structured interviews are widely used under qualitative research as it regarded as the most suitable method for hearing the hidden voices of the participants.[364] The thesis has benefitted from using such strategy by getting an insight into the role of governance and healthcare quality issues at the level of patient's care within the KRI healthcare providers. Although, the interviews were semi-structured, the key questions during the interview centred around the key components of health system governance including the process of medical intervention, the role of law and guidelines, and the quality of healthcare. Further to the suggestions by *Gillbwalker*, to increase internal validity of the data, an effective order was followed through the process of drafting the interview questions, completing ethical application form, selecting the samples, conducting a pilot study, and planning a journey to KRI.[365]

Ethical Considerations: Prior to conducting the interviews, an ethical application was submitted to the *Nottingham Trent University Business, Law, and Social Science College Research Ethics Committees (CREC).* The ethical application forms had to be resubmitted on a number of occasions as at the time of the empirical study, Kurdistan region in North Iraq was subject to ISIS attacks. Overall, the ethical approval process took seven months. The supervisors and ethics committee needed to be confident that the location of the empirical study was safe and that the reputation of the participants, and of the healthcare providers were protected. Concerns for my own safety also needed to be addressed via discussion and completion, submission and assessment of a risk assessment form. In the application for ethical approval, issues of participant reputation were addressed through the *Participant Information Sheet (PIS)* and consent form, which

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[363] Uwe Flick, *An introduction to qualitative research* (Sage publishing, London 2014) 5th edn 28
[364] Uwe Flick (n357) 4; Mark Saunders et al (n355) 310.
[365] Gillbwalker, *Research Methods Recap: Advantage/Disadvantage for each Empirical Research Method* (2017) https://quizlet.com/119726445/research-methods-recap-advantagedisadvantage-for-each-empirical-research-method-flash-cards/ 28 September 2017.

reassured the protection of confidential information and ensured that participant was contingent upon informed consent (Appendix 3). Prospective participants were informed that the researcher was guided and bound by the provisions of the *NTU College of Humanities and Social Science Code of Research Ethics and the Ethical Code of ESRC (Economic and Social Research Council) 2005*. For those participants who preferred to have the interview in Kurdish language, as a native speaker, I verbally elaborated the content of the consent form in Kurdish language (Sorani).

KRI Ethical Approval and Certification Process: In addition to the Nottingham Trent University ethical process, the thesis went through the KRI National Health Service ethical process. This involved the completion of ethical application forms and an interview with committee member within the ministerial department of health. Eventually, the thesis was formally recognised as it was certified by the KRI Ministry of Health (Appendix 2). The certificate was a great achievement, it provided me (as the researcher) with the access to the KRI healthcare providers under both public and private sectors.

Intensity, Homogeneous, and Snowball Sampling: For the purposes of gaining representative results, the samples that are selected from both the KRI public and private health sectors are those healthcare professionals who are contemporary engaged with the process of clinical practice; and those health service leaders, policy and decision makers with the responsibilities of improving the KRI healthcare system. During the process of selecting participants, a number of sampling methods were followed. For instance, '*Intensity Sampling*' was followed as the selection of the participants was based on the information that was required to answer the research questions and achieve the overall aim of the empirical study.[366] Moreover, *'Homogeneous Sampling'* on selecting participants with similar experiences was also followed under the present study as doctors and nurses were selected because they were sharing experiences about governance and healthcare quality issues under the healthcare system of KRI.[367]

[366] Lawrence A. Palinkas et al, Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research (2013) Adm Policy Ment Health https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4012002/ 17 July 2019
[367] Ibid.

Although, a number of the participants were recruited via closed group of KRI healthcare professionals on social media (known as Medical Researchers in Kurdistan), to ensure access to the right participant in study '*Snowball Sampling'* was also followed. . This particular method of sampling involved the process of recruiting subsequent participants based on the recommendations of initial participants. In other words, at the end of each interview, the participants were asked whether they knew someone else with similar experience that would be interested in participating the study. A total of 32 semi-structured interviews were conducted with nurses, doctors, head of hospital department, private clinic owners, hospital directors, health service leaders within the department of health and the ministry of health (Appendix 1). This sample size of 32 interviews was considered to be sufficient as the questions were adequately addressed and saturation was attained due to obtaining similar responses from the participants following the completion of the 30th interview.

Potential weaknesses of the empirical study: Although the objective was to comply with random sampling method and provide every member of the KRI health sector equal chances of participating the research, realistically speaking, this was not a straightforward process. For instance, due to political instabilities in the KRI, it was a challenging process to conduct face-to-face interviews in the KRI. As such, the empirical study started with 14 online interviews, whereby members of the Kurdistan Medical Research Group were invited to participate the research. Nevertheless, to ensure a natural approach and avoid the bias of only selecting those who were technologically literate, face-to-face interviews were also conducted within the KRI public and private hospitals.

The interviews were categorised into groups ('*clustered sampling*') of: Healthcare practitioners (doctors and nurses); health service leaders (managers and hospital directors); and health policy makers (members of Department of Health and the Ministry of Health). Doing so enabled me to target further interviews to aid proportionality as between these groups. This aided the garnering of varied perspectives concerning system and practice. A conscious effort was also made to ensure a balance of both private and public sectors professionals were interviewed. Whilst some of the interviews were garnered from snowballing there were also a number who responded to a Facebook page about the research and the interviews specifically. Skype and telephone interviews were often used for these To avoid response bias and to ensure the disclosure of sensitive

information, the protection of the confidential information was brought to the participant's attention under the Participant Information Sheet (Appendix 4).

Pilot Testing: to assess the feasibility of the empirical study, the drafted interview questions were pre-tested through four semi-structures interviews with healthcare practitioners working under the UK healthcare system. Such testing was particularly useful in identifying the challenges of obtaining sensitive information from healthcare practitioners. In order to tackle such issue, the protection of confidential information of participants were particularly highlighted, whereby at the start of the interview, through the participant information sheet (PIS), the participants were effectively informed about the protection of their confidential information (Appendix 2). The additional issue that was identified through pilot testing related to defensiveness by participants. This issue was tackled by discussing the practice of doctors with nurses and discussing the practice of nurses with doctors. In this way nurses, were providing information about the practice of doctors and doctors were providing information about the practice of nurses. Apart from the above challenges no major methodological modification was required following the completion of pilot testing.

Getting to the Field: Following the process of ethical approval, sample selection, and pilot testing, the process of the semi-structured interviews started with the KRI healthcare practitioners via Skype and via phone call. Subsequently, I travelled back to Kurdistan Region in North of Iraq, thanks to the supporters in the Kurdistan Regional Government (KRG), I was given an extraordinary opportunity to conduct face-to-face semi-structured interview under the KRI healthcare system. To gain access to comprehensive information about the KRI healthcare system, I asked a wide range of professionals from a variety of medical speciality, including general surgeon, oral surgeon, general anaesthetic, neurosurgeon, dermatologist, heart surgeon, nurse, senior nurse, children's health doctor, plastic surgeon, KRI WHO representative, members of KRI Department of Health and members of Ministry of Health Department (appendix 3).

Semi-structured Interview Process: To protect the participant's confidential information, the Skype interview were conducted in Nottingham Law School meeting room, whereby apart from me, as a researcher, no other member of staff had access to the location during the interview. The face-to-face interviews were conducted at the participants working place, whereby during the interviews no other practitioner had

access to the room in which the interview was taking place. Additionally, the participants were reminded about the importance of protecting confidential information and were given the opportunity to sign the consent form prior to the interview.

Following a number of supervisory meetings, it was agreed to ask open-ended questions during the semi-structured interviews. To obtain the most relevant qualitative data, an interview guide, which contained a number of themes for discussion, was followed during the semi-structured interviews. The interviews started with open-ended questions about the quality of healthcare, then it was followed by questions on the role of law, health system governance and patient safety measures under the KRI healthcare system. Essentially, the interview process was drawn from critical realism methodological framework as such process involved the opportunity of constructing joint knowledge with the participants. Although, the respondent remained an active agent, the follow-up questions provoked critical discussion on the KRI health system governance.

3.5 Empirical Data Analysis Process

Thematic Data Analysis: To comply with the credibility of the data, this part of chapter three accurately presents the compliance with the phases of thematic data analysis. Thematic analysis is defined by *Braun and Clarke* as "*a method for identifying, analysing and reporting patterns (themes) within data*."[368] Using this method enable me to achieve the overall aim of the empirical study – specifically, the identification of a rich thematic description of the entire data set enabled considerable and detailed analysis of healthcare quality in KRI and the role of governance in supporting it. Under the process of thematic data analysis, six phases were pursued:

Phase one: Familiarizing yourself with the data: in order to be familiarised and develop a thorough understanding with the entire data set, I conducted and transcribed a total of 32 semi-structured interviews (using express-scribe software).[369] The transcription of the interview conversations by the researcher has been regarded as "*a key phase of data analysis*"[370] As suggested by *Flick,* during the process of conducing the semi-structured

[368] Braun, V. and Clarke, V., *Using thematic analysis in psychology*: *Qualitative Research in Psychology*, (2006) 79.
[369] Ibid 88.
[370] Ibid 87.

interviews, I used research diaries to reflect on the process of collecting the data and record the body language of the participants.[371]

Phase two: Generating initial codes*:* In order to identify features of the data and organise the data in a meaningful way, the initial codes were generated through the process of labelling significant information (similar words and sentences which is also known as data extract). The codification of interview transcripts occurs when "*statements from interviews are identified and labelled by giving them a category*".[372] Following the approach of *Braun* and *Clarke*, I codified the interview transcripts manually, using printouts of the interview transcripts. The data is codified by writing notes and coloured pens were used to highlight repeated patterns.[373] Subsequently, the coded data was collated, whereby the extracts of similar data was copied and pasted into another document to compare the statements about a particular point.

The two predominant codes identified were semantic and latent codes.[374] Whilst, semantic codes concentre on the explicit meaning of the data, latent codes are related to the underlying ideas, assumptions and ideologies.[375] The central focus was the semantic codes as the empirical study aimed to explore the KRI healthcare system through a critical discussion of the explicit meaning of the empirical data.[376] In order to capture detailed information about the current healthcare system of KRI, rich thematic description of the entire data set was provided, meaning that equal attention is given to the entire data set.[377]

Phase three: Searching for themes*:* following the codification of the empirical data, the third phase involved the process of sorting codes into potential themes and sub-themes, which had some level of patterned response and were relevant to the research question.[378] Under this process the related codes are collated within a theme or sub-theme. This phase considers the process of searching for themes under the coded and collated data. This

[371] Uwe Flick (n357) 17.
[372] Uwe Flick (n357) 44.
[373] Braun and Clarke (n366) 87.
[374] Ibid 84.
[375] Ibid.
[376] Ibid.
[377] Ibid 89.
[378] Ibid.

goes a step further and searches for sub-themes within the identified themes. Sub-themes are described as "*themes-within-a-theme*."[379] The process of putting codes into themes were visualised by presenting it into graphs, charts and tables.

As not all themes identified could fit into the main theme, some themes were there on the thematic map temporarily and they are called miscellaneous theme.[380] A theme has been described as "*something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data*."[381] For instance, the codes of hours, lack of time, and too many patients have been grouped into the sub-theme of work-related pressure.[382] Themes under thematic analysis can be identified in two ways: bottom-up way (inductive) and top-down way (deductive).[383] The first method is similar to grounded theory whereby the themes are developed from the data set. Nevertheless, the latter (deductive approach) is more relevant as the themes under the present empirical study are driven from the components of health system governance.

Phase four: Reviewing themes*:* The generation of initial codes and the search for themes had the advantage of providing an overview of all identified themes and simplified the process under the fourth phase of reviewing the themes. This phase involved grouping the themes into main themes. For instance, the sub-themes such as professional regulatory authorities, regulations and guidelines have been grouped into the main theme of governance. Under this process, most important parts of the interview conversations were copied and pasted into a different document for the purposes of identifying potential emerging themes.

Phase five and six*:* The final two phases under the thematic data analysis focused on the process of defining the themes and presenting the results. Under the fifth phase the codes are reviewed by looking at how many participants were talking about that particular theme and whether it is related to other main themes identified. Most importantly, under

[379] Ibid 92.
[380] Ibid 90.
[381] Braun and Clarke (n365) 82.
[382] Ibid.
[383] Ibid 83.

this step the emerging themes are developed into thematic charts and are visually presented under chapters 4, 5, and 6.

3.6 Summary

This chapter sought to provide a brief overview of the research method used under the empirical study. It started by elucidating the underlying rationale behind the process of following empirical qualitative research method, whereby it is established that the nature of the research question calls for qualitative research method as the question that is central to this research is about the exploration of the role of governance under current healthcare system. Additionally, the paradigm of critical realism is considered to be the most desirable to the empirical research programme. The distinction between the real and the observable events under such paradigm can lead to the process of exploring the true occurrence of the KRI healthcare governance issues. Subsequently, this chapter illustrated the practical steps taken to analyse the empirical data and to identify emerging themes (which are presented under chapters 4, 5, and 6).

Chapter 4: The Role Health Law in KRI

"A Critical Analysis of KRI Healthcare System Governance"

(Empirical Findings and Discussions)

4.1 Introduction

Chapter four presents rich data in the form of interview statements from empirical qualitative interviews with health practitioners, clinical leaders, and health-related policy makers in the KRI. As indicated under the methodology part of chapter 1, the empirical data was analysed using *Thematic Data Analysis Process.*[384] Under this process, the initial codes are generated by highlighting repeated patterns under the entire data set (the transcribed interview conversations).

Additionally, the generated codes are sorted into semantic themes, which focuses on explicit meaning of the data rather than underlying ideas of the participants (also known as latent themes).[385] The emerging themes under this chapter are developed through both deductive (top-down) and inductive approach (bottom-up).[386] The themes are developed through deductive approach because they are driven from the existing components of health system governance by the *NHS Leadership Academy*.[387] This chapter, discusses four main themes emerged from the empirical data which are 'the role of law, the lack of awareness, non-legal rules, implications on team performance.' Each theme is followed by discussions, whereby the findings are related back to the existing literature and to the benchmarks of best practice for health system governance for the purpose of identifying areas for improvements.

4.2 Emerging Theme: 'KRI HEALTH LAW'

4.2.1 Hard Law

As discussed under (chapter 2.1.1), laws are the corner stone for the effective operation of the healthcare system.[388] The existence of a legal framework and the enforcements of laws within the healthcare providers can have effect of improving the quality of

[384] Braun and Clarke (365) p83.
[385] Ibid 84-89.
[386] Ibid 83.
[387] NHS Leadership Academy, *Healthcare Leadership Model: the nine dimensions of leadership behaviour* (2013).
[388] WHO, *Health laws and universal health coverage* (2018) http://www.who.int/health-laws/en/ 19 March 2018.

healthcare.[389] This first emerging theme 'KRI Health Law' can be described as a semantic theme because is identified through the analysis of the explicit meaning of the empirical data. Although, this theme can be described as semantic theme, it is developed through the application of deductive (top-down) approach as it is based on the first component of health system governance on improving and implementing health law.

The Existence of Hard Law in KRI: Participants 26, 27, 30, and 31 (12% of the 32 participants) recognise both the existence and the implementation of Health Law under the KRI healthcare system. According to participant 30, Kurdistan follows a number of Acts passed by the Iraqi Parliament. As an example, this participant stated that the forensic institute follows the *Iraqi Medical Law Act (1987),* which is introduced by the Iraqi Parliament rather than the Kurdistan Parliament.

Participant 27 (head of Forensic Institute) confirmed the application of hard laws and argued that Article 5 of number 57 *Iraqi Medical Law Act 1987* enabled the forensic department in 2006 to officially become an institute rather than a unit belonging to surgical department under the public sector. Additionally, according to participant 27, the *Iraqi Medical Law Act 1987* was reformed in 2013, whereby *article 37* of *Iraqi Medical Law Act 2013* brought in major changes for the purpose of making autopsy in forensic institute cost-effective. Following this reform, according to participant 27, the forensic institute have a discretionary power to undertake autopsy depending on the case and the practitioners are no longer obliged to conduct a full autopsy in each referral.

Iraqi Hard Law: Following the discussion on the existence of health law, this part focuses on the impact of Iraqi Acts of Parliament. In 1981 the Iraqi Parliament passed the *Public Health Law (Law No. 89 of 1981)* to guarantee medical care and sickness benefit.[390] The predominant objective of such law was to impose a duty on healthcare governing authorities to protect citizen's rights in terms of promoting family health care, nutrition, health education, and mental health. Additionally, the constitution of Iraq which was redrafted in 2005 whereby *Articles 30(1) and (2) of Iraqi Constitution 2005*

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[389] David Clarke (n86).

[390] International Labour Organisation, *Iraq: Medical Care and Sickness Benefit* (2014) http://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=57211&p_country=IRQ&p_count=235 27 June 2019.

imposes a duty on the state to guarantee a healthy life, health security.[391] Article 31 (1) of Iraqi Constitution 2005, provides that "*Every citizen has the right to health care. The State shall maintain public health and provide the means of prevention and treatment by building different types of hospitals and health institutions.*"[392] Further, article 31 (2) provides that:

> "*Individuals and entities have the right to build hospitals, clinics, or private health care centers under the supervision of the State, and this shall be regulated by law.*"[393]

Article 14 of the constitution also imposes a duty on governing bodies to establish health policies and ensure collaboration as it states that "*To formulate public health policy, in cooperation with the regions and governorates that are not organized in a region.*"[394] This point confirms the findings by participants 27 and 30 (above) relating to the existence of legal rules such as the Amended Medical Law Act 2013 by Iraqi Parliament, which is followed by the forensic institute under the KRI healthcare system.

KRI Hard Law: In addition to the Iraqi constitution, the *Constitution of the Iraqi Kurdistan Region* was drafted in 2006. Article 51 provides that the KRI MOH has the duty to provide medical services "*by building hospitals, health centres, and social care centres…and provide means of prevention and treatment.*"[395] Although the constitution of Iraqi Kurdistan region was drafted, the constitution of Iraqi (2005) is supreme and is binding on all parts including Kurdistan region.[396] This indicates that any law passed by the KRI parliament must comply with Iraqi constitution.[397] This is the case, even though KRI has been recognised as a federal region under article 117 of *Iraqi Constitution (2005)* which provides that "*This Constitution, upon coming into force, shall recognize the region of Kurdistan, along with its existing authorities, as a federal*

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[391] KRG, *Constitution of Iraq* (2005) https://www.constituteproject.org/constitution/Iraq_2005.pdf?lang=en> 20 March 2018; C. Ross Anthony et al, (n35) 5.
[392] KRG (n391).
[393] Ibid.
[394] Ibid.
[395] Michael J. Kelly, The Kurdish Regional Constitution within the Framework of the Iraqi Federal Constitution: *A Struggle for Sovereignty, Oil, Ethnic Identity, and the Prospects for a Reverse Supremacy Clause* (2010) 782 Penn State Law Review.
[396] Constitution of Iraq (2005) Art. 13.
[397] Michael J Kelly (n395) 727.

region." [398] As a federal region, the KRI Parliament has established numerous legislations, below is a list of those legislations which are published in Kurdish language and relevant to the thesis:

- Ministry of Justice Act 1992 no 12[399]
- Kurdistan Region Budget Act 1997 no 1[400]
- Solicitor's Act 1999 no 17[401]
- Pharmacists Syndicate Act 1999 no 8[402]
- Healthcare Practitioners Syndicate Act 1999 no 9[403]
- Human Rights Law Act 2001 no 2[404]
- Dentist Syndicate Act 2004 no. 45
- Mental Health Act 2013 no. 8[405]
- Organ Transplantation Act 2018[406]

The list below provides a number of additional legislations passed by the Kurdish National Assembly within the KRI Parliament, some of which are translated in English language.[407]

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[398] KRG (n391).
[399] KRI Parliament, *Ministry of Justice Act: Kurdish version* (1992) <http://www.perlemanikurdistan.com/files/articles/100315100246.pdf> 15 April 2018
[400] Ibid.
[401] KRI Parliament, *Solicitor's Act : Kurdish version* (1999) http://www.perlemanikurdistan.com/files/articles/070415090204.pdf 15 April 2018
[402] KRI Parliament, *Pharmacies Syndicate Act : Kurdish version* (1999) http://www.perlemanikurdistan.com/files/articles/070415083842.pdf 15 April 2018
[403] KRI Parliament, *Healthcare Practitioners Syndicate Act: Kurdish version* (1999) http://www.perlemanikurdistan.com/files/articles/070415083927.pdf 15 April 2018
[404] KRI Parliament, *Human Rights Law Act: Kurdish version* (2001) http://www.perlemanikurdistan.com/files/articles/051015113810.pdf 15 April 2018
[405] KRI Parliament, *Mental Health Act: Kurdish version* (2013) http://www.perlemanikurdistan.com/files/articles/270613103904.pdf 15 April 2018
[406] KRI Parliament, *Organ Transplantation Act: Kurdish version* (2018) http://www.perlemanikurdistan.com/Default.aspx?page=byyear&c=LDD-Yasa&id=2018 15 April 2018
[407] KRG, *Kurdistan Parliament* (2018) <http://cabinet.gov.krd/p/p.aspx?l=12&p=229#landmark_legislation> 20 March 2018

Figure 11: List of KRI Acts of Parliament

Landmark legislation passed by the Kurdistan Parliament

The Kurdistan Parliament has passed several landmark pieces of legislation. These include:

- Kurdistan Region Investment Law (English)
- Kurdistan Region Oil & Gas Law (English)
- Kurdistan Region Amendments of Iraqi Personal Status Law (English)
- Kurdistan Region Amendment to Iraqi Pension and Social Security Law (English)
- Kurdistan Region Law to Combat Domestic Violence (English)
- Kurdistan Region Presidency Law (Kurdish)
  - Amended Kurdistan Region Presidency Law (Kurdish)
- Kurdistan Region Counter-Terrorism Law (Kurdish)
- Kurdistan Region Law on Rights of Family Members of Anfal Victims (Kurdish)
- Kurdistan Region Law on Compensation of Wrongly Convicted Persons (Kurdish)
- Kurdistan Region Law for Board for Disputed Territories Affairs (Kurdish)
- Kurdistan Region Law on Regional Security Council (Kurdish)
- Kurdistan Region Law on Protection of the Environment (Kurdish)
- Kurdistan Region Law on Funding of Projects for Youth (Kurdish)

4.2.2 Soft Law (Quasi Legal Rules)

In addition to hard law, examples of soft law include guidelines, policies, resolutions and codes of conduct.[408] Participants 26 (former WHO associate) and 31 (a policy maker) argue that quasi-legal rules such as guidelines relating to national deceases are provided by international health organizations including the WHO and UNICEF. As evidence, participant 26 argued that "*the WHO has provided a list in order to indicate what needed to be done, this was indicating the targets for each hour. It was the agenda of the job*." Participant 31 (a policy maker) also confirmed that upon request, the WHO is prepared to provide guidelines at the ministerial level.

The office of the WHO representative in KRI is located in the ministry of health department and as confirmed by participant 31, the WHO representative is involved in the process of improving the healthcare system by attending meetings on regular basis. Furthermore, participant 31 emphasised that although guidelines relating to new knowledge, system measures and medical issues are provided by the KRI Department of Health, clinical leaders within the healthcare providers are given a discretion to follow guidelines about surgical and clinical procedures. This finding is corroborated by a WHO report.[409] This report suggests the collaboration of the WHO with neighboring countries

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[408] Andrew T Guzman, Timothy L. Meyer, *International Soft Law* (2010) 172 Legal Analysis https://scholarship.law.berkeley.edu/cgi/viewcontent.cgi?referer=https://www.google.co.uk/&httpsredir=1&article=1694&context=facpubs 24 March 2018.

[409] WHO, *Iraq: WHO intercountry cooperation yields rich health dividends* (2018) http://www.emro.who.int/irq/iraq-news/who-intercountry-cooperation-yields-rich-health-dividends.html 7 August 2019

of KRI to provide support and guidance in cases of emergency. During the new strain of corona decease (COVID-19), the KRI health minister worked closely with the WHO representatives. Whilst the outbreak of corona decease was declared by the WHO as 'international health emergency', the Kurdistan health ministry department followed the instruction of the WHO by taking restrictive measures.[410] The KRI ministry of health followed the WHO guidance on establishing dedicated healthcare providers; raising awareness about the restrictive measures through the media; and the closure of public places including schools and universities.

4.2.3 Non-legal Rules

In addition to legal rules, non-legal rules such as (norms, religious values, and moral obligations) have also an impact on the behaviours of healthcare practitioners. Although the breach of non-legal rules has no legal consequences, breach of such rules can have a negative impact on the relationship between healthcare practitioners. As indicated previously (chapter 2.1.3), the failure to obey non-legal rules can lead to informal sanctions such as being isolated from a particular group.[411] Under the present empirical research programme, the majority of the participants are from the opinion that hard laws are not successfully implemented at the level of patient's care. As an alternative to legal rules, the participants are claiming that they are relying to a great degree on non-legal rules. More specifically, the empirical findings suggest that the KRI healthcare practitioners are relying on information from medical books, culture and routine; guidance by senior practitioners; meetings and workshops; and the information obtained from independent research by an individual practitioner.

Empirical Findings on Non-legal Rules: Participants 6, 16, and 30 are from the opinion that healthcare practitioners are following non-legal rules which are established through routine and are influenced by the KRI culture. Whilst participant 30 was unsure about the origin of non-legal rules, he argued: "*This is the culture within the center and eehh…we have been working in this way for many years*." In order to ensure common

[410] Kurdistan24, *Iraq, Kurdistan coronavirus infections steady, as Iran cases soar* (2020) https://www.kurdistan24.net/en/news/e9fec1bf-3881-4223-bf36-885f35c9743f 15 March 2020
[411] John W. Davis, *Contemporary Issues in Biomedical Ethics* (The Humana Press Inc, New Jersey, 1978).

standards without legal rules, participants 6 and 16 proclaimed that similar routines are applied to all patients on daily basis. Participant 16 asserted:

> "*In the evening the doctor will assess whether the patient's condition has improved, if not then the doctor will decide that the patient should stay for another day in the emergency department… The doctor stays in the diagnosis room, we will notify the doctor as soon as possible so that the doctor can attend the patient*."

Above all, Participant 30 explicated the routine in forensic institute:

> "*We work step by step … For example, the case comes through the police to us, then necessary we refer the case to the medical department, and they make a draft report, then the report comes back to us as legal department, then we examine the report and consider whether there are any errors within the process of the case*."

Oral Guidance: As an alternative to soft law, the empirical findings also suggest that healthcare practitioners are relaying on the oral guidance and instructions by senior professionals in the course of practice or meeting. Such guidance is perceived positively by participants 8, 17, 23, and 25. According to participants 8 and 17, the guidance by senior health professionals works well in some hospital departments such as gynecology. Participants *23 and 25* are particularly enjoying the guidelines presented in an oral form during regular meetings by hospital managers and consultants. Participant 23 stated:

> "*This meeting consists of different parts, the first part is post call meeting, the doctor that was on call the day before and eeh… the permanent doctor will talk about cases and special circumstances. eeehh…The second part of the meeting is about the teaching and new knowledge part. If there are special circumstances, and rare cases will be discussed..*."

Furthermore, participant 25 disclosed:

> "*We have meetings, which I like it very much. Our seniors give us a lot of information and how all the patients have been seen and how they managed, this will be presented in a data show in the presentation*."

Nevertheless, on the other hand it can be argued that only 4 participants (12.5 %) are perceiving the oral guidance positively, which indicates that about 87.5% of the participants have not shared such view. Realistically, oral guidance cannot always be in patient's best interests. In cases concerning patients with critical conditions, it is almost impossible for healthcare practitioners to make time and seek oral guidance from senior practitioners. Predominantly, it is almost impractical to corroborate consistency of healthcare practice and to determine whether such guidance is in accordance to reasonable standards and

Self-regulation: Based on the participant's perceptions, the healthcare practitioners are self-regulating through the observation of colleagues and the attendance of regular meetings in order to manage own behavior and ensure self-control and self-management.[412] As indicated above under the second emerging theme of non-legal rules, 37.5% of the participant (including 1,6,8,15,16,17,22,23,25,27,29, and 30) indicated that they are self-regulating themselves as an alternative of guidelines and health regulations.

Conventions: As indicated under chapter 2, (social) conventions are concerned with accepted standards that have developed through tradition and are serving the function of facilitating coordination.[413] The empirical findings suggest that conventions are followed within the KRI healthcare providers. As evidence, participants 6, 16, and 30 are claiming that non-legal rules which are developed through the tradition and culture. Based on the healthcare practitioner's perceptions, norms are playing an important part within the KRI healthcare providers whereby it has the effect of exerting influence over the attitude of healthcare practitioners within the process of medical intervention.

Independent Research & Conference Attendance: According to participants 1, 15, 17, 22, 27, and 29 practitioners (18.75%) are attempting to enhance their knowledge and improve their practice by conducting independent research and attending both national and international conferences. For instance, participants 1, 22, and 29 indicated that some healthcare practitioners are conducting independent research by searching the internet and reading books on regular basis. As evidence, participant 29 argued "*if I have noticed that certain medication is not effective, then I was prepared to do research in this area.*"

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[412] Monique Boekaerts, Paul R Pintrich, and Moshezeidner, *Self-regulation: an Introductory Review* (2000) San Diego, Calif. : Academic Press.
[413] Nicholas Southwood, Lina Eriksson, *Norms and conventions* (2011) Philosophical Explorations.

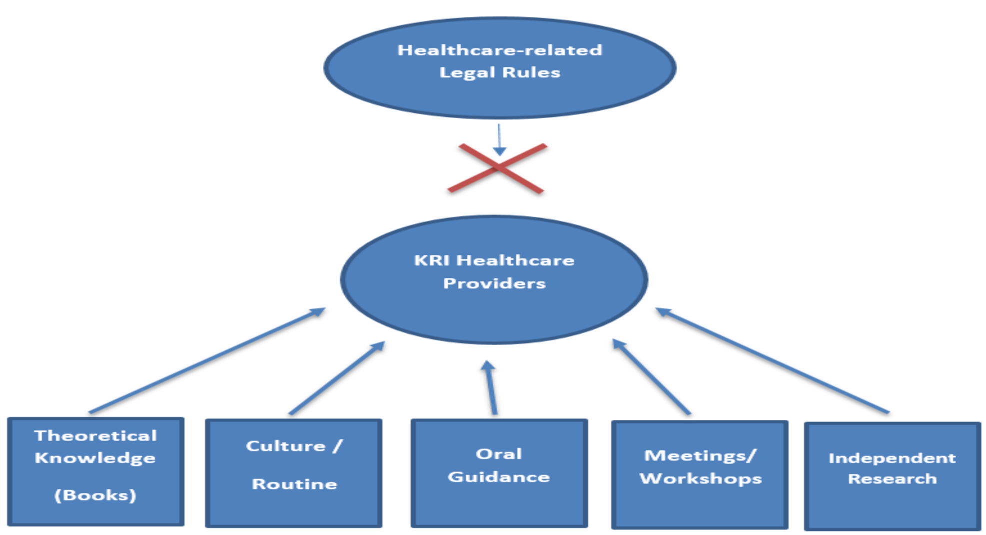
Moreover, p*articipants 1, 15, 17, 22, 27, 29* stated that they are using books as an alternative to guidelines and protocols.

Books: Unsurprisingly, the use of books is subject to critics as participant 29 argued that the use of books does not focus on practical aspects but rather on theoretical aspects. Participant 15 criticized the use of different books from different schools as he was from the opinion that it can lead to disagreements between healthcare practitioners and he attested:

> "*I follow human neurosurgery, my friend my follow, Cabin Neurosurgery or Wilkins Neurosurgery*."

The findings relating to non-legal rules are elucidated under the figure below. As it can be seen, due to the non-existence and or no implementation of legal rules, healthcare practitioners are regulating themselves by following numerous non-legal rules. The empirical findings indicate the sources from which the non-rules originate are theoretical knowledge from books; culture and routine; guidance by senior practitioners; meetings and workshops; and independent research by a number of practitioners to justify their practice.

Figure 12: Non-legal Rules in the KRI Healthcare Providers



4.2.4 Synthesis and Discussion

Conflicting Views on the Existence of Law: The aforementioned findings show the participant's views on the existence of law within the KRI healthcare providers differ substantially. What is critical in this instance, is that only those participants (26, 27, 30, and 31) at the management level are aware about the existence of both hard laws and soft laws. As evidence, participant 26 is a former WHO Associate; participant 27 is the head of Forensic Institute; participant 30 is a Medical Lawyer; and participant 31 is a policy maker within the KRI Department of Health. On the other hand, according to the majority (87.5%) of the participants, hard laws and soft laws have no direct role at the level of patient's care. Although participant 31 (Head of KRI Department of Health) indicated regulations are established by the DoH and that duties are imposed under the managing teams to introduce guideline on the process of medical practice, the majority of healthcare practitioners are indicating that no guidelines and regulations exist within the KRI healthcare providers.

Thence, it can be argued that there is a disconnection between the introduction and knowledge of legal rules under the KRI healthcare system, and potentially, issues with their enforcement as the result. The validity of such finding is further confirmed by the existing literature. For instance, the *KRG Cabinet* provides that the former *KRI Minister of Health* raised issues relating to the lack of clear job descriptions within the healthcare providers.[414] Furthermore, an international research organization (known as RAND Corporation)[415] found that in the KRI "*Job descriptions and staff performance standards are lacking...*"[416] Under this report it was concluded that under the KRI healthcare system not only regulations are absent but there is also a failure to implement the *WHO International Health Regulations (2005)* on reportable national diseases.[417] Even though, the research by RAND Corporation was conducted in 2010 and the RAND report was published in 2014, the present empirical study of this research confirms that the issues relating to the lack of regulations, guidelines and job-descriptions are still existent.

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[414] KRG Cabinet, *Health minister: Top priority is improving primary healthcare* (2006) <http://cabinet.gov.krd/a/d.aspx?s=010000&l=12&a=14384> 20 March 2018

[415] Which was sponsored by the Kurdistan Regional Government in 2010 to explore issues within the KIR healthcare system.

[416] C. Ross Anthony (n35) xiv, 17.

[417] Ibid 144.

Measuring the above findings against the benchmarks on developing and implementation of laws and regulations, a number of arguments can be put forward. It can be argued that although such findings do not suggest issues relating to over-regulations, such findings do suggest that under the KRI healthcare system there is a failure to develop professional regulations with distinct characteristics of proportionality, transparency, focus and agility. Such findings also suggest the failure to vertically and horizontally implementation of existing rules.

Non-legal Rules: The empirical findings above indicate that KRI healthcare practitioners are following non-legal rules (in the form of conventions, practices, and moral norms) as an alternative to legal rules. Such practice is in accordance to *'natural law theory'* (a moral theory of jurisprudence by *St. Thomas Aquinas*) as under this theory, human laws are defined by morality rather than legal authorities.[418] As such, it can be argued that KRI healthcare practice is based on interpretivism approach as due to the challenges relating to the acceptability of law in the health care, moral duties takes priority over legal duties. It can be averred that due to the lack of effective laws, under the KRI healthcare system, personal systems of morality (and perhaps immorality to an extent) are applied at the level of patient's care. The findings suggest that there is a misperception amongst many healthcare practitioners about the status and enforceability of health law. As found under the empirical study of this thesis, some practitioners believe they can somehow ignore legal rules and follow the instructions of senior professionals. Nevertheless, placing exclusive reliance on such instruction is unwise as it does not necessarily mean that their healthcare practice is in accordance of expected standards of healthcare. Additionally, reliance on moral norms in the healthcare prevents consistent practice as such rules are not systematically and formally codified.

Moral norms and obligations such as treating patients without payments during the economic and political issues are also regarded as an accepted practice by a number of KRI healthcare practitioners. As evidence, participant 18 (nurse) claimed that although he was not paid, he felt morally obliged to attend the A&E department and treat patients. He argued that it was morally wrong to neglect patients. This participant thought it was morally wrong to neglect patients. More specifically, participant 18 stated:

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[418] John Goyette, Mark S. Latkovic, and Richard S. Myers, *St. Thomas Aquinas and the Natural Law Tradition : Contemporary Perspectives* (Catholic University of America Press 2004) 3.

"But for me as a nurse I am obliged, even though I would do the same even if I was not obliged, to be very nice and to beg them sometimes in order for the patient to accept the proposed medical treatment. I have been told not to act even if I was hit by the patient or the family member of the patient."

This point was further confirmed by participant 16 (senior nurse) as he argued:

"*We have medical staff that are coming from outside the city and are spending too much money in order to commute to work. This is even more difficult for those that are working voluntarily. We have the time-table you can look at it later*."

Such norms of treating patients without consideration are related to those norms which are often driven by normative ethics: consequentialism, utilitarianism, and egoism.[419] The example of moral duties to treat without being paid is also in accordance to the normative ethic known as '*altruism'* as the above practitioner was bringing about advantages to patients by treating patients without being paid.

Consequences of Breaching (Non-) legal Rules: By questioning the KRI healthcare practitioners, it can be argued that under the KRI healthcare system, non-legal rules outweigh legal rules as the majority of healthcare practitioners are not recognizing the existence of legal rules and due to the lack of clinical negligence system there are no legal consequences for failing to obey legal rules. Such findings further confirms the *RAND* report, which provides that the information relating to existing legal rules are not distributed and not communicated to the healthcare practitioners at the level of patient's care.[420] Nevertheless, the failure to obey non-legal rules does make healthcare practitioners accountable to one another.[421] For instance, the failure to follow the instructions by a senior practitioner has a negative impact on the interpersonal connections between healthcare practitioners and can lead to social sanctions.

A good example of non-legal rules affecting interpersonal connections between healthcare practitioners in the KRI is when participant 15 was involved in a disagreement and made the following statement: "*I said I will punish you, he said you cannot. He said*

[419] Julinna C. Oxley, *The Moral Dimensions of Empathy: Empathy, Altruism and Normative Ethics* (Palgrave Macmillan 2011) 59 https://link.springer.com/chapter/10.1057/9780230347809_4 16 April 2018.
[420] C. Ross Anthony (n35) iv, 17.
[421] Nicholas Southwood, Lina Eriksson, *Norms and conventions* (2011) Philosophical Explorations.

here you are let us see what you can do." The existing literature confirms serious attacks on healthcare practitioners within the KRI healthcare providers, as it is reported that recently a physician was shot in his private clinic with silent gun.[422]

Measuring such findings against the benchmarks on the implementation of laws and regulations (Chapter 2.1.2), it can be argued that the existing legal rules are not vertically implemented. In fact, the KRI Parliament has taken initiatives to improve quality of healthcare by introducing Acts of Parliament. For instance, *Article 2(4) of Kurdistan Region Investment Law (July 2006) Law no (4)* approves the investment on projects for improving health and environment.[423] Additionally, *Article 8(5)* imposes a duty on the state to invest money "*To safeguard the environment, maintain public health and safety, and comply with standardization and quality control systems, in accordance with international standards*."[424]

Nevertheless, it can be argued that unlike the Iraqi Parliament, the KRI parliament has not introduced a particular Act such as the Medical Law Act that would clarify the duties and responsibilities of the KRI health service leaders.[425] This is the case, even though the KRI Parliament has a number of standing committees including health and environment committees with considerable power to establish Health Law to improve the quality of healthcare.[426] Although, due to the failure of successfully implementing the existing legal rules, non-legal rules has certain advantages including flexibilities and the clarification of roles and responsibilities,[427] it could be speculated that it can lead to inconsistent practice within the healthcare providers.

[422] Basnews, *One Suspect Arrested over Shooting Physician in Sulaymaniyah* (2018) Kurdistan http://www.basnews.com/index.php/en/news/kurdistan/485115 12 July 2019
[423] KRG, *Kurdistan Region Investment Law* (2006) http://cabinet.gov.krd/p/p.aspx?l=12&s=020000&r=315&p=293 20 March 2018
[424] Ibid.
[425] Kurdistan Regional Government, *Legislation* (2018) http://cabinet.gov.krd/p/page.aspx?l=12&s=000000&r=418&p=333&h=1&t=0 14 March 2018
[426] KRG, *Fact sheet: About the Kurdistan Regional Government* (2018) http://cabinet.gov.krd/p/p.aspx?l=12&p=180 20 March 2018; KRG, *Kurdistan Parliament* (2018) http://cabinet.gov.krd/p/p.aspx?l=12&p=229#landmark_legislation 20 March 2018
[427] Filippo M. Zerilli, *The rule of soft law: An introduction* (2010) 9 Journal of Global and Historical Anthropology.

4.3 Emerging Theme: "LACK OF AWARENESS OF REGULATIONS AND GUIDELINES"

Having identified the healthcare practitioners' views on the non-existence of Health Law within the KRI healthcare providers, the second theme emerged from the empirical data is centered around the healthcare practitioner's awareness of clinical guidelines and regulations. The theme is developed using inductive approach as it has emerged from the data, which can be described as semantic theme because it has been identified through the analysis of the explicit meaning of the empirical data relating to legal rules.

4.3.1 Implementation Challenges of KRI Health Law

Due to the issues relating to the disconnection between the law and practice, this part of the chapter focuses on the implementation challenges of KRI Health Law at the level of patient's care. As it can be seen below, the presented empirical statements suggest conflicting views relating to awareness of clinical guidelines and regulations. Whilst 28% of the participants are claiming that the law is established but not implemented, 31% of the participants are of the opinion that law is not established and neither implemented. Under this chapter, such views are critically analyzed for the purpose of identifying challenges to the implementation of KRI Health Law.

Established/ Unimplemented Health Law: Even though only those participants at the management level are claiming both the existence and the implementation of clinical guidelines and regulations, participants (including participant 3, 12, 15, 16, 18, 22, 23, 24, 28, and 32) claim that health law exist but are not implemented successfully and have no priority at the level of patient's care. As evidence, participant 12 argued that "*In this country the law is not above everything*." Furthermore, participant 15 argued that "*We are facing problems in application, otherwise we have laws.*" Participant 23 (a hospital director) voices his concern as he did not find the law to be effective and argued: "*We also have certain rules although they are not very practical.*" The underlying rationale behind the existence of non-practical rules within the KRI healthcare providers are discussed below (under chapter 3.2.2). Furthermore, participant 24 (assistant director of training center) argued that although guidelines are provided by KRI Nursing Council (Hobay Kargery Paristyari), it is subject to criticisms as he stated that "*this is not sufficient, and our healthcare system need to be reformed*."

Most importantly, participants 3, 18 and 28 suggested that the law has no priority at the level of patient's care. As evidence, participant 28 argued "*we have guidelines, we don't care, we do what is necessary at the time*." Moreover, according to participant 16 (a senior nurse) although legal rules such as guidelines are provided to divide the responsibilities between college and graduate nurses, in practice, within the A&E department the responsibilities are not divided, and everyone is working together to save the life of the patient.

Non-established / Unimplemented Health Law: Based on the empirical findings, 31% of the participants (including participants 2,4,6,7,8,9,17,25,26, and 29) do not recognise both the existence and the implementations of Health Law within the KRI healthcare providers. Particularly, participants 2 (member of health quality improvement) and 8 (General Practitioner) confirm that no internal regulations exist within the healthcare providers of KRI under both public and private sectors. Additionally, participant 29 (Heart Surgeon) argued that the law has no deterrent effect within the KRI healthcare providers, as he states:

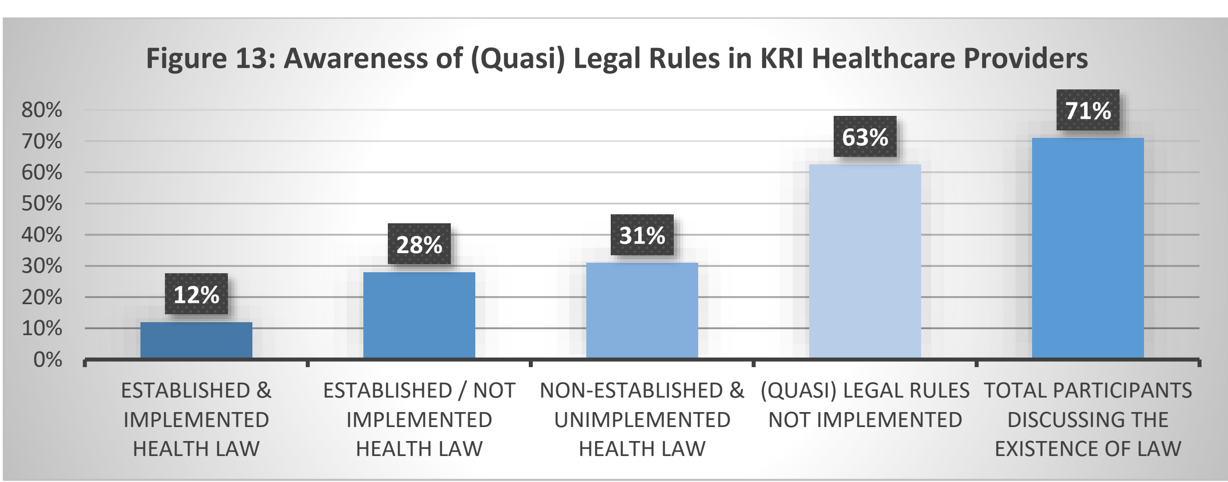
> "*there is no law to prevent you from using certain medications. So, it depends on the characteristics of the doctor...*"

In addition to the non-recognition of regulations and protocols, participant 2 compared the KRI healthcare system with the UK healthcare system and argued that in KRI no guidelines such as NICE guidelines are followed in the hospitals. Furthermore, participant 8 (a general practitioner) argued that unlike the UK, leaflet or small booklet does not exist to inform healthcare practitioners and patients about particular medical conditions or medications. Moreover, participant 9 (a hospital director and a heart specialist) compared the KRI healthcare system with the healthcare system of Egypt whereby he stated that unlike in Egypt, we do not have clinical guidelines to reach international standards.

Although, participants 7, 24, 25 and 29 are confirming that no guidelines exist within the KRI healthcare providers to clarify roles and responsibilities, unsurprisingly, participants 12, 13, and 17 were not even familiar with clinical guidelines and did not consider it to be part of their job. As evidence, participant 12 (a general anesthetist) argued:

> *"Sorry can you explain this? What do you mean by guidelines? .... Well, because we are working in the hospitals, the operation rooms, this attempt is not for us, it is merely a job of ministry."*

Furthermore, participant 8 was not aware about the contractual responsibilities within the public healthcare providers of KRI and argued that contracts only exist within the private hospitals. In addition to the lack of clinical guidelines, participants 8 and 26 argued that no job-description within the KRI healthcare providers exist. The chart below presents the findings relating to the awareness of legal rules at the level of patient's care by the participants of this empirical study. In total 20 participants (including 2,3,4,6,7,8,9,12,15,16,17,18,22,23,24,25,26,28,29, and 32) are arguing that (quasi) legal rules are not implemented at the level of patient care. As it can be seen below, 71% of the participants were discussing the existence of healthcare related legal rules within the KRI healthcare providers. As it can be seen below, 31% of the participants are not aware about the existence and the implementation of health-related legal rules.



4.3.2 The Rationale for Non-implementation of Health Law

The empirical findings indicate various challenges for the lack of awareness of Health Law under the KRI healthcare providers. According to the participants (including 2,3,4,9,10,18,24,28, and 32) political interference, economic issues, and ineffective laws are regarded as the major obstacle for successfully enforcing laws at the level of patient's care. Each obstacle is considered in detail below.

Political Parties Interference: Such interference is regarded as one of the principal grounds for the non-recognition of Health Laws. According to participants 3 and 4, political parties with significant powers in KRI Parliament are to be blamed for the failure to develop Health Law. Furthermore, participant 10 (A&E department director) argued that it is not easy to introduce laws, he argued that two months before the interview date he tried to establish hospital protocol but failed because various reasons including political interference. This point was confirmed by participant 24 (assistant director of training center). Participant 24 argued that although they had plans to introduce guidelines, political and economic issues are regarded as an obstacle to preventing to prevent such development. He elucidated that the process of introducing legal rules such as an Act of parliament or regulations need sufficient support by political parties.

Economic Issues: In addition to political interference, economic issues are regarded to be one of the obstacles for introducing and implementing legal rules. According to participants 2, 3, 9, and 24 successful implementation of legal rules needs funding for relevant training programs, equipment, and for the recruitment of relevant professionals from different roles to make healthcare practitioners aware about new rules and to assess the effectiveness of the rule. As evidence, participant 3 argued that the failure to assess the effectiveness of introduced legal rules prevents the successful implementation at the level of patient’s care.

Ineffective Law: The findings indicate that the failure to assess the effectiveness of legal rules, leads to unpractical and outdated law. As such, as participant 32 (a policy maker) argued that the law governing the professional regulatory authorities such as doctors syndicate, nursing council and dental council is outdated. Moreover, participant 9 (a heart specialist), compared the KRI healthcare system with the Egypt healthcare system, and argued that instead of the implementation of *European* and *American* guidelines, under the KRI healthcare system outdated books are utilized as a guideline during the process of medical intervention. Participant 3 added that the failure to allocate time for the application of law is also a major obstacle for implementing legal rules as she argued: “*The main reason is that we lack timing and we lack plan to solve this issue*.” This issue is further confirmed by participants 18 and 28 and they add that no sufficient time is allocated for the healthcare practitioners to follow relevant rules. The chart below provides a summary of the empirical findings about the reasons for the failure to have effective legal rules at the level of patients care.

Figure 14: The Rationale for In-effective Laws

Health-related Law

Reasons for No Implementations

Healthcare Providers of KRI: Level of Patient's Care

Ignorance of Law

Failure to Assess effectiveness

Out-dated Law

Economic Issues

Political Party Interference

Time

4.3.3 Repercussions on KRI Healthcare quality

Although, it can be proposed that the no-recognition of Health Law by healthcare practitioners, does not necessarily mean non-existence of health law as very often complicated laws are simplified and converted into practical steps. Nevertheless, it is less likely for such proposition to be realistic under the KRI healthcare system, as the empirical findings suggest that the lack of legal rules have grave repercussions on the quality of KRI healthcare. According to participants 3, 8, 18, 22, 25, and 32, the predominant examples of such grave repercussions are patient safety hazard, medical errors, and inconsistent practices within the KRI healthcare providers.

Patient Safety Hazard: According to participant 3, the lack of legal rules relating to storage and quality control of medications has led to serious patient safety failures such as the provision of expired medication. This point was further confirmed by participant 32 (a policy maker) as he argued that due to the lack of regulations, the government is not authorized to undertake quality control in pharmacy, which is regarded as a patient safety hazard.

Medical Errors: According to participants 3 and 25, the non-existence and non-implementation of (quasi) legal rules are the overriding reasons for medical errors. Additionally, according to participants 18 and 22, the non-compliance of regulations and guidelines have led to the unethical practice and inequality within the healthcare

providers. According to participant 18, medical practitioners (including incompetent practitioners) are being employed without following a formal process of job application. More specifically, participant 6 contended that the lack of regulations causes difficulties within the decision-making process of withdrawal of life-sustaining treatment. He stated:

> *"our society, the patient is under ventilation, it is unclear who can discharge this patient outside the intensive care ... a patient….eehhh. under ventilation for about two or three weeks and they have not any chance to survive and then the patient is not discharged to provide a bed for another patient*."

Inconsistent Practice: Furthermore, according to participant 22 (children's health specialist) self-rules by healthcare practitioners has led to the application of unreasonable rules and inconsistent practice which is not in patient's best interests. The point relating to inconsistent practice was further confirmed by participant 8 as he argued: "*in the hospital sometimes there is one type of antibiotic and in another hospital, they don't have it*."

4.3.4 Synthesis and Discussions

Following the presentation of the empirical statements made by the participants, a number of propositions can be made. First of all, the empirical findings relating to the existence of health law on the provision of health services is further confirmed under the existing literature. For instance, the *Constitution of Iraqi Kurdistan Region* provides that the KRI MOH has the duty to provide medical services,[428] which has resulted in provision of free national health services.[429]

The second proposition is that although a limited number of laws are introduced by Iraqi and KRI parliament, due to the lack of effective clinical guidelines and regulation such law is not successfully implemented at the level of patient's care. Such proposition is further confirmed through the identification of conflicting views relating to the awareness of clinical guidelines and regulations and the disconnection between law and practice. As it can be seen on the chart, non-existence of effective clinical guidelines and

[428] The Constitution of Iraqi Kurdistan Region (2005) Art. 21; Unrepresented Nations and Peoples Organizations, *Constitution of the Iraqi Kurdistan Region* (2004) http://www.unpo.org/article/538 29 March 2018

[429] John Quinn (n38); Tawfik-Shukor (n2)

regulations leads to non-recognition of health law, this ultimately leads to the non-implementation of health law.

Figure 15 Implementation of Health Law

The validity of this empirical findings relating to the lack of legal rules is further confirmed by the exiting data such as *Tawfik-Shukor* and *Khoshnaw* argued that the healthcare system is poorly regulated, and no guideline is in place to update staff with the latest developments.[430] They stated:

> "*The organizational structure of Kurdistan's regional health 'system' is a microcosm of Iraq's wider national system (from which it was historically developed), reflected by its key attributes: centralized, politicized, non-transparent, disorganized, with no clear governance, regulatory, financing or accountability framework, let alone vision or goals*."[431]

Due to the criticisms on successful implementation of legal rules, the KRI legal system can be regarded as a semi-developed legal system. As indicated by *Murati*, the non-implementation of health law due to the lack of clinical guidelines and regulations means that non-legal rules can take priority over legal rules.[432] This indicates, that due to the lack of awareness of law, the KRI healthcare practice is clearly below the reasonable standards of care and is not reaching the benchmarks of best practice. As under the

[430] Tawfik-Shukor (n2) 1.
[431] Ibid.
[432] Besnik Murati, and Elmi Morina, *The rule of law* (2015) 284 Academic Journal of Business, Administration, Law and Social Sciences.

benchmarks of best practice, quasi legal rules are established to ensure successful implementation of health law. Therefore, it can be argued that the non-implementation of legal rules within the KRI healthcare providers is an identified area for improvement. It should be noted that the existence of guidelines and regulations will assist the process of clinical leadership by determining an acceptable behavior and ensuring a high quality of healthcare through the clarification of rights and responsibilities whereby healthcare practitioners are exhorted to act in a particular manner.[433]

4.4 Emerging Theme: "IMPLICATIONS ON TEAM PERFORMANCE"

4.4.1 KRI Health Care Team

The third theme emerged from the empirical findings relates to the impact of the non-implementation of health law on team performance within the KRI healthcare providers. The empirical findings indicate that 62.5% of the participants are not satisfied with the existing team performance within the KRI healthcare providers. Participants 3,4,5,7,9,10,13,14,15,16,19,20,22,25,26,28,29, and 30 believe that the lack of effective guidelines within the KRI healthcare providers have a negative impact on the team performance amongst nurses, doctors, and healthcare leaders. Following the analysis of the empirical findings, it can be argued that the KRI healthcare system involves hierarchy of medical professions, which is further illustrated under the pyramid chart. This part of chapter 3 considers the impact of the lack of legal rules on practitioners-leaders' relationship; doctor-nurses' relationship; and nurse-nurses' relationship.

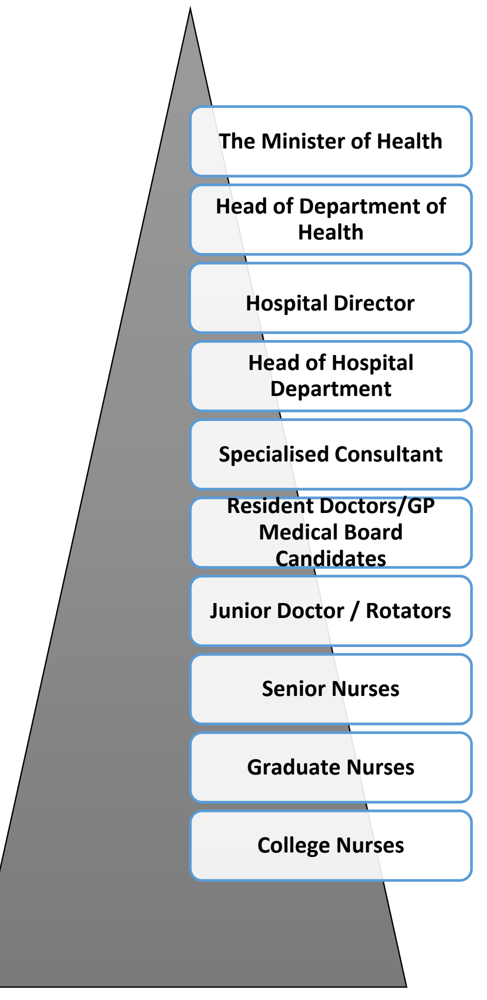


Figure 16: KRI Healthcare Team

[433] Angela Yu (n 74) 23.

4.4.2 Practitioner-Leader Relationship

In the context of this research, the definition of healthcare practitioners includes nurses and doctors; and the definition of healthcare leaders include head of hospital department (specialised professionals), hospital directors, and a member of the Department of Health and the Ministry of Health. In terms of healthcare leaders, the empirical findings indicate that each department of KRI hospitals have a head of department, which is usually an allocated specialised consultant who is overseeing the functions of healthcare practitioners. As evidence, participant 30 explicated the process:

> "*in each hospital eehh we have head of department* **…** *in the hospital of BATNI, eehh we have head of department [of BATNI]. We appoint someone that is experienced ... We also have head of nurses, that has the duty of providing guidelines for nurses*."

The empirical findings suggest that 46.86% of the respondents (including participants 4,5,7,9,10,13,14, 15,16,19,20,25,28,29, and 30) are not satisfied about team performance between healthcare practitioners and health service leaders. They emphasise that the failure to clarify responsibilities has led to a number of issues including the practice by unqualified manager; esoteric targets and goals for improvements; ineffective leadership; unequal treatment; domination of doctors; and ineffective communication. The empirical findings confirm that such issues have a negative impact on the team performance between healthcare leaders, doctors and nurses, which is further illustrated below through the presentation of empirical statements by the participants.

Employment of Unqualified Leaders: Participants 13 (dermatologist), 14 (general surgeon), 15 (Neurosurgeon) and 19 (hospital director) suggest that political clientelism plays a crucial role during the process of appointing health service leaders. For instance, according to participant 13 the assigned health service leaders including hospital directors and head of departments are uncertified and inexperienced as they are appointed through recommendations by political parties:

> "*Those people eeehh that have a high position, they are not professionals, they eehh must have a medical background, they must have experience in business administration, and they must have had the training on how to run hospitals. But*

> *our management team because they have been given the job by eehh political parties...*"

The above point is further confirmed by participant 15:

> "*Unfortunately, those who are becoming managers in our hospital are eeeh from somewhere taking those responsibilities and for example you have a staff who have higher position than the manager because they are close to political parties...*"

Qualification as a requirement is also recognised by participant 19 (head of A&E department). Although, it should be noted that this does not suggest its existence within the KRI healthcare providers. However, participant 19 argued "*Those that get higher position must have medical backgrounds as eeh doctors*." Such point correspondents to the existing requirements by the *UK Medical Leadership and Management* as it claims that qualified leaders are required to have relevant qualification for the purposes of applying evidence-based approaches and take strategic steps to improve the quality of health services.[434]

Lack of accountability: The lack of rules to ensure the employment of qualified and well-experienced clinical service leaders, means lack of accountabilities, thus, imprecise duties to work towards common goals and shared rewards. According to participants 4, 9, 13 and 14, due to the lack of professional regulations and guidelines, clinical leaders are under no duty to improve the quality of healthcare within the KRI healthcare providers. As evidence, participant 9 (a hospital director) stated "*I was a director for three years and in that time, I could not have done any work because there was no one telling me*." Participant 13 stated that the managing teams are not focusing on the quality of healthcare services, as he argued

> "*Really our system is not good, the ministry of health focuses on quantity rather than quality. it is preferred for a doctor to see as many patients as possible rather than providing best quality if medical treatment. The ministry of health only prefers the highest number of patients that are seen in a day. They will note only*

[434] Faculty of Medical Leadership and Management, *Leadership and Leadership Development in Health Care: The Evidence Base* (2015) 2 https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/leadership-leadership-development-health-care-feb-2015.pdf 2 July 2019

for example in [...] hospital that 1OO patient is seen in one department, another 2OO patients are seen in another department."

The lack of initiatives to improve the quality of healthcare, was highlighted by participant 14, who stated:

> "[hospital managers] *are just performing a routine without development, so it is just a duty to manage some works without thinking about new plans… Eeh collect the number of staffs, regulating the salary, eeh just eeeh managing the basic works, no improvements*."

Not Responding to Failures: Due to the lack of accountabilities, participants 5, 7, 13, 16, 20, and 28 are from the opinion that health service leaders are not responding effectively to failures reported to them. Specifically, participant 5 was not satisfied about the supervision by managing teams and scored 4 out of 10. Additionally, participant 7 claimed that the supervision in healthcare has become less satisfactory over the years. A good example that was disclosed by participants 13, 16, 20, and 28 is related to the failure of health service leaders to respond to the reported issues about the allocation of medical staff and the imposition of workload pressure. As evidence, participant 28 (a senior nurse) stated

> "*We have mentioned so many times before, that so many patients cannot be treated by a few healthcare practitioners. Each nurse should have a maximum of three patients. But we were not listened to. At the moment 18 patients are looked after by two nurses. Beside this we have another 40 cases coming in during the night*."

Participant 16 confirmed the ongoing issues relating to workload pressure and stated, "*As we have very limited time and we understand that most of our medical staff is working long hours without good rest*." Participant 13 added that due to the lack of clinical guidelines and professional regulations, clinical service leaders are not effectively managing issues relating to work pressure on medical practitioners and recommended that:

> "*the management team should be aware of the number of patients treated in order to arrange sufficient amount of staff and medication and also in order to ensure high quality of care*."

Absence of Health Service Leaders: In addition to the lack of accountabilities and the failure to respond to issues, participants 4, 9, 10, 25, and 29 suggested that health service leaders are often absent without permission from the hospitals. Whilst arguing that supervision depends on the characteristics and the personality of the supervisor to provide support, participant 4 stated: "*I could not find my supervisor because she was doing shopping*." This point was further supported by participant 29, as he stated:

> "*The head of our department is the heart specialized consultant, that is not always present. But he is on call … we can call him when we need him…if they need PCI* [private chronic intervention], *we call the senior doctor … Otherwise he is not always present… eehh we are working on his behalf*."

The absence of health service leaders including specialised consultants as head of hospital departments during the practice of less experienced professionals leads to unsafe environment. This was expressed by participant 9, who admitted that:

> "*When were left in charge of patient, … it was difficult to eeehhh diagnose the patient and we were left on our own and had guess what the illnesses were*."

Further the same participant added that such issue is more severe during the practice by medical students with almost no experience:

> "*it is wrong to allow students without experience to work in emergency department. In this department it is difficult to get experienced doctors to guide you and very often you are left on your own... in the emergency departments … It is difficult for junior doctors to find a specialized doctor … ehhh in most cases specialized doctors are not available and they don't even answer their phone when they are needed*."

Such issue was acknowledged by participant 10 (as a hospital manager) and as a result proposed to establish:

> "*nighttime consultancy for the paramedics in association with the doctors that they should be supervised by senior doctors*."

More importantly, due to the lack of professional regulations and clinical guidelines, participant 25 stated that the presence of health service leaders (including specialised doctors as head of departments) are more demanding:

> "*we don't have guidelines. Eeehh nobody will ask you or eeh let you know what was your fault in your management eeeh or your friend's management. You will manage it by your information*."

No Guidance by Health Service Leaders: It is not a surprise that the lack of accountability, the failure to respond to issues, and the absence of health service leaders leads to the non-fulfilment of health service manager's duties to provide guidance. This is confirmed by participants 5, 15, and 25. For instance, participant 5 is of the opinion that no sufficient instructions are provided to guide healthcare practitioners on how to communicate effectively with patients and they are acting the way they think is right to communicate. As evidence, participant 5 argued:

> "*The way we communicated with patients we thought it was right. We don't give relevant information for our patients*."

Due to the lack of professional regulations and clinical guidelines, guidance by supervisors are more demanding within the KRI healthcare providers. Although, on the other hand, participant 25 argued that managers including specialised consultants are holding regular meetings and are providing oral instruction and guidance, which are seen beneficial, according to participant 15, the guidance provided is not effective. He argued:

> "*the head are having meetings on weekly basis with manager, but the manager will tell them general things, they will talk about political things, and when the head of the staffs have to talk about how to be more relaxed…*"

Inconsistent practice: As the result of the lack of guidance by health service leaders, participants 8 and 15 argued that the hospital leadership lacks the courage to ensure consistency in practice is maintained. Specifically, participant 8 argued:

> "*nowadays consultants in one place and junior doctors are in another place. I think there is a gap between them… For example, we have a consultant describing morphine it is a very costly antibiotics, it costs about $30 dollars. It costs the hospitals too much actually he prescribes only this drug for patients. So, the junior doctor has to follow their rule*."

Further participant 15 stated:

> "*you know in medicine we have schools; you follow some school; your friend will follow other schools. Unfortunately, we do not have protocols. This is another issue… For example, in spine trauma, …I give some drugs, tomorrow the college as another doctor will come and asks oooh who has given this drug, and therefore cancels my prescription and prescribe another drug. Another example, I plan to perform operation for the patient, and the next day other doctors will come, and he is tired and postponed the operation to another day*."

Unequal treatment: According to participants 15,16, and 28, the lack of accountabilities due to the absence of professional regulations and clinical guidelines has led to issues of unequal treatment and differentiation between doctors and nurses. For instance, according to participant 15 (neurosurgeon) an enhanced relationship is necessary between managers and healthcare practitioners including nurses. He argued *"general director of health system should care about it, not only for doctors but also for nurses."* This point was further confirmed by participant 16 (senior nurse):

> "*Under this system, doctors are supported and respected. But this does not apply to us because there are many volunteers to replace us. This is why they don't care about us…They are putting pressure on us to work…. They are differentiating between us*."

The point relating to unequal treatment was submitted by participant 28 (a senior nurse) as she found that practitioners were treated unequally during the process of allocating funding to attend international workshops. She stated:

> "*our complaint reached the head of the Syndicate, even our head of department was not disclosing the correct information. He only said that he was not aware of the process. But when I went to him, he was actually copying the names. The courses are all wasta* [bribe]*, I am sure*."

(In) effective Team working: This section of chapter three involves two conflicting views on the effectiveness of team working under the KRI healthcare system. On the one hand, despite the issues considered above, participants 8 and 12 are satisfied about the existence of teams working. For instance, participant 12 stated "*we have groups for each*

ward that is making sure that everyone is doing their job..." Furthermore, participant 8 argued that in some department there are good relationships between doctors and managers as he argued: "*Yes, there is a good collaboration…As I said before, our relationship is only in accordance to the process and we don't have any problems in this area*."

Nevertheless, such satisfaction about team performance is only claimed by 3.12% of the participants. On the other hand, contrary to this finding, 37% of the participants (including participants 4, 5, 7, 9, 10, 13, 15, 16, 25, 28, 29 and 30) are not satisfied with the support provided by health service leaders. The lack of satisfaction could be due to the failure to provide guidance, inconsistent practice, and unequal treatment. For instance, when participant 20 (a training manager) was asked about the existence of team performance, she was not satisfied and replied "*It is zero, when I was working with a German company, only there I saw a real teamwork. Healthcare practitioners are supposed to support each other*."

Based on these responses from the participants, it can be argued that the scantiness of qualified clinical service managers and the unclarities in relation to the duties for improvement intercepts a supportive and respectful environment. Such a proposition is further supported by participants 8, 15 and 25 who are from the opinion that the lack of qualified leaders and clinical guidelines has led to unclarities of duties and responsibilities, which ultimately has precipitated disagreements between leaders and practitioners. As evidence, participant 8 argued "*it is not like eeeh, there is not a good relationship between up to now because there is not a job description*." Additionally, participant 15 (neurosurgeon) perceives that the absence of rules within the KRI prevents effective team performance, as he stated:

> "*It is a disaster, unfortunately. We don't have team work rules, between the doctors we may have good relationships especially in our department but eeeh a team which is called medical team of most of senior, eeh rotators, senior house officers, nurses, medical staffs, unfortunately we have these teams and we don't have eeeh a rule*."

Doctors Dominance: The view relating to doctor's dominance is shared by participants 3, 13, 19, 20, and 25 as they claim that the existence of unqualified health service leaders and the lack of guidance enables doctors to dominate the healthcare providers. Participant 19 (hospital manager: head of A&E department) provides that:

> "*Doctors, sorry for going into details about the doctors it is not nice, but all the power is given to doctors under the current healthcare system… The problem is that that doctor is everything*."

The domination of doctors over clinical service leaders within the KRI healthcare providers is further confirmed by participant 3, as she argued that *"The director of hospital, eeh I don't think they have a control over the doctors."* According to participant 13:

> "*about 70 per cent and 80 per cent most of those doctors that have been practicing for a very long time do not find it necessary and do not care about the management…Doctors are doing what they want*."

Interestingly, participant 13 suggests that even if clinical service leaders were implementing new methods for the purpose of improving the healthcare system, doctors would follow the traditional forms of practices. As evidence, participant 13 stated:

"*We have doctors that have been practicing for 30 to 40 years and do not allow further improvements, they only want to follow the old methods of practice*." In addition to some doctors being unwilling to exhibit professionality by adapting to developments in medical science there appears to be a potentially related issue of some doctors not feeling that they have to account for their actions. As participant 25, General Practitioner, went as far as implying that the laxness of the system was such that the only check on a doctor would be his or her own self "*Nothing will happen, no one will ask you like that. You will do it as a doctor. If you feel as responsible, then you should do it*."

Unauthorised Absence of Doctors: In addition to the issues raised relating to the absence of health service leaders, participants 14 and 29 claimed that doctors are also occasionally unjustifiably absent. Further participant 29 (heart surgeon) also claimed that consultants are not always present as he argued:

> "*The head of our department is the heart specialized consultant, that is not always present. But he is on call, this means that we can call him we need him. Those patients that are suffering from acute MI, if they need PCI private chronic intervention, we call the senior doctor to attend the patient … Otherwise he is not always present…*"

As illustrated under chapter 1.2.3, due to the existence of dual healthcare system in the KRI, the majority of doctors are also working most of the days in private clinic. As such, participant 14 (dermatologist) submitted:

> "*For other medical staffs I am not really satisfied because it is just, not so bad it is not so good. Eeh I think, but they are working eeeh when they go outside the hospital, they are working as a doctor…*"

4.4.3 Doctor-Doctor Relationship

Team performance: This section of chapter three involves contradicting views in relation to the existence of effective team performance under doctor-doctor relationship. Participants 4 and 8 are from the opinion that despite the lack of guidelines on clinical procedures, occasionally, there are some cases of effective teamwork. As evidence, participant 8 argued:

> "*Well, it actually depends on the doctor. I have seen in some hospitals it is very good, because it is like, eeeh there is no job description but there are some rules.*"

In this context, it can be argued that participant 8 is confirming the previous proposition on the role of non-legal rules within the KRI healthcare providers. Notwithstanding, on the other hand 31.25% of 32 respondents (including participants 3, 4, 8, 9, 13, 14, 15, 22, 25, and 29) are not satisfied with the existing relationship between doctors. For instance, participant 9 (who has worked under both KRI and Egypt healthcare system) made comparison between the two system. He stated in Egypt

> "*I am a general practitioner in heart conditions. If I see a patient eeeh before making the decision I have to let my team know. This is part of teamwork. Once contacted the team are coming and supporting me within the process of medical treatment … However, in Kurdistan, there is no such thing…"*

According to participants 4 and 25, the lack of courage by leaders to ensure effective team working has led to lack of support by fellow doctors and even professional jealousy within the KRI healthcare providers. Participant 4 asserted: "*But back home if someone is developing successfully then other are trying to attack him in the back in order to destroy him. Does not let him to reach the level he wants to achieve*." Additionally, participant 25 further confirmed that absence of support as she stated: "*We don't have teamwork. I am just alone. Eeh* [silence] *... we are left alone in the hospital…*"

Poor Communication Between Doctors: Participants 15, 16, and 18 there is not always an effective relationship between doctors during the process of medical intervention. For instance, participant 15 (a neurosurgeon) is of the opinion that the lack of guidelines to clarify the rules prevents an effective team performance, as he stated:

> "*It is a disaster, unfortunately. We don't have teamwork rules, ... eeeh a team which is called medical team of most of senior, eeh rotators, senior house officers, nurses, medical staffs, unfortunately we have these teams and we don't have a rule*."

Participant 16, as a senior nurse is blaming senior doctors for poor communication with junior doctors: He argued that

> "*Sometimes, the junior doctor is prescribing the medications and doctors are criticizing for prescribing such medications. Eeh ... Then the doctor will prescribe other type of medications*."

This point is further confirmed by participant 18, a nurse who spoke with quiet concern about the willful failures of doctors to treat patients in some cases:

> "*We had cases, I do not want to attack doctors as a nurse, but this is the reality…But the failures are clear from the doctors as they have the powers and they are the one that make the decisions ... eeeh ... We had doctors (doctor A), when he noticed that the patient was referred by another doctor (Doctor B) from their own private clinic, he (doctor A) had stated that he did not want to treat that patient as it was not his own patient. Even though the patient was admitted to the hospital on the name of doctor A*."

4.4.4 Doctor-Nurse Relationship

Effective Team performance: This section provides contradicting views on the professional communication and collaboration between doctors and nurses. On the one hand, 12.5% of the participants (including participants 14, 16, 17, 19, and 28) confirm the existence of effective teamwork between doctors and nurses. For instance, participant 14 (a general surgeon) stated:

> "*I am very glad to work in this department, we are just working as a friend, just as a team we are working. If someone need help, we will provide help eeeh we go for difficult cases in a group, we perform difficult operation in a group as do also neuron surgeries*."

Additionally, participant 16 (a senior nurse) explained the process of team performance:

> "*Of course, when we come in the morning at 8am we have a list of the names of patients, the doctors and the illnesses… When the staff members of the other shift arrive, we will tell them all the information…The doctor stays in the diagnosis room, we will notify the doctor as soon as possible so that the doctor can attend the patient. Then the doctor will treat the patient with extra medications*."

Participant 16 further added

> "*We have guidelines that divides the responsibilities such as nurses should put cannula and basic tests and doctors should diagnose illnesses. Those nurses that have completed university are doing more complicated jobs such as intubation. But sometimes in emergency situation we have to do anything to save patient's life. Sometimes the doctors are doing nurses jobs if it is necessary and if the nurse is treating another patient. As nurses sometimes we do prescribe medications for simple illnesses*."

The process of team performance between doctors and nurses is further explained by participant 17:"*We have different responsibilities under our role, for example we are measuring patient's blood pressure. We also monitor the patients and eeeh we are making doctors aware if the patient's condition become worse…We also assist doctors in cutting down vines*." Moreover, participant 19 (head of A&E Department) clarified the process of team working as he argued:

> "*every treatment is noted in the file, in emergency times when the doctor is not available, the notes on the file will be used and the doctor will be contacted. Otherwise we have junior doctors and board doctors available to do everything necessary for the patient. They have the power to do everything for the patient*."

Participant 19 further argued that he is satisfied with the team performance by doctors as he stated: "*the doctor does everything before he or she leaves and instruct the junior doctors…It is good, normal, we don't have major issue … Of course, I want to say that we have very good experienced medical practitioners and most of them have done a very good job*." Although, participant 28 (a senior nurse) suggest that nurses are required to act outside their area of expertise, she was satisfied with the existing teamwork between doctors and nurses and argued: "*I personally am very happy to work with the doctors and nurses here. I have not had issues… we receive certain cases where which is not actually our job, but we all are prepared to do what is necessary at the time*."

Ineffective Team Performance: According to 37.5% of the participants (including participant 4,6,8,9,13, 14,15,16,17,18,25,29), team performance between doctors-nurses is subject to criticisms. Predominantly, the issues disclosed by the participants include indistinct roles and responsibilities; dysfunctional diffusion of responsibilities, communication failure between senior nurses-junior doctors; blame culture; lack of esteem and commitments by nurses. The empirical statements and findings relating to each issue is presented and discussed below.

Indistinct Roles and Responsibilities: Participants 14, 17, 18, 25, and 29 are of the opinion that the lack of clinical guidelines prevents the clarification of duties and is regarded as an obstacle for ensuring effective team performance between doctors and nurses. Whilst explaining the process of team performance, participant 17 (a nurse) argued that due to the lack of clinical guidelines, nurses are required to follow the instructions given by different doctors which causes confusion in cases concerning dissimilar medical opinion:

> "*No, we don't have guidelines, but we have law to tell us that muqim junior doctor is in higher position eeeh …That we should always follow their instructions…it was even more confusing for me as a nurse. In some cases, I had to go back to*

> *the second doctor and explain that during the previous visit this patient was treated in this way by the previous doctor...*"

This point was further confirmed by participant 25, as she stated:

> "*I think the job of nurses in the hospital remained unknown. Eeeh you know why, when they don't do their job properly, I think it is the system fault we cannot blame the nurses for this. The system eeh … We should blame the system … Eeeh there are just limited information, they are being told just do and it is not specific*."

Furthermore, participant 29 (heart surgeon) argued:

> "*I am not totally aware of the job description of nurses; I feel like nurses are not doing what they supposed to do. I don't think a nurse that have graduated from the university is only able to measure blood pressure and heart rate. I don't think that*."

Dysfunctional diffusion of Responsibilities: the empirical findings provide that due to the level of inexperience by nurses, doctors are taking the responsibilities and are performing the duties of nurses. For example, Participant 4 (oral surgeon) having worked under both the KRI healthcare system and the UK healthcare system, compared the functions of nurses and stated:

> "*When I come here when I fill a tooth, I am not allowed to touch, but back home … the dentist is touching everything. The nurses are not doing anything they just look at the patient coming in and going out. Here when you go to hospital, you hardly see any doctor. It is the nurse that is doing the job. But in Kurdistan all of the responsibilities are on the doctor. Everything is on the should of the doctor. There are no duties for nurses...*"

Conversely, Participant 6 (general surgeon) share the same concern with participant 4. He stated: "*sometimes I do something which the nurse should have done for the patients. So, yes, eeehhh that is the problem*." Furthermore, when participant 8 (a general practitioner) was asked whether he was doing the job for nurses, he replied "*Yes, for example checking blood pressure, blood sugar and everything*." Participant 9 (heart surgeon) had empathy for doctors and argued "*there are so many responsibilities on the*

doctor, they are doing the most basic jobs..." As a result, participant 25 as a doctor was not satisfied with the work of nurses. She stated

> "*If everybody did their job, it will make our job easier…For example if a doctors and nurse and medical staff and eeh all we receive a patient we work together, this will make our job easier and it will make the patient more comfortable and it will be more safe … eeeh But now we are alone in the hospital and we are doing everything alone and we have little time to do it. That is why I cannot manage this large number of patients by this capability*."

Communication Failure between Senior Nurses and Junior Doctors: According to participant 17, graduate nurses (more specifically senior nurses) with many years of experience often find themselves in a difficult situation when it comes to teamworking with junior doctors with almost no experience. Participant 17 explained:

> "*Eeeh, doctors see themselves very high like that they are at the top of a mountain and we as graduate nurse from university are in the middle and nurses from college are at the bottom…At the same time, junior doctors during their training they used to follow our instructions but once they become junior doctors, when I tell them that something should be done in this way as my own opinion, they don't like it. Again, junior doctors are calling consultants in order to make sure that I was telling them the right things…they don't like the advice from senior nurses even though practically we have more experience.* ***Does it affect your relationship?*** *Yes, of course it effects it too much*."

What participant 17 is suggesting is the lack of job-description to clarify senior nurses' duties and the unclarities in relation to the status of senior nurses has an impact on team performance. Such point is further illustrated under the chart below.

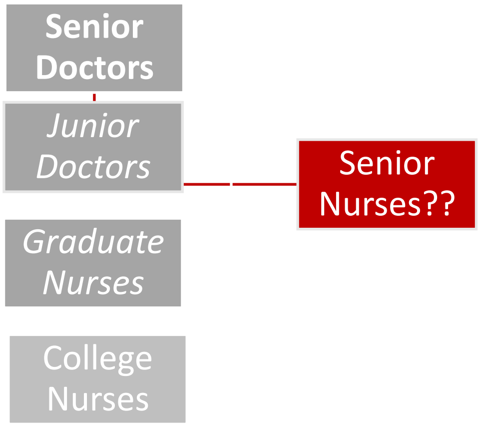


Figure 17: The Status of KRI Senior Nurses

The specific example below by participant 18 (nurse) confirms the above issue between senior nurses and junior doctors:

> "*I can give an example… During the last winter, I had a night shift, we had a case where the patient did not have a file and the patient was in a critical condition. It was difficult for me to treat the patient without a file as the patient was suffering from allergic reactions. I asked a senior nurse who had 15 years' experience eeeh … So, the senior nurse prescribed the medications and treated the patient immediately. Later after ten minutes a junior doctor came and started shouting at the senior nurse … eeh the junior doctor kept saying that you are not a doctor and should not act as a doctor…. Eeh Instead of saying thank you, the doctor started shouting at the nurse in front of the patients in the ward. If the patient had died it would have been a problem for the doctor as she should have been available*."

Blame Culture: on the other hand, a number of doctor participants (including participants 4, 13, 15 and 29) are of the opinion that the lack of guidelines and job-descriptions for nurses is the reason for the lack of experience by nurses within the KRI healthcare providers. In other words, doctors are blaming nurses for the lack of

experience. For instance, participant 4 (an oral surgeon) is of the opinion that nurses are not educated and not trained:

> "*we need nurse training. Which is very important. The doctors are fine, but nurses are horrible. I have been in hospital; I have been working with them and I know how they have been dealing with patients. Actually they [nurses] don't have any education at all...For example, if a patient has got temperature, I have been in the hospital and I know, nurses don't come to check the temperature on regular basis… in Kurdistan at 11pm they give medication to patient and then close the door of their office and go to sleep..*."

Participant 13 (a dermatologist) confirmed the above issues relating to nurse's inexperience, as he added:

> "*The problem is that nurses do not have the experience to ask relevant questions in order to refer the patient to the specialized practitioner. Sometimes, the patients are assisted and referred by the cleaner rather than experienced doctors*."

Participant 15 (neurosurgeon) further argued:

> "*Unfortunately, I don't know whether you are aware of this, but the nurses do only blood pressure…we don't have good nursing system, and this is the main problem… Although nurses are working hard, they need more medical knowledge… actually we have problems in the system, especially nursing system I can say it is zero*."

It was perceived by participant 29 (Heart surgeon) that the lack of guidelines has an impact on the knowledge of nurses and the life patients. He stated

> "*…our nurses are not experienced to a high level. Sometimes we have had nurses that instead of treating the patient, have walked through different wards to find the doctor, by that time the patient had died."*

Lack of commitments and self-esteem: According to a number of doctor participants (including participants 4 and 15) due to the lack of guidelines and job-descriptions, nurses are not aware about their responsibilities, which has resulted into lack of

commitments and self-esteem. As a result, participant 4 (an oral surgeon) is of the opinion that doctors are doing the job for nurses:

> "*You know whoever is working there they should work 24 hours. Is like that. Not watching your mobile basically or sitting down and talking about things [she means that health workers must be 100% committed to their work] that is how the system should work. They should be available when patients need them. When the patient buzzed on the button then the nurse should be available straight away. But in Kurdistan region as a patient you need to go and knock on their door and ask for help but they don't open the door to help you.*"

According to participant 4, nurses are absent:

> "*Yes, within the intensive care unit…nurses should be there like bees surrounding the patient. But eeh you cannot find nurses in that circumstances. It is the doctor that is doing the nurses job*."

The lack of commitments was further confirmed by participant 15 (neurosurgeon) as he claims that nurses are not acting immediately:

> "*For example, … you have to ask the nurse to take the blood pressure, the nurse will not act immediately eeeh, but the nurse will act anytime as she or he wishes*."

4.4.5 Nurse and Nurse Relationship

Interpersonal Connections: Participant 17 is satisfied with the level of connection connections between nurses; however, he claims that the number of nurses is inadequate and only small numbers are university graduates:

> "*We have good staff; we have some that are not graduated but they are good. Even though there have been times when we did not have sufficient staff, but we have managed to control the situation*."

Whilst participant 17 is satisfied, participants 18, 20, and 26 are dissatisfied with the interpersonal connections between nurses. The participants are suggesting a number of reasons for such dissatisfaction including the lack of guidelines to clarify the roles and responsibilities of nurses at different levels of qualification. The KRI nursing system consists of four levels of nursing educational background including senior, graduate, and

college nurse. According to participant 26, there are some improvements within the KRI healthcare system for abolishing short-term nursing courses to avoid unexperienced nurses: "*In recent years it was good to abolish nursing courses, now we have only college and university students... eeeh our students are doing two years rotation, and therefore university nurses have higher responsibilities*."

Poor Description of Duties: Despite the fact that nurses are coming from different educational backgrounds, participant 20 (a graduate nurse) stated that nurses are being treated on the same level, she argued:

> "*Our nurses are educated in eeeh Medresay Mumarizat[course], 3edadi Tamriz[course], Ma3had [college], University… In this region all four nurses are looked at with one eye. There is not a difference and they are called nurses, and everyone has the same duty*."

Communication Failure Between Graduate and College Nurses: Due to the lack of roles and responsibilities according to participants 17 and 26 the relationship between college and graduate nurses are subject to criticism. For instance, participant 17 is of the opinion that college nurses are not willing to act on the advice by graduate nurses:

> "*We are in a difficult situation because nurses from college don't like us to tell them what to do even though we know more than them, and what they do they go back to the doctor to make sure that we are telling them the right things*."

This point corresponds with the statement by participants 26: "*This system has side effect now and this can affect the relationship of nurses with different qualifications*." This illuminates that the existence of different levels of qualification and the lack of job-description has negative implications on team performance as nurses are uncertain about their role and responsibilities. Furthermore, participants 18 and 20 opined that graduate nurses are not willing to interfere and support college nurses which negatively impacts interpersonal connections between nurses. For instance, participant 18 (nurse) stated:

> "*There is a hierarchy here … generally nurses from university find themselves in higher positions. so, there is an issue here … They say this is not my job, and they don't do it. Senior nurses from university do not want to do IM for example*."

Furthermore, participant 20 (a graduate nurse) asserted that:

> "*there is not a good relationship between eeeh nurses graduated from college and nurses graduated from university. University nurses find themselves in a very high position. Our nurses are in different levels*."

Additionally, participant 20 argued that the lack of legal rules prevents the existence of more qualified and experienced nurses, as she argued: "*…they don't allow more qualified nurses to develop. Because it means that the qualified nurses could replace the head nurses which have lower qualification*." Which suggests that according to participant 20, no sufficient mechanisms are in place to allow college nurses to upgrade their qualification.

Lower Standard of Care and Dissatisfaction: Overall, due to the lack of guidelines and support, participants 9, 22, and 25 are not satisfied with the current healthcare system of KRI and they prefer to work under the healthcare systems of other countries. Participant 9 made comparison between the KRI and the Egypt healthcare system and argued that "*However, I came to Egypt, I have realized that … the standards are much higher*." Furthermore, participant 22 argued that *"...we wanted to live in a country where professionals are working in accordance to the law."*

4.4.6 Synthesis and Discussions

Due to the existence of high degree of medical complexities, team work through effective communication is crucial to ensure a higher quality of healthcare.[435] Whilst, a number of participants are suggesting the existence of team performance under the KRI healthcare system, the majority of the participants claim ineffective team performance under the KRI healthcare system. Based on the empirical findings and the existing literature (KRG Cabinet), KRI healthcare leaders such as members of the department of health and the ministry of health are accountable for failing to provide guidance on effective team performance. As evidence, the former Health Minister stated:

> *"I have started to decentralise the ministry and pass some of the powers down to local government and hospital managers, so that they have some independence*

[435] Mathilde M.H. Starting, Anna P. Neiboer, *Norms for creativity and implementation in healthcare teams: testing the group innovation inventory* (2010) 276 International Journal for Quality in Health Care.

> *in their daily decision-making. This leaves the ministry to deal with strategic planning, which is its main duty."*[436]

Nevertheless, the provision of discretionary power to lower professional bodies could be regarded as the predominant reason for the failure to implement effective team performance guidance. Discretionary powers in the absence of effective follow-up system has had the potential of an inconsistent practice across the KRI healthcare providers.

Figure 18: KRI Political Parties

Due to ineffective accountability and follow-up systems, the findings suggest limited evidence of effective guidance by health policy makers. In addition to the inconsistencies of practice within the healthcare providers, the existing literature (KRG Cabinet) indicates that due to political parties' interferences, even the ministry of health is facing issues of administrative inconsistencies.[437] As it can be seen on the figure, the provinces of Erbil and Duhok are being governed by KDP and the province of Sulaymaniyah is governed by the PUK, unfortunately, the two political parties are hardly unified as there are histories of civil wars in the region.[438]

Following the synthesis of the above themes relating to team performance, the chart below, illustrates the issues surrounding team performance within the KRI healthcare providers. The figure below illustrates some of the issues (red circled) that are present under different relationships. For instance, the issues relating to ineffective treatment and domination of doctors are existent under both leader/practitioner's relationship and

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[436] KRG Cabinet, *Health minister: Top priority is improving primary healthcare* (2006) <http://cabinet.gov.krd/a/d.aspx?s=010000&l=12&a=14384> 20 March 2018

[437] Ibid.

[438] Michael J. Kelly, *The Kurdish Regional Constitution within the Framework of the Iraqi Federal Constitution: A Struggle for Sovereignty, Oil, Ethnic Identity, and the Prospects for a Reverse Supremacy Clause* (2010) 721 Penn State Law Review.

doctor/doctor relationship. The empirical findings also indicate that the issue relating to ineffective decisions making has an impact on both doctor/doctor relationship and doctor/nurse relationship. Finally, the issues relating to poor description of duties of nurses have an impact on both nurse/doctor and nurse/nurse relationship.

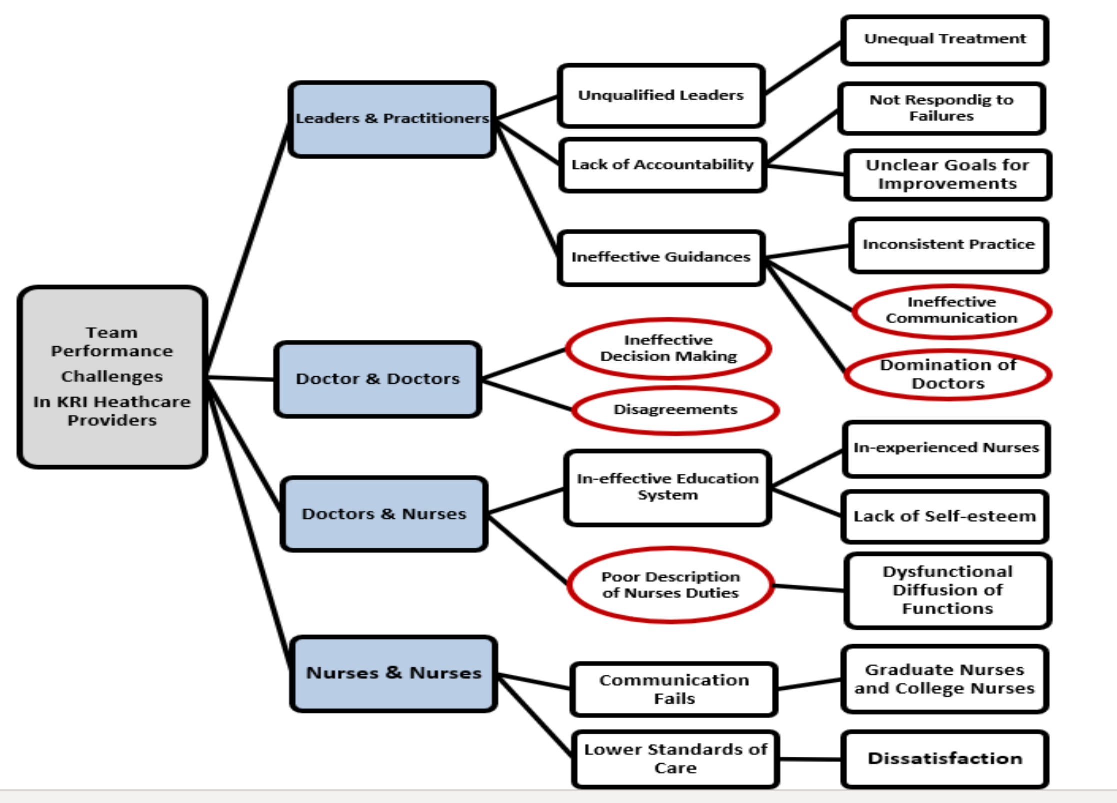

Figure 19: Team Performance Challenges in KRI

Measuring the above team performance challenges against the benchmarks of best practice (2.2.1/2.2.2/2.4.1), it can be argued that such practice is clearly below the reasonable standard of care. For instance, the finding relating to unqualified leaders, which is further supported under the existing literature,[439] is clearly not reaching the benchmarks of best practice. According Rand Corporation, a few healthcare managers are trained, and no protocols are in place to ensure systematic and supportive supervision.[440] Additionally, my empirical study indicates that the issues relating to the

[439] C. Ross Anthony (n35) xxiii, 65
[440] Ibid xxv, xiv

ineffective training and qualification for healthcare leaders are ongoing. Under the benchmarks of best practice, leaders are expected to be qualified, accountable for improving healthcare quality; leaders are expected to respond to failures by learning from mistakes; and they are expected to communicate effectively with healthcare practitioners. In terms of interpersonal connections between healthcare practitioners, under the benchmark of best practice the duties and responsibilities are clarified through clinical guidelines to improve the relationship between healthcare practitioners (including doctors and nurses). The existence of well-experienced leaders and the implementation of effective guidelines to prevent the domination of doctors within the healthcare providers is also under the benchmark of best practice.

As indicated in chapter 2.2.1, the benchmarks of best practice for team performance involves the process of communicating and exchanging information relating to the quality of healthcare between healthcare leaders and healthcare practitioners. According to the UK NHS Leadership Academy, well experienced leaders are engaging the team within the process of improving the quality of healthcare.[441] Although, a small number of participants are claiming that healthcare practitioners are meeting on regular basis and discussing medical cases, it does not indicate that actions are taken to improve the quality of healthcare as there are no legal duties and no systems in place to oversee the functions of the healthcare practitioners. In terms of the educational backgrounds of nurses, in contrast of the empirical study, there are some recent attempts to improve the knowledge of KRI nurses.[442] However, such an attempt is not standardised across the region and as such it is unlikely to reach the benchmarks of best practice.

4.5 Summary

This chapter presented the significant findings relating to the role of health law within the KIR healthcare providers. The role of legal rules is correlated with the first component of health system governance, which aimed to discuss benchmarks of best practice for improving and implementing health law. The empirical findings on the role of law are analysed by using *Thematic Data Analysis Method*. Three themes emerged from the data are KRI Health Law; the lack of awareness of law; and its implications on

441 NHS Leadership Academy, *Healthcare Leadership Model: the nine dimensions of leadership behaviour* (2013) <http://www.leadershipacademy.nhs.uk/wp-content/uploads/dlm_uploads/2014/10/NHSLeadership-LeadershipModel-colour.pdf> 4 October 2016.

442 A.C. Robinson, *In pictures: College honors students in Kurdistan for int'l nurses, midwives days* (2018) Rudaw Health https://www.rudaw.net/english/kurdistan/070520184 12 July 2019

team performance. The empirical findings indicate that although the Iraqi and the KRI parliament have established Health Law, according to the majority of the participants, hard law and quasi legal rules are not effectively implemented, whereby non-legal rules are followed by the healthcare practitioners as a substitution of legal rules. As the result it can be argued that the successful implementation of hard law through effective guidelines can be regarded as an area for improvement under the KRI healthcare system.

Additionally, this chapter highlighted the negative impact of non-implementation of health law on team performance within the KRI healthcare providers. This negative impact is also identified as an area for improvement, which supports my overall hypothesis that the benchmarks of best practice are not being reached. More precisely, the challenges under the performance between the KRI nurses, doctors and health service leaders are regarded as a priority for healthcare quality improvements. The empirical findings relating to accountabilities and leadership under the KRI healthcare system is considered in further details under chapter four of the present thesis.

Chapter 5: KRI Health System Leadership

"A Critical Analysis of KRI Healthcare System Governance"

(Empirical Findings and Discussions)

5.1 Introduction

This chapter presents the empirical findings relating to the KRI healthcare system Leadership and accountabilities. Specifically, participant's perspectives about the role of clinical leaders within the healthcare providers in KRI will be explored. Three emerging themes are discussed: KRI health service leaders, accountabilities, and clientelism. Under the first theme, the functions of the KRI healthcare leaders including the KRI Minister of Health; professional syndicate; health service managers are critically analysed. The second theme discusses the extent of professional accountabilities under the KRI healthcare system. The third theme that emerged from the empirical data, focuses on the existence of political interference (Clientelism) under the KRI healthcare system. Under this chapter, the presentation of empirical findings is followed by synthesis and discussions. In order to provide an overview of the KRI health care system leadership, the findings are related back to the existing literature. Additionally, the findings are measured against the benchmarks of best practice for the purpose of identifying areas for improvement under the KRI healthcare system.

5.2 Emerging Theme: "KRI Health Service Leaders"

Within the context of the research, KRI health service leaders consist of government; the Minister of Health; Department of Medicine; Hospital directors; head of departments; and consultants. Under the present empirical study, participants 1,2,3,5,8,9,10,12,14,16,17,19,23,24 and 30 provided a critical analysis of the KRI health service leaders functions, which are elaborated below.

5.2.1: The KRI Ministry of health (the government)

Functions: According participants 2, 5 12, and 24, the KRI minister of health is responsible for introducing new strategies and new initiatives for the purpose of improving the health care. Participant 2 articulated:

> *"Essentially Kurdistan has the ministry of health and they are quite involved in the process of trying to introduce new initiatives. A few years ago, they were*

enforcing the health improvement council which my father was involved in the process. ... He did a lot of work and held a lot of meeting with Ministry of Health."

Additionally, participant 32 (a policy maker), argued that the KRI MOH regulates the storage and quality control of medications. He argued:

"We made a recommendation to council of ministers ... I work on quality control team in 2012 were not authorized to control the quality of a Paracetamol, now I have authorized for about 800 types of medication to be subject to quality control. However, we still have many problems, and this is that we should go back to the old system which was in operation before the 1990's was the government was the provider of medications and not private companies."

Departments in the Ministry of Health: Pparticipant 24 (training manager) further stated that the KRI MOH regulates health education, nursing system. He explained stated:

"In the ministry we have a department that is called health education... [and] We have a department called HOBAY KARGERY PERSTYARI which is now part of the ministry of health. So, they are in charge of the nursing points and appointments.... yes, I am part of Hobay Kargery Peristyari, we get the guidelines from them."

Moreover, participants 9, 15, and 19 are of the opinion that under the KRI healthcare system the health education department is in place to oversee the process of resolving legal issues occurring within the healthcare providers. Participant 9 stated *"However, the function of legal department is to settle disputes and disagreements or if doctors are not paid RM can raise the issue."* Withal participant 19 stated:

"*legal departments to deal with legal issues... only applies to cases where complaints are made by patients against the healthcare professionals. And this department makes sure that we have legal advisors or solicitors to assist us during a claim.*"

Conversely, participant 15 criticised the functions of the legal department for failing to take sufficient actions and for failing to assess their competencies, as he submitted:

> *"The discipline team should be following nurses and doctors and look what they are doing. To see are they working sufficiently for the patient. They should get feedback from the patients in order to know what needs to be done. But unfortunately, they are here only to take the salary."*

Collaboration with International Health Organizations: According to participants 1, 24, 26, 31, and 32 the KRI Ministry of Health is collaborating with international healthcare organisations. For instance, according to participant 24, there was a collaboration with the Red Cross:

> *"The red cross used to work for three years within the emergency department. They trained the healthcare practitioners, but they did not have the authority to do the follow up... Now, the functions of the Red Cross are very limited under this system. Now due to the current situation we have noticed that the functions of the WHO have been more active in this region."*

The point relating to the collaboration between KRI MoH and the WHO is further confirmed by participant 26 (a former WHO associate):

> *"Of course, it was good because the WHO had high experienced consultants. At that time, we were in the process of setting up new ministerial responsibilities and the WHO had assisted us ... They used to have two functions, one was the provision of training of healthcare practitioners and the second was the provision of medical equipment…we used to get medication, immunization products from WHO…Our hospitals used to complete a form ... These forms also included the needs for training courses..."*

Participant 31 (a policy maker) further explained that collaboration between the KRI MoH and the WHO:

> *"We have life connection with the WHO. The head of the WHO in Suli* [the province of Sulaymaniyah in North Iraq] *attends the ministry department on weekly basis. If we have any problem he is supposed to be here and sometimes he has to attend our meetings… WHO have identified certain dates for particular illnesses, for example world day of diabetics"*

Additionally, participant 32 (a policy maker) stated that:

> *"Yes, we have a very good relationship with the WHO, they support us especially, now in this situation with economic crisis they do provide medical support to refugees…Sometimes we do get medications for refugees, however, for undertaking systematic measures, we did not have support for this. We do get medical resources, including medications and immunizations… but the main pressure is on the government… If we ask for it, they are prepared to provide guidelines."*

Collaboration with Doctors, Managers, and Directors: on the one hand, participant 3 is from the opinion that there is no effective system in place to ensure communication between doctors and government. For example, she stated: *"Yes, the lack of communication has an important impact on this issue. We do not have good communication between doctors and government."* On the other hand, participant 24 was satisfied with the connections between managers and the KRI MoH, as he stated:

> *"We are closely connected with the ministry of health and Dr *** is in collaboration. In the ministry we have a department that is called health education [Ta3lim Sa7i]… We have proposed our follow up system to this department, and we are looking forward for this to be accepted…every year we are making proposals to the ministry of health. You can see on this booklet what we did in 2014.* ***Yes,*** *but this year due to the existing economic crisis… we are not obliged to have this data, but we find it necessary to keep all the data. And every year we are displaying on the data show"*

Furthermore, findings show that there is collaboration between KRI and Iraq due to referral of KRI medical reports to Baghdad. For example, participant 29 explained that: *"we will only have a hand-written file, but this goes directly to Baghdad and it will be burned after a few years."* The exiting collaboration with the KRI MoH is further illustrated under the chart below:

Figure 20: KRI Collaborative Initiatives

KRI MOH

Collaborates with:

Iraqi MOH

International Health Organizations

KRI Department of Health

KRI Hospital Directors

KRI Training Managers

5.2.2: KRI Department of Health

Findings show that the KRI department of health regulates the functions of resident doctors, chief resident doctors, and those doctors that are members of medical board. This was elaborated by participant 10:

> *"Our doctors are divided in three levels, we have 1) the rotators, the interns, 2) the resident doctors or registrars, 3) senior doctors. Senior doctors are directly regulated by their department of health in general hospital* **…** *which regulated the doctors of the whole city not just my hospital."*

5.2.3: KRI Healthcare Professional Syndicate

The existence of health care professional syndicate is recognised by participants 1, 5, 8, 9, 13, 15, 16, 17, 18, 19, 22, 23, 25, 28, 29, and 32. According to participants 9 and 28, the KRI healthcare system includes different types of syndicate including syndicates for doctors, dentists and nurses. For instance, participant 17 argued *"Yes, we have syndicate to support us, they don't support us directly, they will first consider whether we are right in our action, then after that they will decide whether to support us or not."* Furthermore, participant 23 stated *"we have doctor's syndicate for supporting doctors ..."*

Critics of KRI Syndicate functions: the functions of the syndicate were subject to criticism by 34% of the participants (including participants 8, 9, 13, 15, 16, 17, 18, 25, 28, 29, 32) for failing to support healthcare practitioners and provide guidelines. For

instance, according to participants 8 and 9, although the syndicate is registering healthcare practitioners, they do not have an active role under the KRI healthcare system. Participant 8 stated:

> *"No, they don't have that role actually… I have not seen them in anything to be honest. They give you an ID card with your picture on it. This will make you a member of them and that is it…We need an active body and not a dead body like doctor's syndicate. Because all the members of doctor's syndicate have their own private clinic and they don't have time for their duties ... We should have an active body."*

Participant 9 further confirmed the statement regarding the registration of healthcare practitioners:

> *"We have doctor's syndicates, it is true that we as doctors are being registered, but we are automatically being registered without any assessments…We are given an id card as a member of doctor's syndicates."*

No support by syndicate: According to participants 13, 15, 16, 17, 18, 25, 28, 29 the KRI syndicate fails to provide support to the healthcare practitioners. For instance, participant 13 stated that, *"unfortunately, this syndicate it is like eeeh it does not exist for us. I am practicing since 2008 up to now I have not seen any role or support of this syndicate."* Participant 15 gave a contrary view and argued that the syndicate does not improve the skills of doctors:

> *"doctor's syndicates should play an important role in this process of enhancing doctors' skills. Which they are not doing…No, doctors syndicate is only on paper, their role is to protect doctor's rights. They should improve the scientific performance of the doctors ... I am a doctor for five years and I have not seen a seminar by doctor's syndicate. Sorry hhh…"*

Additionally, participant 16 argued that *"Yes, we have nurse syndicate. But this is …ehh not effective. Eeeh but this Syndicate is not supporting us..."* Further, participant 17 also stated "*Yes, we have syndicate to support us, they don't support us directly..."* Pparticipant 18 was also not satisfied and stated:

> *"We have syndicate, but they don't have a good role and they don't listen to us. They always find an excuse to refuse your request. It will be a waste of time and cause headache because I am sure they will not do anything for us."*

As a general practitioner in public hospital, participant 25 argued "*we are left alone in the hospital. Nobody will defense*." Participant 28 is also of the opinion that KRI syndicates are not enhancing professional knowledge:

> *"Walla no, I have not benefitted anything from this syndicate***…***Now I am working in this hospital since 2005 and before this I have been working outside the city since 2002. Since then I have only attended one training course and this was in Suli* [the province of Sulaymaniyah in North Iraq]*..."*

This point relating to the lack of support was further confirmed by participant 29 as he stated:

> *"I personally have not had any support from the syndicate. But generally, there are complaints about the role of syndicate by doctors … Now doctors are striking, the syndicate does not play any role to support doctors and to make sure that they will get paid."*

Outdated Law to Govern the KRI Syndicates: According to participants 22, and 32 the healthcare professionals syndicate is governed by outdated law. For example, participant 22 argued that due to the lack of law, doctors are not being supported as he stated, *"It is like it doesn't exist, it is all this government making it in this way…There is no low, without law you cannot benefit from it."* Most importantly, participant 32 (a policy maker) argued that the law regulating the KRI syndicates is outdated and does not operate in the public best interest, as he stated:

> *"…I am from the opinion that certain law such as the law relating to doctor's syndicate and dental council, are outdated and should not operate nowadays. The interest of populations is not taken into account, however, only the interests of the syndicates are taken into account."*

5.2.4: Professional Regulatory Authority (PRA)

According to 46.86% of the participants (including participants 2,3,4,5,6,7,8,12,13,14,15,20,24,26, and 29) PRA such as the General Medical Council does not exist under the KRI healthcare system. As evidence, participant 7 argued *"We don't have it, there is not regulatory bodies in Kurdistan, there is no regulatory body for people who are close to the ministry. There is no regulatory body at all."* Furthermore, Participant 29 stated *"We don't have a committee or such a body"* The empirical findings indicates that the lack of PRA has grave repercussions on the KRI healthcare system.

In-effective /Inconsistent Clinical Guidelines: Participants 2 and 29 claim that under the KRI healthcare system, no PRA are in place to set up clinical standards. For instance, participant 29 argued:

> *"We don't have a committee or such a body but eeh for example every hospital here under the system the only duty that has been imposed on us that we have been guided is that we should make the patient satisfied."*

Incompetent practitioners: Findings suggest that due to lack of regulatory bodies, patients are not confident and have no trust in the practitioners. Participant 2 explained that: "*... as the result there is not a lot of confidence in the profession… eeh the lack of regulatory bodies is also preventing doctors from upholding their professional reputation."* As evidence, participant 29 further indicated that he is not confident:

> *"Although I am part of this region, unfortunately, I have to say that each of us are not doing the jobs we are supposed to do. It is either abusing the duties or overdoing the duties. What I mean by this is eeeh I am a doctor; it does not mean I know everything. I want to admit ... eeeh we don't know every type of sub-speciality. But the main problem is that we don't do the job we are supposed to do."*

According to participants 2, 3, 6, 9 20, and 24 the additional repercussion from the lack of PRA includes the failure to assess doctor's practice and separate competent practitioners from incompetent practitioners. For instance, participant 2 argued *"There is not a body to set a standard and to conclude that professionals are competent."* Furthermore, participant 3 stated "*we don't have regulatory bodies, we don't have a system to assess doctor's practise."* Participant 6 also stated:

> *"when doctor do well, they should be separated from those who do not work well. Really speaking, there is no such regulatory body eeeh there no well authorized system to ehhh… to separate the good from the bad professionals."*

In addition to the above, participant 9 argued:

> *"Actually, when we started our job, there is some kind ...eeh monthly review [silence] ... but I don't think they will look into that too much because I have not seen anyone like serious consequences…they don't take that seriously…In Kurdistan before you graduate from medicine school, you will do two years training ... This could be criticised because students are responsible of serious cases before even graduation."*

This point relating to incompetent practitioners being put in chapter of serious cases was confirmed by participant 20:

> *"Last year we did teach the whole year, but when we calculated the total teaching period for nursing college is only 9 months. After this short period a student will be named nurse and they are looking after patients in critical conditions. I personally did four years university and when I entered the hospital, I did not have any practical experience and I was put straight away in charge of serious cases."*

This point relating to the failure to assess the competence of healthcare practitioners was further confirmed by participant 24 as he argued "*We don't have system that would check whether the healthcare professional is following the instructions provided during the training. We don't have follow up*." As the result of the failure to assess doctor's practice, participant 4 argued that *"without regulatory bodies it is likely that errors can occur."*

No improvements: According to participants 7 and 20, due to the lack of regulatory authorities, no strategic plans are in place to make improvements. As evidence, participant 20 (training manager) stated:

> *"Yes, at this point it is for the decision maker to introduce, as a nurse ... 22nd year of me working under this healthcare system. But I have never seen this system to set up certain strategic plans and to make it into actions…Eeh under*

> *this healthcare system I am not under the control of any authority that would oblige me to provide training. This is our own initiatives…"*

5.2.5: KRI Health Service Managers

Functions: Participant 1 described the functions of hospital directors and argued: *"There is a managing team that is responsible for the whole hospital. If a patient has a complaint, then everything will be recorded in the file and this file will be reviewed by the health directorate…Yes, the health directorate will investigate the case. Accordingly, they will review the actions of the doctors."* Further, it was also discovered that each hospital department is managed/supervised by the heads of health departments, consultants/chief resident doctors, and senior nurses. For instance, participant 30 stated:

> *"in each hospital we have head of department…For example in the department of internal medicine [BATNI], we have head of department of BATNI. We appoint someone that is experienced and suitable for that position. This should be a doctor that would provide guidelines for the doctors under his or her group. We also have head of nurses, that has the duty of providing guidelines for nurses. The head of nurses is also working in the ministry department and is available here."*

Within the healthcare providers, findings reveal that consultants are guiding healthcare practitioners (particularly junior doctors) during the process of medical intervention. For instance, participant 10 (hospital manager) claim that:

> *"we have registrars, majority let us say 9O per cent are medical board students / diploma students. They also have their own regulations and their own schedule for the duties and also, they regulations inside the hospitals how to work…It is provided by chief resident doctor, this body is providing the schedule of their duties. The schedules are being assessed by the head of the department. At any level the senior doctors can intervene to provide further knowledge for the junior doctors."*

In addition to the role of Chief Resident Doctors, participant 8 argued: *"Here the consultant is like the head, everyone following their rules [daily instructions]."* Furthermore, participant 9 stated:

"consultants… it is like the head of most junior doctors. In our region most, doctors that work in public hospitals are the young doctors who are general practitioners and are not specialised."

Participant 16, clarified the responsibilities of senior nurses further:

"As a senior nurse, I am responsible and am supervising nurses from college or other staff. If one of the medical staffs does not follow the rules, such as going outside without authority, then I will make sure that this will not happen again by questioning them and giving warning or reducing the amount of monthly payment. Those who cannot attend due to illnesses, then they will have to notify us and make sure that someone else is working in their place."

Furthermore, participant 12 argued that different bodies are in place to ensure sterilisation process and supply medical equipment. He stated:

"We have different groups that is overseeing the functions of the sterilisation team for example, or we have groups for each ward that is making sure that everyone is doing their job properly… And we have bodies in place named Syane and this bodies are replacing the oxygen bottles... "

Collaboration at hospital level: Findings show that hospitals are not only exchanging medical staff but also medical equipment to save patient's life. For instance, participant 6 stated:

"One day I was called, and the patients was coming suffering from hemorrhage, the patient needed to be catheterized and this catheter was not available, and which is not expensive. And I asked other hospital and I brought the catheter from other hospital to treat the patient. In this case the patient survived, and I did well."

Nevertheless, the exchange of medical staff was criticised by participants 6 and 8, they argued that although the exchange of staff across hospitals leads to the exchange of ideas, it prevents doctors from being settled. For instance, participant 6 stated:

"There is a communication between hospitals, but every team should have own ward, own intensive and own operating room. Sometimes you are working in one

hospital after two or three months you should work in another hospital. Doctors should have their own place and should be settled."

Collaboration between hospital directors and training managers: According to participant 24, the training center is collaborating with the director of hospitals and nursing college whereby nurses are invited to attend the training courses, as he stated:

"We make the director aware and we get the authority. Instead of working in the hospital, the nurses are attending our courses. We have many many courses. ***Do you have only contact with nurses from the hospitals or also the nurses from the universities?*** *Yes, we are collaborating with the college of nursing at university of Sulaymaniyah. We have students attending our courses…We need to have a good relationship; we are working under their authority and under their instructions. It is up to them to decide how many healthcare practitioners they want to refer to our training center, they cannot refer all the practitioners as they need them in the hospitals to look after their patients…"*

Further, healthcare providers in rural areas are also collaborating and being supported by the training center as participant 24 stated:

"During the last year we also ran workshops within the hospitals outside Sulaymaniyah such as Ranya, Qaladze, Kalar, Koya."

Additionally, in order to ensure follow up, the collaboration between hospital directors and training managers after the provision of trainings is further confirmed by participant 26, as she stated:

"Before setting up the plans, we were making use that the plans are meeting the nurse's needs. At the same we were warning the hospital directors about certain important points and we were giving guidelines to the director on how to make sure that those points are followed. In certain circumstances we were also making the ministry of health aware of the points…At the same we were warning the hospital directors about certain important points and we were giving guidelines to the director on how to make sure that those points are followed. In certain circumstances we were also making the ministry of health aware of the points…"

Collaboration between Hospital Managers and Forensic Institute: Findings show evidence of collaboration between the forensic department and police stations within urban and rural areas; hospitals; and the courts. As evidence, participant 30 stated:

> *"We collaborate with all police stations inside and outside the city.... Yes, we do collaborate with even the police stations of other cities and it is a very large number... Yes, for example in Kirkuk we had a case concerned with severe burning injuries and the patient was referred to the Sulaymaniyah emergency hospital. Some patients are brought even from the Arabic districts such as Diyale or Tkrit... We also work with private hospitals... Sometimes we are asked to the court for further explanation and other times, the doctor that investigated the body is required to attend. If our doctor has made an error and the court is suspicious, and the court asks for another doctor's opinion."*

Critics: Nevertheless, the empirical findings suggest that the functions of KRI healthcare managing teams including consultants and directors are subject to criticism and this is considered below.

In-effective collaboration: The existence of collaboration was not recognised at the level of healthcare practice by the KRI healthcare practitioners (including participants 3, 4, and 5). As evidence, participant 3 argued "*Yes, the lack of communication has an important impact on this issue. We do not have good communication." "There is no organisation in this area either. If there is not a good system, then there is no organisation."* Finally, due to the lack of effective professional regulatory authorities, participant 5 argued "*There is no communication between the professionals and the regulatory bodies at all."* Moreover, according to participant 2, the requirements under the KRI healthcare system is preventing collaboration at international level, as she stated:

> *"they introduced in the last years a new requirement practice within the region professionals need to be registered with the board that you have to speak Kurdish. This surely will prevent and go against the idea of collaboration. I mean if you want people with good experience, then that is kind of excluding professionals with good skills from abroad."*

Ineffective management by hospital directors: Participants 7, 9, 15, 20, 25, and 29 are of the opinion that the functions of the KRI hospital management team are subject to criticism. As evidence, participant 7 stated *"There is no one in dealing with the problem. That is why healthcare in that part of country is incomplete."* The failure to take actions is further confirmed by participant 15 as he stated *"Well eeeh what I can do is maybe I tell the manager that in my opinion this doctor should act like this, but I don't think even the manager, or the general director will take this seriously… the manager will tell them general things…"* The point relating to the failure to act is further confirmed by participant 25 as she stated:

> *"Yes, we told them that we need some security guards, in our hospital, rooms and our examination room eeeh even for the privacy of the patient, they told us that eeh he cannot manage that and make the situation eeeh better.* ***Who did you tell?*** *The manager of the hospital."*

The findings reveal that system failures such as not imposing a legal duty to act and to be present are one of the reasons for ineffective managements. For instance, participant 29 stated *"The head of our department is the heart specialised consultant that is not always present."* Furthermore, participant 9 claimed:

> *"Ehh, the system is certainly very bad, a director can voluntarily decide to take actions and take complaints into account, but under the system there is no authority in place to consider complaints and take actions. So, under the system the director does not have to act. So, it depends on the personality of the director. Sometimes the director decides to consider the complaint… I was a director for three years and in that time, I could not have done any work because there was no one telling me."*

Participant 13 further argued:

> *Under any hospital of other countries there is a system called hospital managements. Unfortunately, we don't have this here in Kurdistan region. Under this position the management team should be aware of the number of patients treated in order to arrange sufficient amount of staff and medication and also in order to ensure high quality of care."*

As a result, participant 20 (as a training manager) was not satisfied with the functions of hospital managers and is of the opinion that

> "*decision makers are making decision in their own best interests rather than the public generally. Patients best interest are not taken into account during this process…I can ask or recommend the hospital director within the process of referring healthcare practitioners, but I cannot order or oblige within this process. The hospital director is free to decide whether to refer or not to refer the healthcare practitioners"*

Unqualified managers / hospital directors: Findings reveal that hospital managers and directors are lacking the requisite qualifications. This was highlighted by participant 13 who stated:

> *"Those authorities that have a high position, they are not professionals, …eeh the directorates must have a medical background, they must have experience in business administration, and they must have had the training on how to run hospitals ... Even if you as healthcare professional make recommendations for improvements, the situation may get worse rather than better. And this the main reason why there is a focus on quantity rather than quality. Eeh However, patients need to be treated in accordance to a good standard of care. Not having medical background will cause all the issues mentioned above."*

The lack of experience was also confirmed by participant 14 who stated:

> *"Eeh it is just a routine, they are just performing a routine without development, so it is just a duty to manage some works without thinking about new plans… to collect the number of staffs, regulating the salary, eeh just eeeh managing the basic works, no improvements. There is no new way of developments. Eeeh scientifically one."*

Additionally, participant 15, asserted that:

> *"Unfortunately, those who are becoming managers in our hospital are eeeh from somewhere taking those responsibilities and for example you have a staff who have higher position than the manager because they are close to political parties…"*

As a result of in-experience by the hospital managers and directors, the empirical findings indicate that doctors are dominating healthcare providers. For instance, participant 3 suggested that:

> *"There is an issue of planning. The director of hospital, I don't think they have a control over the doctors."*

5.2.6 Synthesis and Discussion: KRI healthcare leaders

KRI Healthcare Leaders: The empirical findings and the existing literature indicate that KRI healthcare leaders consists of MoH, DoH, Syndicates, and clinical management teams. A report by the KRG Cabinet suggests delegation of powers to the clinical managing teams: "*we have started to change some of its foundations. In the past health ministers controlled every single little decision. Sometimes these decisions were made subjectively, depending on the minister's mood or on other politicians' demands, regardless of any objective research or planning…"*[443] The above was indicated in 2006, the empirical findings suggest that this is implemented, as according to participant 31(a policy maker), hospital managers have the duty to provide guidelines about clinical process:

> *"If we get new information about certain medication, we put that into writing and refer it to the hospitals to make them aware of whether this medication should be used or should not be used. They provide guidelines on systematic and medical points. About further details about the surgical process will be provided by the hospitals themselves."*

Notwithstanding, the above finding cannot be generalised as participant 31 is a policy maker as, out of 32 participants, only participant 31 is indicating the provision of discretionary powers. In 2010, RAND Corporation conducted a research on KRI healthcare system and it was found that the lack of a system for management has led to inconsistencies across the three governorates of KRI.[444] More specifically, no coherent system is in place to ensure the continuity of care through referral system and the improvement of healthcare quality through a system of reporting failures and learning

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[443] KRG Cabinet, *Health minister: Top priority is improving primary healthcare* (2006) <http://cabinet.gov.krd/a/d.aspx?s=010000&l=12&a=14384> 20 March 2018
[444] Melinda Moore et al, (n36) 80.

from mistakes.[445] The finding in this empirical research suggest that due to the lack of qualified managers, there is a failure to ensure efficient distribution of medical staff and limited resources. As such, failure has led to both work-pressure on existing medical staff and waste of scarce resources. As evidence, participant 29 stated: "*unfortunately, I have to say that each of us are not doing the jobs we are supposed to do. It is either abusing the duties or overdoing the duties.*" This suggests that in-effective management has precipitated confusions for existing practitioners.

The existing literature by the WHO (2006) and Kurdish public health writers (2010) indicated that the failures by the KRI healthcare leadership are related to the rapid expansion of health sector in KRI.[446] Although, issues relating to ineffective healthcare managers were raised by the WHO (RAND corporations, 2010), the empirical findings of this research confirms that the issues are ongoing. This clearly indicates that the current practices by KRI health managing teams are not reaching the benchmarks of best practice. Under an ideal healthcare system, leaders are competent in distributing resources and services efficiently; and ensuring continuous care and quality improvements through the development and implementation of system.

KRI Professional Syndicates: Similar to the functions of the General Medical Council (GMC) in the UK, under the KRI healthcare system the professional syndicates were established to register medical practitioners. Notwithstanding, a research conducted in 2010 found that professional syndicates have a weak role under the KRI healthcare system (particularly under the private sector).[447] Likewise, the majority of the participants under the empirical study of this research are not satisfied about the functions of the KRI syndicates for failing to assess the competency of healthcare practitioners; failing to provide guidelines; and failing to support healthcare practitioners in cases of dispute. This clearly indicates that the functions of professional syndicates have not improved, and such issues are ongoing.

As such, the findings of this empirical research added to existing knowledge on the functions of KRI professional syndicates. The participants perceptions relating to the

[445] C. Ross Anthony et al (n35) 68.
[446] WHO, *Iraq Health System Profile* (2006) 20 Regional Health Systems Observatory World Health Organization http://apps.who.int/medicinedocs/documents/s17295e/s17295e.pdf 24 May 2018; Nazar P Shabila et al (n32) 5.
[447] Nazar P Shabila (n32) 3.

non-implementation of legal rules (chapter 5.2.3) complements critiques concerning KRI professional syndicates. Due to the lack of a system for renewals of doctor's license to practice, it can be argued that the KRI system of professional regulatory authorities falls significantly below the benchmarks of best practice (chapter 2.4.2).

The KRI health system consists of a number of syndicates and the expected standards are set under a number of Acts of Parliament. Kurdistan Doctor's Syndicate and Kurdistan Nursing Syndicate are examples of KRI syndicates. The functions of these syndicates are regulated by *Doctors Syndicate Act of Iraqi Kurdistan (2000)* passed by Iraqi Kurdistan Parliament. According to section 4 of this Act, doctors are expected to satisfy a number of requirements such as being a citizen of the KRI and have a settled status in the region. The additional requirements relate to criminal conviction and holding relevant qualifications (section 4(3)).

The *Doctors Syndicate Act of Iraqi Kurdistan (2000)* also provides a clear overview of Syndicates duties in terms of regulating the functions of doctors. Such duties consist of supporting doctors (section 3(2)); overseeing the functions of doctors under private health sector (section 3(4)); providing guidelines (sections 3(10)); increasing doctor's knowledge and the implementation of such knowledge through the process of overseeing doctor's practices (section 3(13)).

Whilst the Act provides that syndicates have a statutory duty to conduct annual review of doctor's licence to practice (section 7(1)), the empirical findings of the thesis suggests otherwise. According to the majority of the participants, doctor's licence to practice is not subject to regular review. This, therefore, suggests a disconnection between the law and practice under the KRI health sector. Based on the empirical findings, the rationale for non-implementation of the Act is due to the lack of essential resources. According to the majority of the participants, the lack of high-quality medical equipment and ineffective authority to regularly assess healthcare practice has led to the non-application of the law at the level of patient's care. As evidence, a report published in 2019 indicates

that due to budget issues and health system failures the majority of KRI practitioners are planning to leave the KRI healthcare sector by immigrating in Western countries.[448]

In addition to *Kurdistan Professional Syndicates*, the process of specialising doctor's practice is overseen by *Kurdistan Board of Medical Speciality (KBMS)*. Whilst this board was established under Kurdistan Act of Parliament known as *Chapter 6 of law 10 (2008),* the functions of the KRI health administrative organs are governed by Iraqi Act of Parliament called *Public Health Law, Law No. 89 (1981)*. With regards to the regulatory jurisdictions arising from the semi-autonomous nature of the KRI, it is arguable that since 2005, the powers conferred to the KRI Parliament are formulated under the Iraqi constitution. In other words, the KRI Parliament was empowered, under the Iraqi constitution, to pass Acts and eliminate confusions in terms of public authorities' statutory duties. As long as an Act of Kurdistan Parliament is compatible with the major principles laid down under Iraqi Parliament, professionals are obliged to follow the Acts passed by Kurdistan Parliament.

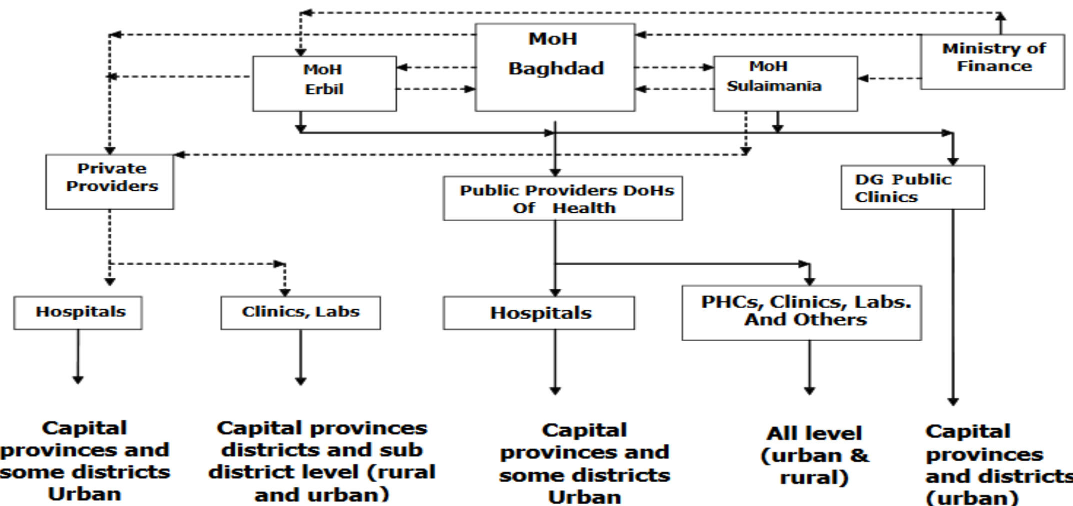
Collaboration: As considered under chapter 2.4.1, collaboration through collective leadership is regarded as one of the most important components of health system governance.[449] The existing literature indicates that the responsibilities of the KRI MoH includes the regulation of the health of KRI population under both public and private sectors; and also the collaboration with the *Ministry of Higher Education* to ensure medical training and education.[450] The chart below illustrates the existing collaboration between the KRI MoH and the public and private sectors:[451]

[448] EKurd Daily, *Over 1000 Doctors Left Iraqi Kurdistan Due to Economic Crisis* (2019) https://ekurd.net/doctors-left-iraqi-kurdistan-2019-01-02

[449] Keogh B, *Improving the Safety of Patients in England National Advisory Group on the Safety of Patients in England* (2013) 25 http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf 4 October 2016.

[450] KRG Cabinet, *Health minister: Top priority is improving primary healthcare* (2006)

[451] WHO, *Iraq Health System Profile* (2006) 20 Regional Health Systems Observatory World Health Organization 22.



Although, my empirical findings and existing literature show evidence of collaboration, in 2010, it was reported that the gatherings between the KRI MoH and Iraq MoH are subject to criticism. *Towfik-Shukur* argued: *"Currently, both Baghdad and Erbil's MOHs lack clear strategic policy directions, resulting in uncoordinated planning and fragmented projects."*[452] Additionally, the existing literature confirms the validity of empirical data relating to the existence of collaboration between the KRI MoH and international health organisations. For instance, the *KRG Cabinet* confirmed that they were funded by the WHO to conduct surveys for the purpose of obtaining quality indicators about the health of the KRI population.[453] Although, both the KRI policy makers and healthcare practitioners (under the empirical research) are satisfied with the services provided by the international health organisations, such services do not provide long term solutions under a failing healthcare system.

Measuring the above findings against the benchmarks of best practice (chapter 2.2.1), it can be argued that there is a failure on the part of health service leaders to work closely with healthcare practitioners by getting them involved with the process of improving healthcare quality. As such, it can be asserted that the KRI health service leaders are failing to act under the traditional approach of 'collective leadership'.

[452] Ali Towfik-Shukur, Hiro Khoshnaw (n2) 5.
[453] KRG Cabinet, *Health minister: Top priority is improving primary healthcare* (2006).

5.3Emerging Theme: "Holding to Account"

The second emerging theme focuses on accountabilities at both institutional and individual healthcare practitioners' level within the KRI healthcare providers.

5.3.1 Healthcare Professional Accountability

About 44% of the participants (including participants 1, 3, 9, 10, 15, 16, 17, 18, 19, 20, 23, 26, 28, and 30) are of the opinion that individual healthcare practitioners can be held accountable either by the hospital management teams or within the courts as participant 1 stated: *Doctors can be punished if they do something that no one else would do."* This clearly indicates that doctors can be held accountable if they act below the standard of care, which is according to participant 1, practising in a way that no other healthcare practitioner would do.

Process of disciplinary actions under KRI healthcare system: According to participant 1, although no system is in place to regulate the process of accountability, different bodies are in place to investigate the case; hold practitioners accountable and defend the practitioner. As evidence, participant 1 stated:

> *"If the doctor neglects the patient, then there will be liabilities… eeeh as a system no, we have doctor syndicate …eeeh will defend doctors. And the health directorate will investigate the case…If a patient has a complaint, then everything will be recorded in the file and this file will be reviewed by the health directorate."*

Findings show that the director is considering received complaints, however, there are no duties to investigate and make referrals according to participant 9, who stated:

> *"Ehh, the system is certainly very bad, a director can voluntarily decide to take actions and take complaints into account, but under the system there is no authority in place to consider complaints and take actions… So, it depends on the personality of the director."*

Additionally, participant 10 explained the process of accountability and stated:

> *"First of all, the head of the Department of Health starts by an investigation of the issue, he will ask the doctor … if the problem is a small one such as not considering the medical history of the patient. Then the head of the department will provide a*

warning ... Most of the times it will be solved like that. Sometimes if the issue is serious, it will be raised to the general directorate of health in Sulaymaniyah [DOH]. And they will go through the problem again. They will ask for a committee by the manager of the hospital like me or the doctor that was involved and head of the department of health and member of the legal institute inside the general directorate. This committee again will investigate what happened and if they find anything, they will provide let us say punishment of that person."

Further, participant 18 stated that there are contractual duties between him as a practitioner and the hospital director, and that breaching those terms will lead to accountabilities. He stated:

> *"I have been given responsibilities towards the patient, staff and the hospital and have signed for it. If any errors occur, I have signed for it and I will be liable..."*

The process of accountability through the legal department (known as ReAse) within the Ministry of Health is explained further by participant 19:

> "*We have eeeh director, hospital managements, syndicate, legal departments (within the ministry of health) to deal with legal issues… eeh where complaints are made by patients against the healthcare professionals. And the legal department makes sure that we have legal advisors or solicitors to assist us during a claim. But complaints start in the hospital by the director and we try our best to solve the issues in the hospital. So, the actions are step by steps*."

However, participants 20, 23, and 30 argue that even though hospital management teams including the directors are responsible for taking actions, there is a discretionary power not to make referrals. More specifically, participant 20 argued: *"The hospital director is free to decide whether to refer or not to refer the healthcare practitioners*." Participant 30 further confirmed this point and argued:

> *"...it is for the head of the department to take action. For instance, the head of BATNI / Hanawi department can decide to dismiss a healthcare professional if he or she does not do their job properly… Firstly the case will be considered in department of health [SAHA] and if the family is convinced then the case could be settled there…"*

Additionally, according to participant 30, in cases of patient's death as the result of medical errors, the issues are investigated by the forensic department:

> *"... patients are admitted whilst being a live and die in the hospital…If the case needs to be investigated by our forensic department, then we have the duty to refer back the report…"*

Types of disciplinary actions under KRI healthcare system: The empirical findings indicate that there are different types of accountabilities under the KRI healthcare system, including reporting, warning, cutting payments; displacing by giving lower responsibilities; not providing certification; dismissing from job either temporarily or permanently; and imprisonment through referrals to the court.

Reporting Failures: The process of reporting an incompetent medical staff is a challenging process according to participant 15, who regrets taking the initiative. He stated that:

> *"... eeeh I was working in a hospital outside the country outside the Sulaymaniyah city in the countryside. It was my first month duty. Actually, I was very serious, I punished a staff, I became very very tired until I did this punishment. About a week I went to the house management, the hospital managers, even I went to the minister of the health. It was such a fatal mistake; it was a very very big mistake.*
>
> ***Can you please be more specific?***
>
> *Yes, I had a patient with severe chest pain, the patient was sweating, repeated vomiting, I was suspecting Myocardial perfusion, then I had to send the patient to our laboratory, eeeh they kept the patient for about three hours in from of the lab…Then I went inside the laboratory and asked the staff in the lab what have you done to this patient. Then the staff told me I did not do the test for your patient. Then I said why. Eeeh He said because I don't like to do it right now…I said why? He said because eeeh yesterday I saw you and you did not say to me hello. I don't like you…he was about to kill a patient just for my hello…I said I will punish you, he said you cannot…So I even talked with the manager of the hospital…Yes, I did, I took the punishment letter to every room. So that every could know that medical staff could be punished. From then when I asked anyone to do something,*

> *they said yes yes, I will do it. But unfortunately, I was very very tired to do the punishment and I hope that is will not be repeated again."*

Warning: the first type of disciplinary action under the KRI healthcare system is to issue a warning, which according to participant 17 have an impact on their reputation as it was stated: *"There are consequences… eeh Warning, it will be a black point in their file, it is not nice."*

Displacement: according to participant 28, those healthcare practitioners who are not practising well, are given lower responsibilities and are being displaced:

> *"those practitioners that were not helpful have been send downstairs to treat those patients in stable conditions. Sometimes we have patients that need immediate treatment in a few seconds."*

Reduction of Employees' Salaries: According to participants 10, 16, and 26 one of the disciplinary actions is to reduce practitioner's payment. As evidence, participant 16 argued:

> "*As a senior nurse, I am supervising nurses from college or other staff. If one of the medical staffs does not follow the rules, such as going outside without authority, then I will make sure that this will not happen again by questioning them and giving warning or reducing eeehh payment*."

Furthermore, participant 26 argued that within the training center:

> *"if a registered practitioner of the course did not attend the course then we were cutting their payment. We were also providing certification after each course and those that broke the rules would not get a certificate."*

Dismissal from job: Additionally, according to participants 18, 23, and 30 under the disciplinary proceedings of KRI healthcare system there are chances of dismissal from job. As evidence, participant 23 argued:

> *"Yes, we have had doctors that have been dismissed from their job permanently or for a limited time. We also have had doctors that have been put at lower position and have had lower responsibilities. We have also asked doctors to*

undergo training before further practise. There was the type of punishment that are available against doctors."

This was further confirmed by participant 30:

"Yes, that happens, and it is for the head of the department to take action. For instance, the head of BATNI / Hanawi department can decide to dismiss a healthcare professional if he or she does not do their job properly."

Imprisonment (Court proceedings): according to participants 1, 3, 9, and 30 in cases of serious harm to patients, healthcare practitioners are referred to the courts and imprisoned. As evidence, participant 9 argued:

"…ehh that is the problem there are accountabilities. Sometime if you do too much work they will take to the court. Therefore, it is better not work. There was another director who repaired the hospital because changing light bulb he was taken to the court because of wasting resources… eeh the director was dismissed from his job. eeh [silence] I know the director personally."

Further, participant 9 provided the second example:

"the director before me lost his invoice and the case was also taken to the court, two people because of this was charged for 6 years imprisonments and they were dismissed [from their job]."

Findings reveal that although accountabilities are not announced publicly in the media, under the KRI healthcare system the healthcare practitioners are held accountable. As this was highlighted by participant 30 (a policy maker):

"We have referred doctors to the courts, we have had a doctor that was charged for 18 months. We do take actions, but we do not report it to the media… we don't want to criticise our services. We don't want to make the people aware of what actions we are taking. This is why the public is complaining very often, the complaint about us that we do not take actions against our healthcare practitioners. I don't want to come out and tell the public that I have taken this action against my doctor. why should I do this? I should not be proud of taking actions against my own doctors."

As such, participant 30 suggests that disciplinary actions against healthcare practitioners are kept confidential to keep public trust. Notwithstanding, this approach can be criticised. In fact, the public are aware about the failures under the health sector and the failure to disclose information relating to disciplinary actions can potentially lead to public mistrust.

Figure 21: KRI Accountability System

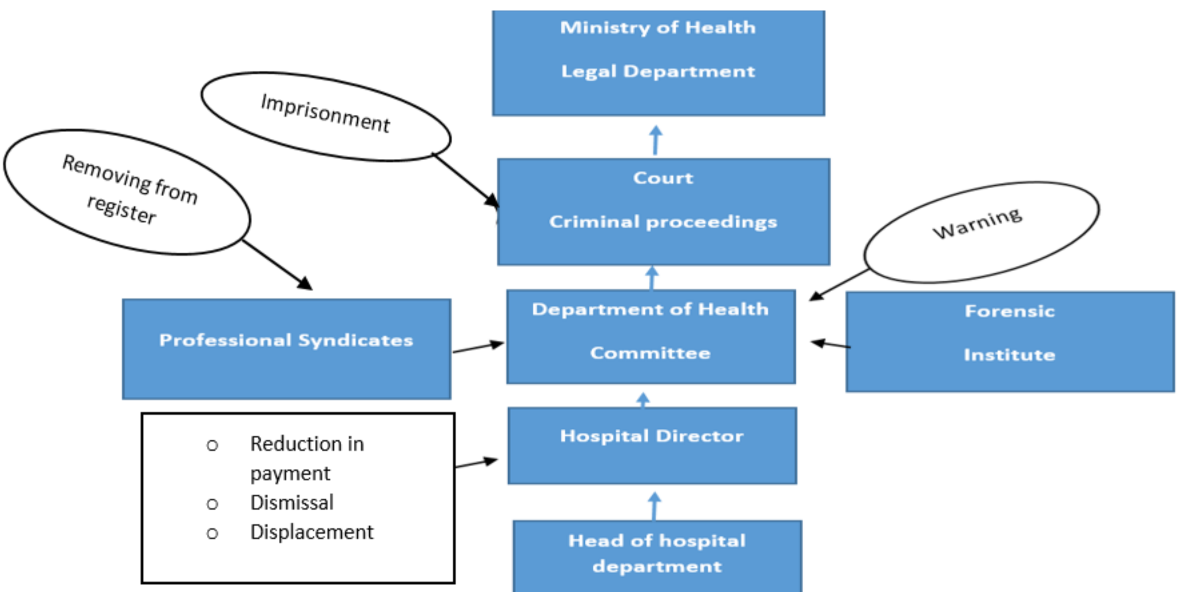


Figure 21 articulates the professional bodies involved within the process of holding healthcare practitioners accountable under the KRI healthcare system. As it can be seen, the head of departments/hospital directors are made aware of the failure either through the patient or medical staff; if the manager is satisfied and decides to take actions then they put the issue into writing and refer it to the Department of Health, whereby a committee is set up and if necessary, the forensic institute investigates the case. At the same time the professional syndicate will be involved to support the doctor. The empirical finding indicates that very often a warning is issued, and the case is dissolved at the initial stage. Whilst, those cases concerning gross negligence are referred to the courts, cases concerning policy considerations are brought to the attention of the health ministry department.

5.3.2 Institutional Accountability

Additionally, according to participants 1, 9, 23, and 29, healthcare institutions need to be blamed for system failures. For instance, participant 1 stated:

> *"If there is something wrong with the system, then the doctor is permitted ... because doctors are not the reasons. If a patient needs ventilation and is not available, then there will be no liabilities."*

Furthermore, participant 9 is of the opinion that healthcare providers need to be held accountable for putting in-experienced practitioners in charge of patients in critical condition:

> *"it is wrong to allow students without experience to work in emergency department. In this department it is difficult to find experienced doctors to guide you and very often you are left on your own… eeh of course the system should be blamed."*

According to participant 29, healthcare providers need to be blamed for the imposition of work pressure on healthcare practitioner that can lead to errors:

> *…We have had doctors that have discharged 80 patients in a day, under which it was impossible for some patients to become well in one day and there is no authority to ask how this was possible."*

As a result, participant 23 (a hospital director) claimed there is a responsibility to set aside a budget to avoid system failures:

> *"As a director ... When the systematic failures are reported, eeeh the head of the department will report it to us, if it is possible, we can set the budget aside for it to be solved. [Silence] But this is not happening very often."*

This suggests that although systematic errors are reported, and the above stated participants are recognising system failures, these findings are not suggesting the existence of institutional accountabilities under the KRI healthcare system.

5.3.3 Barriers to Accountability

On the other hand, according to 50% of the participants (including participants 3, 4, 5, 6, 7, 9, 12, 14, 15, 18, 19, 20, 24, 25, 26, 27, and 30) the obstacles to accountabilities are

deriving from political and economic issues whereby it has led to the absence of effective regulators which means no enforcement of law and no follow up to ensure accountabilities. Below each barrier is considered in further detail.

Political and Economic Crisis: The findings show that the current political instabilities and economic issues have made it even more difficult as doctors are working for free and it is unlikely for them to be held accountable. Participant 18 argued that:

> "*especially now. it is even worse now. Before the boycott and before the strike where practitioners were being paid, although everything was developing, there was no focus on accountability. Now we don't expect anything in this crisis."*

Ineffective regulatory authorities: Due to the lack of professional regulatory authorities, participants 3, 18, 19, 20, 25, 26, and 27 substantiate that the lack of accountability of healthcare practitioners under the KRI healthcare system. As evidence, participant 3 argued:

> *"No, we don't have such a system…But we don't have regulatory bodies because we don't have a system to assess doctor's practise…Because of lack of regulatory bodies…if someone does something wrong eeeh there are no responsibilities for them."*

The lack of accountabilities due to the absence of effective PRA is further confirmed by participants 18, 25, 26 and 27. For instance, participant 18 argued "*No, no one is there to make them accountable. It is almost impossible to hold health practitioners accountable"* While participant 25 argued: *"They will admit that is case have been done wrongly but nobody will do anything…No, they will tell you that this was wrong but there is no questioning about this."* Participant 26 endorse: *"No, we did not have the authority to hold any healthcare practitioner accountable."* Lastly, participant 27 is from the opinion that "*There is no one in dealing with the problem. That is why healthcare in that part of country is incomplete."*

Ineffective rules: According to participants 9 and 26, PRA are ineffective as in some cases a legal duty is not imposed on them to take actions. For instance, participant 26 stated: *"No, we did not have the authority to hold any healthcare practitioner accountable."* Furthermore, participant 9 argued:

> "*Ehh, the system is certainly very bad, a director can voluntarily decide to take actions and take complaints into account…So under the system the director does not have to act. So, it depends on the personality of the director. Sometimes the director decides to consider the complaint*."

As accentuated above, ineffective PRA means no introduction and enforcement of rules and therefore no accountabilities. For instance, participant 3 is also of the opinion that the failure to establish regulations is an obstacle to hold those practitioners to account who are treating patients with expired medications:

> *"The government fails to provide regulation where under doctors could be hold accountable…patients had become blind was because the medication has not gone through quality control. We do not have regulations for the storage of medications… [She proclaimed] Because of lack of ... guidelines, if someone does something wrong… there are no responsibilities for them.*"

Furthermore, the findings show that due to the lack of effective guidelines, the law has no priority. Participant 5 claimed: *"Based on individuals there is nothing to push them to follow those guidelines. There is no kind of punishment to follow the guidelines."* This was further confirmed by participant 25, as she stated: *"Really this is our problem, we don't have guidelines. Nobody will ask you or eeh let you know what was your fault in your management eeeh or your friend's management."* As a result of the failure to introduce effective regulations, participant 12 argued that "*In this country the law is not above everything*."

No enforcement of existing rules: according to participants 6, 15, 24, and 30 the lack of follow-up system to ensure the enforcement and the implementation of new knowledge is one of the main reasons of lack of accountabilities. For instance, participant 6 stated that even if failures are reported, no actions are taken:

> *"We said to the person who are responsible ... they promised to provide everything ...but after two weeks but then it will come back to zero."*

The point relating to the lack of enforcement of rules to avoid accountabilities is further confirmed by participant 15 as he stated:

> "*we don't obey the rules. For example, if I see some defects in a medical staff, even if I report it ... eeh it will not be solved according to the rules unfortunately. It will be solved as we call it Ashairy [tribe]…They will be bringing you together, and they will be asked to forgive each other. ... Eeh* it will be solved between them… [Silence]"

No follow-up system: Additionally, participants 24 and 30 are of the opinion that the lack of accountabilities is associated with the absence of follow-up system. For instance, participant 24 argued:

> *"we don't have accountability under this system and therefore we don't have follow up. The final stage of a training course is following up but since we don't have follow up system, we don't have a complete training course and therefore we cannot say we are successful… Yes, we do advise them, but to what extend is this taken into account depends on the system of the hospital. Whether they follow it or not, there is no accountabilities."*

Political intercession: According to participants 4, 6, and 15, due to the support by political parties under the KRI healthcare system, there are no accountabilities for negligent doctors. Participant 4 stated: *"People die, no one is to blame."* For instance, participant 6 stated: *"if a doctor is wrong the regulatory body cannot take action if that doctor has close connection with political parties*." Participant 7 claimed that due to political interference in some cases even managers cannot ensure accountabilities:

> *"We did complain ... eeh But the problem is that those mistakes happen without punishment…eeh I cannot remember last time when someone was hold accountable because of the lack of knowledge or making an error. Unfortunately, in my country even some doctors if they make mistake and people die from the injection because of lack of knowledge they are not accountable."*

Furthermore, participant 14 is also of the opinion that managers are powerless when it comes to political interference:

> *"Eeh I told my boss but eeh, one time I saw this happening, but the political party controlled the decision of my boss. So, this is the problem. … eeeh I told her, I was inside the operation, I didn't let her to perform that because ... eeh she was not sure what she was doing, and she tried to perform … but I had only issue with one, who was politically supported."*

Withal, participant 14 also claimed that due to the support by political parties, some doctors are able to impose sanctions on fellow healthcare practitioners:

> *"you cannot act against the will of doctors as they are very powerful under this system. Some doctors are imperator, they have close contact with political parties, and you cannot act against their will."*

The point relating to political interference is further confirmed by participant 15:

> *"What I mean I should only actually only tell the manager of the hospital and he should be the one that would take the responsibilities. But the manager was not able to give any punishment. Because the person at fault in the lab was close to political parties. I asked the manager to give punishment, but he said he cannot. Then I went to the general manager of the healthcare system of Sulaymaniyah he said he cannot do anything…You know under our system you cannot punish anyone."* Figure 22 illustrates the link between the failure to impose legal duties on PRA to introduce rules and the lack of professional accountabilities.

Figure 22: Impact of KRI Accountability System

5.3.4: Synthesis and Discussion: Accountability

Holding to account: on the one hand, my empirical findings suggest that there are a number of disciplinary proceedings against healthcare professionals including warning displacement; dismissal from job; reduction in payment; removal from register; and imprisonment. The KRG Cabinet, under the existing literature, also indicates that the ministry of health has taken actions against negligent doctors as according to the KRG Cabinet: "*In addition, we have shut some clinics and banned a few doctors from practicing because they were involved in malpractice.*"[454] On the other hand, my findings do not indicate such disciplinary proceedings against KRI clinical leaders such as members of MoH and DoH. More specifically, they suggest that the healthcare providers are not held accountable for system failures.

The findings of this empirical research and the existing literature evince that the functions of healthcare leaders are subject to criticism for failing to ensure accountabilities. According to the WHO, the lack of an effective system of accountability is often due to the failure to impose legal duties on health service leaders to oversee the functions of healthcare practitioners.[455] Further, my findings suggest that although the KRI hospital directors are aware of potential disciplinary procedures, according to the majority of the participants, often no disciplinary actions are taken against negligent doctors. Additionally, the existing literature (Melina Moore) suggest that even in cases of disciplinary procedures, no effective follow up system is in place to prevent the reoccurrence of such failures.[456]

Even though, the existence of standards under legal rules on its own is not sufficient as some legal rules are not vigorously enforced, under the benchmarks of best practice a clear and effective standard is set up through clinical guidelines to clarify duties and responsibilities. As such, it can be argued that the existing KRI system of accountability does not reach the benchmarks of best practice. Due to the limited effective clinical guidelines under the KRI healthcare system, there are unclarities in terms of expected standards. Additionally, due to the lack of effective regulatory authorities in the KRI, it

[454] KRG Cabinet, *Health minister: Top priority is improving primary healthcare* (2006) http://previous.cabinet.gov.krd/a/d.aspx?s=010000&l=12&a=14384 13 July 2019

[455] WHO, *Iraq Health System Profile*, Regional Health Systems Observatory World Health Organization (2006) 29

[456] Melinda Moore et al (n36) 23.

is less likely for disciplinary actions to be taken against negligent practitioners. As such it can be inferred that although non-legal rules are followed under the KRI healthcare system, without formal standardisation of such rules, it causes inconsistent practice across healthcare providers. The additional requirement for ensuring accountabilities is to have persistent and consistent healthcare leaders. Nevertheless, due to political interferences under the KRI healthcare system, the existing healthcare leaders are not consistent and are not determined to hold politically supported practitioners accountable.

Measuring the above findings against the benchmarks of best practice (chapter 2.2.3), it can be argued that under the KRI health service system, a system of accountability is not consistent. Although the lack of accountabilities means less chances of a blame-culture within the healthcare providers, the lack of effective professional regulations and guidelines, has negatively impacted the KRI health service team performance and the quality of healthcare.

5.4 Emerging Theme: "CLIENTELISM"

Although, the political parties' powers under the healthcare systems of developing countries are broadly discussed, the influences of such powers are hardly ever researched. This part of chapter five, presents the empirical findings relating to clientelism and its impact on healthcare practice. Clientelism is the third that theme emerged under this chapter of the present thesis. From the empirical findings, a majority (53%) of the participants (including participants 2, 4, 6, 7, 9, 12, 13, 14, 15, 16, 17, 18, 20, 22, 28, 29, and 31) are of the opinion that political parties interfere with the practice of KRI healthcare professionals.

Politically directed healthcare system: the empirical findings suggest that political parties are playing an active role during the healthcare practice and that KRI has a politically directed healthcare system. As evidence, participant 6 argued that *"in Iraq as general, political parties are major part of every hospital*" this point was further confirmed by participant 9, as he stated, *"political parties are playing the most important role."* Furthermore, participant 20 argued *"Our healthcare system is being controlled by political parties and it has an important role in every department of the hospitals*." This was further confirmed by participant 22, as he stated: *"Here is now like a big forest, those*

with most power will do whatever they want to do." Participant 29 confirmed also the role of political parties within the KRI healthcare providers, as he replied: "*Yes, a great role and 100 per cent."*

The subsequent theme that emerged from the empirical study is clientelism as the empirical findings shows that some of the KRI healthcare practitioners are empowered in exchange for political support during elections. For instance, *participant 4*, argued that the healthcare practitioners are given money by political parties (bribe) not to whistle blow the failures, she stated *"they give them money to shut their mouth*." Furthermore, participant 14 argued that political parties are listening to those medical staff who are voting for them:

> *"I meant medical staffs, sorry eeeh they are a huge number of staffs because the political parties need votes, therefore, the political parties are listening to medical staffs, rather than following the rules."*

Additionally, participants 9, 14, 16 and 29 share similar views about the existence of political interference within the KRI syndicates. As evidence, participant 9 stated

> "*There are many syndicates as doctor's syndicate which are supported by political parties and once, they [doctors/ nurses] are supported they are in stronger position …this association support those who are close to political parties."*

Politically supported syndicate: Participant 14 argued: *"Eeh really, we have syndicate of doctors and I am not happy about this, from 2012 I have my certificate, I did not benefit from this, because they are supported by political parties."* This point relating to political interference was further confirmed by participants 16 and 29. Participant 16 stated: *"Yes, we have nurse syndicate. But this is run by political party and is not effective…*" While participant 29 argued *"In itself doctor's syndicate is powerful, as they are part of the political party. They could do more, eeeh but we have seen nothing."* Unsurprisingly, the empirical findings indicate that the existence of political interference has led to various issues under the KRI healthcare system including injustice, exoneration, antagonism, and deterioration.

5.4.1 Injustice

Unequal payment: According to *participants 9 and 22*, the existence of political interference has led to unequal payment whereby only those practitioners with political support are being paid well. As evidence, participant 9 argued: *"As a doctor I am paid less than a police officer. People think that all doctor are paid a very huge amount every year. But that is not the case, only those doctors get paid who are close to political parties."* Participant 22 shared the same view about not being paid a fair amount and stated *"I am not political, and I cannot get more. Here is not about what you deserve it is about who you are.*"

Unfair treatment: According to participant 4 due to political interference, healthcare practitioners are being treated unfairly, as she stated *"No, even if there are courses. There are always priorities for someone else that is very close to political party and those close to the management services."* Differentiation during the process of funding courses is further confirmed by participant 28:

> *"two years ago, eehh two doctors went to Jordan for medical training. But not everyone will get this chance and they were nominated by the hospital director. Eeh it it was in accordance to their preferences. Actually, we complained about this as it should have been in accordance to the level of experience. I don't know how those people were appointed… Those were chosen that were close to political parties and…"*

Additionally, participant 14 claimed that political involvements within the process of appointing doctors for medical specialty board led to unfair treatment and had an impact on his well-being:

> *"I am not happy with that because the political issues are covering all. Four years ago, I submitted my proposal to the board to be accepted for medical specialities…one of the the political parties put another person into my place…but I after finishing six months I have been expelled from the board…I was eeeh I quitted from the Iraqi board …The political issue here is not like that, but they will create a document for you and you will be …. Eeeh …. Sight,,,,,eeeh [the sound was like crying] yes, it is very bad system….Believe me my results were excellent, only three people could have been accepted, the other two people did deserve to be there, but the other person that was put in my place had lower*

results but because his father played role in political parties, he was put into my place…That is unfair."

Participant 14 continued to explain that he was involved in road traffic accident:

"The accident affected my nerve system, which I still suffer from…I had a road traffic accident…The problem is that the political parties are above the law…They make the law against you."

Physical Abuse: Participant 9 argued that political interference has led to physical abuse within the KRI healthcare providers:

"For us as doctors it is very difficult to adapt ourselves into a failing system. We as doctors suffer because we get into arguments on daily basis. There are even times when doctors are hit in Erbil very recently a doctor was hit, he was a consultant and have worked for about 38 years. He was hit by an unqualified person who was supported by political parties and there were no charges."

This point relating to physical abuse was further confirmed by participant 29:

"We also have had doctors that have been treated very badly by political body's security guard. They have been even hit. … eeh other example is that camera has been taken into the consultation rooms without the consent of doctors and have provoked doctors to act wrongly and have published this further in the media."

Additionally, according to participant 28, those patients/families who are supported by political parties, are breaking the rules within the KRI healthcare providers. This participant emphasised that in some cases even hospital managers are unable to take actions and control the situation:

"The law is that each patient should have one family member [as a visitor for inpatients], *if very tired two. But here because of nepotism sometimes they have 5 family members…We used to have people from political parties, and we could not report this eehh … even the director cannot tell them."*

Nepotism: according to the participants 4, 9, 13, 14, 15, 17, 18, 22, and 29 the political parties are interfering with the process of employing healthcare practitioners. For instance, participant 4 is of the opinion that the employment of incompetent practitioners

through political parties has a negative impact on patient safety and can lead to serious harm to patients as she stated:

> *"There are people who don't have any qualification and are practising…they have no experience to be put in charge because they are like butchers and can cause harm. We as oral surgeon were no happy with this and we complained. But they told us we can't do anything about this because their people have strong politicians behind them… eeh those people did not have any clue about viral infections, and this is why many people have hepatitis B."*

Further, participant 17 confirm the need of political parties' support during the process of employment:

> *"there are times where someone have good experience and good qualification, but they don't give a high position because that person is not close to political party. Sometimes, they put someone without good experience or qualification in a very high position because of the relation with the political parties."*

Even participant 18 admitted that he got the job through connections with political parties as he stated that: *"until now I have been supported by someone in order to start work without showing my diploma."*

Additionally, participants 9, 13, 14, 15, 20, 22, and 29 are claiming that unqualified managers are recruited under the KRI healthcare system through political support. For instance, participant 9 asserted that:

> *"There are possibilities that a person will assess that even their qualification will be lower than my qualification. The system includes nepotism, even under a course they can prevent you from succeeding by making test so difficult."*

Participant 13 attest that the management teams of KRI healthcare providers are not qualified and competent for that position:

> *"our management team because they have been given the position through political parties eeeh... Under any hospital of other countries there is a system called hospital managements. Unfortunately, we don't have this here in Kurdistan region."*

The existence of unqualified healthcare managing teams was further confirmed by participant 14:

> *"Even there is a lot of unqualified persons that hold or govern our medical system here. Because their political party put them in that position."*

Participant 15 also argued that unqualified managers are in return of political votes:

> "*Unfortunately, those who are becoming managers in our hospital are eeeh from somewhere taking those responsibilities ... eeeh because they are close to political parties… everything is linked to elections there are managers who have trying to make people to be satisfied with the political party they belong to. They are looking for what can I do in my office so these staffs will vote for my party during the next elections*."

However, participant 20 was reluctant in admitting the existence of political interference, she stated:

> *"Although this what I say my affect my position eeeh silence, of course appointing healthcare practitioners are all through political parties. I would like to remind you I am not part of any political party; I only try my best to do my job properly. This is the main reason that I am still here and not having a higher post. If you interview others that have a high post, you will realise that they don't even have a bachelor's degree rather than master's degree. Eeeh ... a good example is that my current director has only graduated from college and not university, but I am under the control of him."*

The point relating to employment of low qualification and lack of experience is further confirmed by participants 22 and 29. Participant 22 stated: *"They may even have lower qualifications than the doctors. Not only lower qualifications but also lack of experience is an issue."* While, participant 29 asserted that *"We have had doctors that was so competent, but not position was given because they were not part of the political party."*

5.4.2 Exoneration

Participants 7, 12, 15, 24, 28, and 29 share the similar views about the fact that politically supported practitioners are absolved from blame under the KRI healthcare system. For instance, participants 7, 12, and 24 are of the opinion that those who are supported by political parties are dominating the healthcare providers and are immune from accountabilities. As evidence, participant 7 argued *"there is no regulatory body for people who are close to the ministry."* Furthermore, participant 12 stated *"We cannot go against the members of political parties and cannot criticise them for being treated differently. In this country the law is not above everything."* This is further confirmed by participant 24:

> *"you cannot act against the will of doctors as they are very powerful under this system. Some doctors are imperator, they have close contact with political parties, and you cannot act against their will."*

Findings further reveal that in some cases even the management teams cannot take actions, as evidence participant 14 said

> *"eeh he or she will pass without any punishment… Eeh I told my boss but eeh, one time I saw this happening, but the political party controlled the decision of my boss... We complain but no one listen. I want to tell you how hard it is, really there is no government, we have two main political parties here. So, eeeh there is no government to work to govern our medical staffs."*

The difficulties in succeeding in an action against those practitioners who are supported by political parties is further confirmed by participants 15, 28 and 29. For instance, according to participant 15, it is difficult to report those practitioners who are close to political parties:

> *"I said I will punish you, he said you cannot. He said eeh here you are let us see what you can do. So, I even talked with the manager of the hospital… What I mean I should only actually only tell the manager of the hospital and he should be the one that would take the responsibilities. But the manager was not able to give any punishment. Because the person at fault in the lab was close to political parties. I asked the manager to give punishment, but he said he cannot. Then I*

> *went to the general director of the healthcare system of Sulaymaniyah he said he cannot do anything."*

Most importantly, participant 28 argued that in some cases the managing teams are preventing the claim from being referred and are treating those practitioners who are not supported by political parties unfairly:

> *"We did, our complaint reached the head of the syndicate, even our head of department was not disclosing the correct information. He only said that he was not aware of the process. But when I went to him, he was actually copying the names. The course is all about nepotism, I am sure."*

This is further confirmed by participant 29:

> *"No because, it is all about whether you are the family of the director, or if you are close to someone that is powerful... I personally have faced issues in this department, I have been complaining and nothing has happened. This is how it work, and it is not systematic… Those at fault have been protected by political parties."*

5.4.3 Antagonism

Inequitable subordinate communication: Due to political interference, the empirical findings (including participants 9, 14, and 22) indicates that some highly qualified healthcare practitioners who are not supported by political parties are treated as less important and this has a negative impact on their relationship. According to participant 9, sometime those nurses who are politically supported have more powers than doctors. He argued "*As doctors we cannot take actions against nurses because most of them are supported by the political parties…"* This point is further confirmed by participant 14:

> *"But after all, political parties' control this, for example … during the post call meeting eeeh but the person that is supported by the political party can do what he wants. Because they have the support from the political party."*

As a result, some practitioners including participant 22 are suffering:

> "*The process is torture eeeh … those who got the qualification in Bagdad, previously they have signed for the Saddam regime and this is how they got into that position. And now they are showing off because they have high position*."

Unfair treatment of patients: Not only healthcare practitioners are being treated unfairly, (according to participants 12, 29, and 31) patients are also being treated unfairly within the KRI healthcare providers. For instance, participant 12 argued:

> *"For example, a family member of the healthcare practitioner comes and gets priority, or someone who is close to political party gets priority and is seen before emergency patients and eeh this leads to complaints and un-satisfactions."*

Participant 29 shared the same view and stated:

> *"Not only for doctor, but also for patients those that are close to political parties are put in front of the waiting list and will get anything they want"*

Even participant 31 (a policy maker) claims that those patients who are close to political parties have more chances of receiving better care, as he argued:

> *"someone close to the political parties will be treated by more doctors but they will receive the same medical treatment and medications."*

5.4.4 Deterioration

Unequal healthcare standards: The issues of different healthcare standards across KRI provinces is perceived by participant 4:

> *"The politician is effecting everywhere. If you are not the member of that political party, then you don't have power to do anything. In Erbil is a different story and in Sulaymaniyah is a different story. Each political party is working in different ways and adopting different standards. So that is a problem."*

Prevention of quality improvements: The empirical findings (including participants 2, 4, 9, 12, 13, 22, and 24) indicates that improving the KRI healthcare system is dependent on political party's authority. For instance, according to participant 2, the establishment of new hospital buildings was approved by the existing KRI political parties, as she stated

"Kurdistan Children Hospital is focusing on maternity and children matters. [….] donated money to make this project successful..." Nevertheless, according to participants 4, 9, 12, 13, 22, and 24 the need of political party approval to make improvements is regarded as an obstacle. Participants attest that political parties are not committed to making improvements under the healthcare sector. As evidence, participant 24 stated: "*our healthcare system needs to be reformed. But in this country, we need political party's authority*." Furthermore, participant 9 argued:

> *"When they were building public hospitals, I contacted the minister and recommended an Italian company, but no one listened to me. Because they contracted other company cheaper to set aside half of the budged for themselves… Unfortunately, our government is spending the limited budged on military and weapons rather than the healthcare system... eeeh managers cannot change the system because they do not the authority to do so… [Silence] Even ministers cannot change the system"*

The point relating to the difficulties of improving the healthcare system due to political party's interference is further confirmed by participant 12 as he stated *"we are in a country where improvements are very difficult. We cannot go against the members of political parties and cannot criticise them."* Moreover, participant 22 opined that political parties are not committed to making improvements:

> *"No, the limited sources are all being stolen, this political parties are doing what they want. They are the main reason for … healthcare and educational failures. And now they are the main reason for this economic crisis. They are stealing the wages of our professionals eeeh..."*

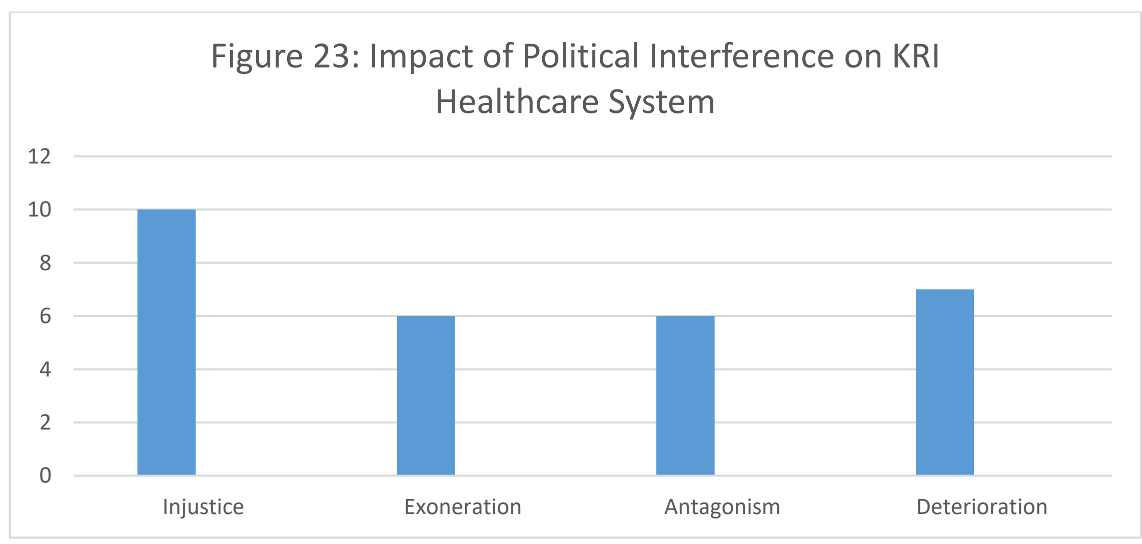
Unenthusiastic practitioners: Additionally, according to participants 4, 9 and 13, due to political interference, practitioners are reluctant to be involved within the process of improving the healthcare. For instance, participant 4 argued:

> *"Even if there is someone who is very good and comes up with a good idea to improve the system, but because it does not belong to any political party. The politician does not give him the chance to do that."*

Furthermore, participant 9 asserted that:

> *"Our government is working in a way to make people silent; it does not work in a way to make improvements in a practical way. Eeh I can ...eeh For example this has led to a way that health professionals cannot instruct the patient in a diffident but better way... eeh People are scared to work independently to improve the system..."*

As a result, participant 13 claims that healthcare practitioners are unenthusiastic in making recommendations for improvements as he stated, *"Even if you as healthcare professional make recommendations for improvements, the situation may get worse rather than better."*



As it can be seen on the chart above, injustice, exoneration, antagonism, and deterioration are the impact of political interference on the KRI healthcare system. 10 participants (4, 8, 9, 13, 15, 17, 22, 28, 29) are of the opinion that political interference have led to unfair treatment. According to 6 participants (including 7, 12, 15, 24, 28, and 29) the political interference has led to exoneration whereby politically supported practitioners are absolved from accountabilities. Participants 9, 12, 14, 22, 29, and 31 provide that political interference has led to antagonism whereby it has a negative impact on healthcare practitioner's relationship. Finally, participants 2, 4, 9, 12, 13, 22, and 24 indicated that political interference has the effect of preventing improvements within the KRI healthcare system.

5.4.5: Synthesis and Discussion: Clientelism

Political parties involvements: The issues relating to political interference and nepotism under the KRI healthcare system was reported in 2010 and it was stated "*Staff appointments at the MoH and DoHs are predominantly based on political affiliation and nepotism, and not core competences…*"[457] This is congruous with the explanation by *John Quin,* as he argued: "*It is very possible that this corruption also carries into areas of official appointment of top level and decision making policy positions relying on nepotism and political affiliation."*[458] My research findings support this statement. As indicated above, the power of political parties influences the process of official appointment of health service leaders including hospital directors.

Although, researchers and academics have attempted to identify the role of political parties under the KRI healthcare system, such roles are not comprehensively uncovered under the existing literature. As evidence, *John Quin*, who researched health security of Kurdistan region, argued *"Upon my health surveys and assessments within the region, no corruption was overt, and no doctor or healthcare management official was willing to speak with me about such claims on the record*."[459] Fortunately, my findings do provide a comprehensive overview of the impact of political parties' involvements under the KRI healthcare system. As specified above, a number of health service leaders and practitioners are holding positions in politics, whereby political parties support is regarded as one of the sources of powers in the healthcare providers. As the KRI health system is financially dependent on those political parties who hold the office of the government, the right to healthcare is also dependent on decisions of political parties.

Measuring the above findings against the benchmarks on health service leadership and professional regulatory authorities (chapter 2.2.1 -2.2.2), it can be argued that political ideologies has continued to be part of the KRI health system governance. As the findings suggests that under the KRI healthcare system politicians are pursuing unprecedented number of measures inappropriately that leads to unjust treatments. Even though the involvement of international health organisations in the process of health policy decision-making can decrease political parties' role, often the functions of the representatives of such organisations are overseen by political parties, thus, it would make no difference.

[457] Ali Towfik-Shukur et al (n2) 3.
[458] John Quinn (n38).
[459] John Quinn (n38).

Predominantly, it can be argued that the current practice by KRI healthcare leaders does reflect upon the theory of the *Leader Member Exchange (LMX)* whereby politically supported practitioners are favored.[460]

5.5 Summary

This chapter provided an overview of KRI healthcare system governance with a particular focus on the function of KRI healthcare leaders; the process of accountabilities; and the role of political parties. Following Thematic Data Analysis process, a number of themes emerged from the empirical data. For instance, under the theme of "KRI healthcare leaders" the participant's perspectives relating to the functions of healthcare leaders were considered in detail. Furthermore, the second theme of "holding to account" provided an overview of the responsibilities imposed on the practitioners and the process of disciplinary actions. Finally, and most importantly, under the third emerging theme (clientelism) the impact of political involvement on the current healthcare system was considered in detail.

Although, previous research has indicated the issues relating to KRI healthcare governance, this study provides a wider understanding and a comprehensive overview about the perspectives of KRI healthcare practitioners relating to the functions of KRI healthcare leaders. This is the case, even though the findings under this research cannot be generalised as the empirical study was only targeted at the practitioners and the policy makers in the province of Sulaymaniyah and not in the provinces of Erbil and Duhok. The findings relating to the KRI healthcare leaders will be utilised under chapter 7 of this research for the purpose of making recommendations for potential solutions.

[460] Michael West, *Leadership and Leadership Development in Health Care: The Evidence Base* (2015), Centre for Creative Leadership, pp10-12, https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/leadership-leadership-development-health-care-feb-2015.pdf 25 May 2018

Chapter 6: The Quality of Healthcare in KRI

"An overview of KRI Healthcare Quality Issues"

(Empirical Findings and Discussions)

6.1 Introduction

This chapter aims to explore the impact of governance on the quality of healthcare. This chapter critically discusses three themes that emerged from the empirical research programme. Whilst the first theme concerns the KRI patient safety practices, the second theme focuses on patient-centred care and the third theme examines the risk management initiatives under the KRI healthcare system. Under this chapter, each theme is followed by a critical synthesis, whereby the findings are drawn together and measured against the benchmarks of best practice to identify areas for improvements.

6.2 Emerging Theme: A Critical Analysis of Patient Safety Practices in KRI

6.2.1 Patient Safety Issues in KRI

Medical errors: it is unfortunate that preventable medical errors occur within the healthcare providers on a daily basis.[461] Unsurprisingly, under the empirical study of this research, participants 2, 14, 15, 16, 19, 20, 23, 25, 29, and 30 concede that the existence of medical errors under the KRI healthcare system due to various reasons including system failures; the failure to treat patients within a reasonable time (work pressure); and employment of incompetent practitioners due to political interference. According to participant 29, medical errors occur due to the existence of unjustified process and lack of guidelines:

> *"Although I am part of this region, unfortunately, I have to say that each of us are not doing the jobs we are supposed to do. It is either abusing the duties or overdoing the duties. What I mean by this is eeeh I am a doctor; it does not mean I know everything. I want to admit… There are some sorts of ECG's that I may not know scientifically."*

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[461] IOM, *To Err is Human Error: building a safer health system* (1999) 1.

Participant 29 added that due to the lack of professional regulatory authorities, medical errors are not prevented:

> *"Under any profession we have negligent bodies, and of course we have negligent doctors, we have doctors that behaving inappropriately. We need to have a system that would prevent the practice of those type of professionals or withdraw their qualification."*

Reporting Errors/Failures: Whilst, participants 12 and 23 claim that failures are reported to healthcare management teams and actions are taken, participants 1, 2, 4, 6, 7, 13, 14, 15, 16, 18, 25, and 29 are reluctant in reporting failures due to various reasons including the lack of systematic measures to take actions; the formation of a blame-culture; and potential for losing job. For instance, according to participants 2, 7 and 29, no system or authority is in place under both public and private sector to request feedback and investigate failures reported by both healthcare practitioners and patients. Additionally, participants 4, 6, 18 and 25 are feeling hopeless and are resisting to report failures as they are of the opinion that the KRI healthcare managers are not qualified and are not experienced enough to take actions. As evidence, participant 18 stated:

> "*there have been times where I was prepared to run the risk and have made the director aware of the issue, due to the lack of a process no actions were taken. Since the director is not a doctor do not understand the failures...*"

This indicates that managements will not question about the nature of medical actions including any failures. As a result, medical practitioners are not willing to report, as participant 25 argued "*Really you should report but eeeh I didn't see any practical like that... they will admit that is case have been done wrongly but nobody will do anything*." Furthermore, according to participant 4 healthcare managers are not approachable, as she stated: *"At that time there was a manager at the hospital, she was mad. Nobody could even talk to her. Even the staff ... were scared of her."* Additionally, participants 15, 16, 18, and 25 are reluctant in reporting failures due to practical problems such as blaming and having inauspicious relationship with fellow practitioners; and having the potential of losing job. For instance, participant 18 argued:

> *"even if I make the director aware, doctor have discretion and there is not much you can do, if I as a nurse took actions then there would be chances that I could be quitted from my job. I do not want to run that risk."*

As a result, participant 15 is suggesting disinclination in whistleblowing failures and fears in speaking up, as he stated:

> *"In order to be a doctor under this system you need to keep yourself silent, don't bother about anything and can do the job in an easy way for your own best interest. In this way you are safe without any troubles."*

Barriers to Learn from Mistakes: Due to political interferences, professional jealousy, political instabilities, and budget restrictions (according to participants 1, 2, 3, 4, 5, 6, 10, 13, 14, 16, 23, 24, 25, 31, and 32) improving patient safety and learning from mistakes in the KRI is not a priority. As evidence, participant 31 stated:

> *"Now we are suffering from economic crisis ... we are in a difficult situation and we are in war and we have political issues. Therefore, now we are mainly focusing on saving people's life and not bringing changes… In recent years we are moving backward instead of moving forward."*

Lack of professional Support: Moreover, participants 4, 10, 13, 16, and 18 are from the opinion that due to political party's interferences and due to jalousie amongst practitioners and leaders, improving patient safety is not a priority under the KRI healthcare system. As evidence, participant 4 argued: "*We cannot go against the members of political parties and cannot criticize them*." Moreover, participant 13 argued

> "*in our hospital we have someone, as a director of the department prevents any improvement and prevents the application of new methods. If there are any other doctor that come up with new ideas, he prevents it and make them not to talk about the new ideas anymore... the situation may get worse rather than better"*

More specifically, participant 18 asserted that making suggestions for improvements or reporting failures has a negative impact on professional relationship:

> *"I have been very active in the ward and have made sure that I treated every patient effectively. My college saw that patients were appreciating my help, they were jealous and tried to make problems for me...I believe if we were to set up a*

healthcare professional bodies it should not impose a duty on me to oversee the functions of my college, this could affect our relationship."

Restrictions on Healthcare Budget: Whilst participants 1, 2, 12, 19, 24, 26, and 31 are suggesting free access to health services, participants 1, 2, 3, 6, 10, 18, 22, 25, 26, 28, 29, 31, and 32 proclaim that political instabilities in Iraq has a major impact on KRI healthcare finance. As indicated before, the national budget is allocated by the central government in Baghdad, however, the political instabilities have an impact on the allocation of national budget by Iraqi government. For instance, participant 1 stated "*Since the establishments of ISIS, there have been major pressure on the financial income to the health services…unfortunately. Now it is difficult to get the money from Baghdad."* This point is further confirmed by participant 32:

> *"now after 2014 because of ISIS attack and because of the decrease of oil price...because of the economic crisis whereby the budged from Bagdad have stopped, we have faced many problems within the provision of healthcare under this system although we continue to provide medical intervention however, it is not to the same standards as in 2013…"*

The impact of war on priorities in KRI is further confirmed by participants 2: *"Unfortunately, due to issues of priorities and after the attacks of ISIS the government tends to focus on this as priority."* More specifically, participants 22 and 29 are blaming the political parties for economic and political instabilities. For instance, participant 22 argued:

> *"the limited sources are all being stolen; this political parties are doing what they want. They are the main reason for genocide [Anfal campaign], civil war and of course the healthcare and educational failures. And now they are the main reason for this economic crisis. They are stealing the wages of our professionals and they are not acting in the public best interest. They should not be called a government. Government means law."*

Additionally, participant 29 suggested corruption by healthcare leaders whereby the limited budget is not utilised appropriately: *"We don't know, the money may be there but could be used for other unauthorized purposes."*

Increasing KRI population / refugees: in addition to budget restrictions as a result of political instabilities, participants 3, 4, 6, 8, 31, and 32 are of the opinion that political instabilities has led to the increase of refugees (1 million 900 thousand) in KRI, which has a negative impact on the limited medical resources. As evidence, participant 6 argued:

> *"Nowadays we have political problems in Iraq and all people from other parts of Iraq escape to Kurdistan as refugees to Sulaymaniyah and we have even people from Syria coming. Yes, the hospital is not enough, even the government does not provide the satisfactory services that are required."*

No-payments, Strikes, and Hospital Closures: According to participants 6, 12, 18, 20, 22, 23, 29, 31, and 32 the economic crisis due to political instabilities has led to the non-payments of healthcare practitioners including training managers. For instance, participant 12 stated: *"We have staff working as voluntary without any payment. It is very difficult for being supported even though we are trying our best to achieve the best standards. I personally, it has been three months I have only received one-month salary."* Additionally, participant 18 is of the opinion that

> *"At the moment we are in a very bad situation. Now in this hospital we are 35 volunteers. If we leave this job, I believe that this hospital will also be closed. Because the other healthcare professionals are on strike and as they have not been paid for months. At the moment the number of working hours is reduced, and the staff member are not happy about this as they cannot afford their daily life."*

Participant 32 (a policy maker) also admitted the decrease of payment, as he said: "*our healthcare staff are not being paid as much, their salaries have decreased, I can say that that the current budget is not enough...*" Moreover, participants 2, 18, 20, 19, and 29 are suggesting that the strikes of healthcare practitioners have led to the closure of hospitals and training centres. For instance, participant 18 argued:

> *"Now we are facing a very difficult economic situation, most of the hospitals are closed down… SHAR hospital, a beautiful building but due to the current economic situation the healthcare professionals are on strike and therefore it is not operating."*

The closure of hospitals has the potential of increasing risk of harm to patient according to participant 29:

> *"many hospitals now are empty and have been closed down. And this is a disaster for patients. The hospitals outside the city are closed down and the patients have to travel to the city which has limited places and it is extremely difficult."*

The impact of political instabilities and the current economic crisis is further clarified by participant 32 (a policy maker):

> *"...because of this crisis most of those projects have stopped, now after 2014 because of ISIS attack and because of the decrease of oil price, because of a large number of refugees coming to the region, which are more than 1million 900 thousand people, because of the economic crisis whereby the budged from Bagdad have stopped, we have faced many problems within the provision of healthcare under this system although we continue to provide medical intervention however, it is not to the same standards as in 2013 as our healthcare staff are not being paid as much, their salaries have decreased, I can say that that the current budged is not enough as the population have increased by 30%."*

Figure 24 briefly illustrates the potential impact of political instabilities on the safety of patients under the KRI healthcare system (although such process is more multifaceted than presented below):

Figure 24: Impact of Political Instability in the KRI

Political Instabilities → Economic Crisis → Non-payment of Healthcare Practitioners → Strikes → Closure of Hospitals and Clinics → Omission to Treat → **Harm to Patients**

6.1.2 Lack of Medical Resources

Lack of Essential Medical equipment: Health service resources are indispensable to the process of accommodating quality and health service improvement. Unsurprisingly, participants 1, 3, 6, 10, 18, 25, and 28 indicated that some KRI hospitals are not only lacking advanced medical equipment, but they also lack the most basic and essential medication. As evidence, participant 6 argued: *"the patient needed to be catheterized and this catheter was not available, and which is not expensive."* The lack of medications is further confirmed by participant 25: *"now we don't have enough medications and services in the hospital. we don't have enough drugs, even the emergency drugs that we need for emergency cases."*

As such, participants 6, 10 and 18 attest that in cases of lack of essential medical resources, hospitals are depending on nearest pharmacies. For instance, participant 18 argued

> "*we were in need of certain medications, but it was not available and therefore we had to refer the patient to outside pharmacy to get the medications…For example we have been waiting months to receive certain drugs because we did not have this in the hospitals…My hospital is depending on other branches*."

Participant 8 added that due to the issues relating to limited resources, there is an inconsistent use of medications within hospitals:

> *"sometimes there is one type of antibiotic and in another hospital, eehh they don't have it. For example, one of my friends was working in emergency hospital two weeks ago, there was a patient admitted on one type of antibiotic in the medical emergency hospital and they referred to medical ward but in the medical ward they don't have that anti-biotic. So, you had to change the medication of the patient."*

The above indicates that no equal standards exist across KRI healthcare providers in relation to the availabilities of medical resources, which has a negative impact on the well-being of patients. Moreover, participant 1 indicates that the lack of advanced medical equipment prevents improvements of health services as he stated: *"Now there are lack of equipment and government cannot afford to buy and improve the system."* Moreover, participant 28 is of the opinion that these failures precipitated complications

and additional work pressure on healthcare practitioners: *"we don't have a technological equipment that would control the amount of drops to the patient. So, we have to re-set it every 10 minutes, this does take our time."* The issues relating to lack of resources in Iraq including KRI is further confirmed, in a recent report of 2019, by the *UK Home Office*.[462]

Inadequate Medical Staffing: Participants 10 and 25 proclaim that due to the current economic situation the number of nurses has decreased within hospital departments. Participant 10 argued:

> *"The obvious effect is the decrease of number of nurses available. For instance, in the working hours I had 5 to 6 nurses and this was sufficient, but the economic situation obliged us to decrease the number, I have only 2 nurses. Which is a small number and they cannot provide a total care. And second the nurses are exhausted."*

This clearly indicates that the limited number of medical staffs impose additional and unreasonable work pressure. Below the issues relating to work pressure on KRI healthcare practitioners is considered in further detail.

6.2.2 Workforce Imbalances in Healthcare

Maldistribution of Workforce: The empirical findings (including participants 3, 10, 12, 16, 18, 19, and 25) suggest that the economic crisis has led to strikes and closure of hospitals, which has imposed an extra work-related pressure on KRI healthcare practitioners. As evidence, participant 3 is of the opinion that due to work force, healthcare practitioners cannot treat patients appropriately: *"they have to swear that they will look after the patient…But this is not common in public hospitals due to the pressure and lack of resources."* Additionally, participants 12, 16 and 19 share similar views about the workload on those public hospitals. Participant 12 confirmed that "*About 4OO to 5OO patients are coming to the hospital for treatment."* This was further confirmed by participant 19 *"At the moment we have limited staff. We don't have international*

[462] Home Office, *Country Policy and Information Note Iraq: Medical and healthcare issues* (2019) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/800235/_external__Iraq_-_Medical_and_healthcare_-_CPIN_-_v1.0__May_2019_.pdf 7 August 2019

standards and we have political issues. We are treating up to 450 patients in a day and this is a huge amount."

Dual Practice in Healthcare: From the empirical findings, 65.6 % of the participants (including participants 2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 14, 15, 19, 22, 23, 24, 25, 29, 30, 31, and 32) believe that dual practice by doctors is common under KRI health sector as there is a provision that allows doctors to work under both public and private sectors.[463] Further participants 5, 7, 10, 12, 14, 19, 24, 29, and 32 highlight the lack of a clear delineation between public and private health sectors. Participant 10 elucidated:

> *"Still, we do not have a separate system here in Sulaymaniyah, we have senior doctors working in the hospitals, they have private clinic and at the same time they are working in public hospitals…You can say it is a tradition rather than a will. This has come that way since 196O's and 197O's in Iraq… When doctors become senior, they find it is their right to have private clinic and it is totally legal."*

Participant 32 explained the functions of healthcare practitioners under a dual system as following:

> *"They work in public hospitals in the mornings, and in the afternoon, they work in their own private clinics. Of course, this type of service is internationally known as dual system… private and public services are mixed and not separate. For example, we have doctors who are working in public hospitals, universities and in private clinics..."*

Absence of doctors in Public Health Sector: According to participants 3, 10, 14, 15, 17, 19, 22, 23, 29 and 32, due to the existence of dual healthcare practice, doctors are very often unavailable and are omitting to treat patients under public health sector. As evidence, participant 22 argued: *"here doctors are gone after 12pm to their private clinic. After 12pm you cannot find doctors in public hospitals."* Further participant 29 stated: *"We have doctors that leaves the patients in the public hospitals and treats the patients in their own private clinic."* In order to generate income, participant 10 argued:

[463] C. Ross Anthony et al (n35) 34.

"*When I go back to Kurdistan, I will establish my own private clinic, and in the morning, I will be working in public hospitals. But during the morning I do not want to spend my energy and want to keep my energy for afternoon in my private clinic…most doctors are not paying enough attention in the morning and are not taking the work seriously".*

Participant 10 added that dual practice imposes a major work pressure on doctors as he stated:

"I have an example of someone who is also specialized in heart conditions, he works in one of the cities of Kurdistan, this doctor works in public hospitals in the morning and from 3pm he works in his private clinic, he is working continuously until the midnight (12am) sometimes he sees patients after 12am. The next morning, he is exhausted when he returns to the public hospital. So, he rests during his time in the public hospitals and he does not want to make himself tired, so that he can work in his own private clinic. He does not care and is prepared to give up is job in public hospital because he earns better in private hospitals."

Financial Incentives: According to participants 9, 10, 19, 23, 24, 29, and 30 the principal reason for doctors to focus on private health sector is financial incentives. As evidence, participant 9 stated: *"doctors do not want to work in public clinic because it is underpaid…"* As a result of underpayment, participant 10 is of the opinion that doctors are studying further to set up their own private clinic and increase their income: *"Of course a major factor is financial. When doctors become senior, they find it is their right to have private clinic and it is totally legal..."* Participant 9 clarified this point and stated:

"We need to separate the private with public clinics. If it is separated, then it is more likely that most doctors will choose private clinics … Because of financial matter, doctors earn better in private clinics. If doctors were earning enough in public hospitals, they would never have decided to open their own private clinics … a patient with heart conditions that comes to private clinics for a simple treatment they will have to pay about 200.000 dinars [£130]. Only admission fees are 15.000 dinars [£10], for heart measurement ICG they charge another 10.000 [£7]. and ECO costs at least 25.000 [£17] and medications are above 40.000 [£27] staying in hospital for each night costs at least 100.000 [£67]."

The image blow illustrates the existence of private clinics as it can be seen the white and red boards are advertising medical specialists: [464]

Figure 25: KRI Private Clinic

Impact of workforce on Patient Safety: unsurprisingly, high workload has a negative impact on patient safety as a major work pressure can easily lead to medical error and serious harm to patients. It can be argued that health governing authorities have the responsibilities to ensure effective healthcare practice and better healthcare quality under a system with dual healthcare practice. Participants 9, 17, and 25 are of the opinion that the unavailability of doctors and the omission to treat can be regarded as a patient safety hazard as medical practitioners are left without appropriate supervisions. As evidence, participant 9 argued:

> *"It is difficult for junior doctors to find a specialized doctor to ask questions eeeh … in most cases specialized doctors are not available and they don't even answer their phone when they are needed… it causes a major problem for patients. I have worked in emergency departments and … it was necessity we contacted him he did not respond. Because he was in his own clinic..."*

Additionally, participants 10, 16 and 18 are clarifying the impact of workforce on patient safety, whereby no sufficient time is allocated to communicate and diagnose patient's condition correctly. Participant 10 argued:

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[464] Alamy, *private clinic and pharmacy in Kalar*, Northern Iraq, 2018, https://www.alamy.com/stock-photo-private-clinic-and-pharmacy-in-kalar-northern-iraq-100695455.html 28 June 2018

> *"we have a very high load with a small number of available staffs. So, the nurses or doctors have not enough time to provide proper communication with the patient."*

Essentially, participant 16 suggest that maldistribution of workforce has not only an impact on patients, but also on the well-being of healthcare practitioners. He stated: *"we have insufficient staff... we have very limited time and most of our medical staff is working long hours without good rest."* This corresponds to the findings reported by *Rand Corporation, which provides that "The KRG had not established standards for the minimum number and type of staff to maintain a primary care centre or a minimum set of services to be delivered at each type of centre."*[465] As such, it can be argued that the findings under the present study confirms the existing literature relating to the quality of KRI healthcare and suggests that such issue has not yet been resolved.

6.2.3 Synthesis and Discussions on KRI Patient Safety Practices

Figure 26 (below) illustrates the root causes for medical errors extracted from the empirical findings, which starts with health system failures such as the absence of clinical guidelines to identify standards of healthcare; the existence of workforce imbalances in healthcare; lack of essential medical equipment; and incompetent practitioners due to the lack of professional regulatory authority to assess the practice of healthcare professionals. The empirical findings suggest two types of workforce imbalances (namely temporary and permanent imbalances).[466] The existence of workforce imbalance due to dual healthcare practice can be classified as permanent, however, the impact of political instabilities on workforce can be classified as temporary. The subsequent cause for the increase and continuous occurrence of medical error is the absence of reporting and preventing medical errors system. Moreover, lack of follow-up prevents a system of learning, whereby patient's condition is not monitored following medical intervention or detecting illnesses in advance.

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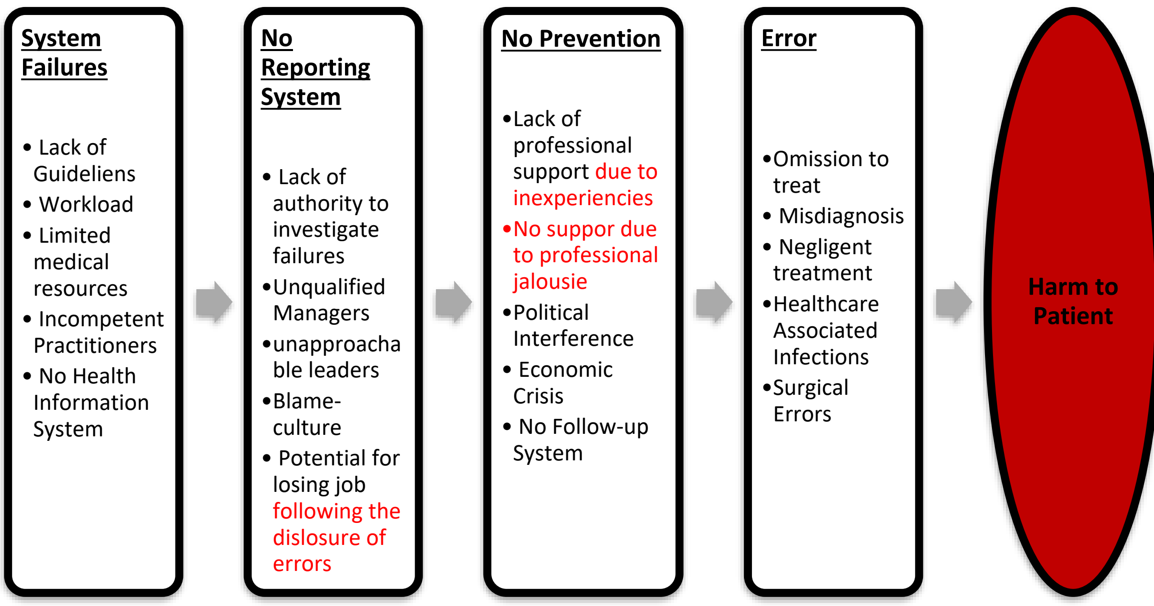
[465] C. Ross Anthony et al, (n35) p3

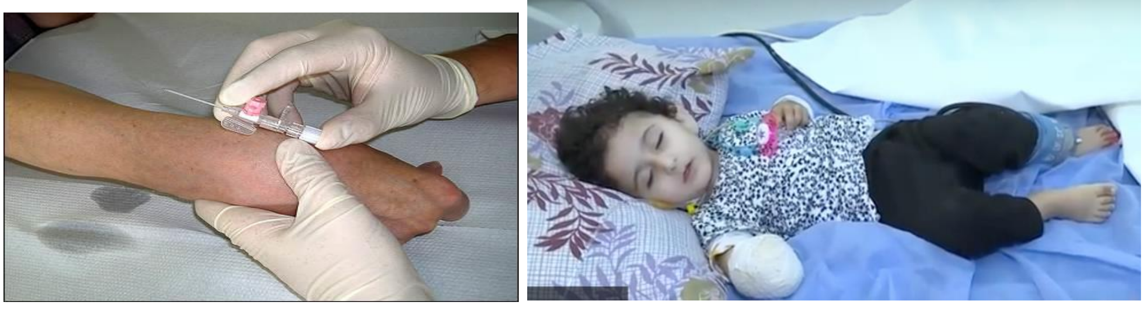
[466] WHO, *Imbalances in the health workforce* (2002) <http://www.who.int/hrh/documents/en/imbalances_briefing.pdf> 17 July 2018

Figure 26: Impact of System Failures in KRI



The empirical findings indicate that strikes by healthcare practitioners and hospital closures as a result of economic crisis has a negative impact on the quality of healthcare. As the findings suggests, the crisis has led to lack of resources, work pressure whereby it prevents patient-centred care and improvements under the KRI healthcare system. A recent case study by *EKurd Daily* confirmed the death of 4-years-old boy following the negligent injection of antibiotics which has led to the protests.[467] A subsequent report (which is in public domain) confirmed the existence of life-threatening medical errors under the KRI healthcare system as a two-years-old patient (on the image below) hand had to be amputated as a result of negligent administration of Intravenous Injection (IV).[468]

Figure 27: Medical Misadventure in KRI



[467] Ekurd Daily, *Medical errors on the rise in Iraqi Kurdistan*, 2017, https://ekurd.net/medical-errors-iraqi-kurdistan-2017-04-18 17 July 2018

[468] Widad Akreyi, *Healthcare System In Kurdistan Region & Medical Errors*, 2018, https://widad.org/healthcare-system-in-kurdistan-region-medical-errors/ 17 July 2018

Although, no disciplinary processes are in place whereby the fears of accountabilities would discourage openness to report failures, the existing systematic failures are regarded as an obstacle for reporting errors and learning from mistakes. Moreover, as indicated above, due to fears of formation of blame culture, the participants of the present empirical study were reluctant in reporting failures. This approach applauds the notion that blame culture is a preventative factor for improving healthcare practice, as the existing literature providers that "*Blame Culture is an important determinant of preventable hospital adverse events and deaths, by reducing openness about incidents and thereby inhibiting organizational learning*."[469]

Measuring the above findings against the benchmarks of best practice on patient safety (chapter 2.3.1) it can be argued that under the KRI healthcare system there is a failure to act in accordance with the international health standards. More specifically, there is a failure to guarantee a safe environment by reducing the risks of harm through the process of reporting failures and learning from mistakes.

6.3 Emerging Theme: The Role of Patient-centred Care in KRI

6.3.1 In-effective Doctor-Patient Relationship

The majority (62.5%) of the participants (including participants 1, 3, 5, 6, 7, 8, 9, 10, 12, 13, 16, 18, 19, 20, 23, 26, 27, 28, 29 and 32) believe that doctor-patient relationship under the KRI healthcare system is subject to criticisms. According to participant 6, doctor's attitude is driven by societal culture, which prevents an effective doctor-patient relationship as he stated: *"But there is a cultural problem in our society when a doctor is not arrogant or if behaving like friendly with the patient, most of the patients believe that this doctor lacks medical knowledge."* Furthermore, participant 9 (hospital director) provides: *"...believe me when I entered his room, he* [the doctor] *did not raise his head to look at my face."* Additionally, participant 18 suggest that due to the doctor's uncooperative behaviour, it is unlikely for patients to disclose all relevant information for the purpose of correct diagnosis, as he stated:

[469] Sharon Komen, *Understanding Blame Culture in Healthcare* (2016) p3 https://openaccess.leidenuniv.nl/bitstream/handle/1887/43515/Komen%2C%20Sharon-s1234137-MA%20Thesis%20ACP-2016.pdf?sequence=1

> *"We have doctors instead of greeting the patient, they have said straight away, what do you have?? I was standing next to the doctor, as a nurse eeeh I did not feel confident because of the behaviour of the doctor ... how can the patient feel good? It is not nice."*

Poor Communication: According to participants 3, 5, 7, 10 and 16, the lack of resources including medical staff has led to a major workforce on the existing medical practitioners, which does not leave time for sufficient communication between doctors and patients. As evidence, participant 10 argued *"we have a very high load with a small number of available staffs. So, the nurses or doctors have not enough time to provide proper communication with the patient."* Moreover, participant 16 stated:

> *"we have to treat other patients which are in critical conditions and have to provide priority to other patients that came later. But this is difficult to explain to the other patient complaining. As we have very limited time..."*

Participants 9 and 19 are of the opinion that poor communication due to system failures has led to the lack of trust and the failure to disclose relevant information to the doctor, which increases chances of misdiagnosis and harm to patients. As evidence, participant 9 stated:

> *"we have some patients that doctors cannot treat them because of the failing system and thinks that the doctor is responsible. The public does not trust our services and we have lost confidence. Eeeh Some patients have not even yet entered the hospital they start fighting with the staff and make problems. They complain so much that as a doctor you feel like you made them ill. This is a stressful situation for us as doctors."*

The above clearly indicates that infective doctor-patient relationship also has a negative impact on doctor's well-being. Additionally, participant 19 suggest that ineffective relationship can lead to arguments, failure to treat and even death of the patient:

> *"one of our practitioners have had an argument with the family of the patient, after two weeks the family of the patient came back to our ward and complained about the practitioner and argued that the practitioner killed their patient as two weeks later the patient had died."*

Participant 13 suggest that nowadays the focus is on a number of patients rather than providing a high quality of healthcare through doctor-patient relationship:

> "*Really our system is not good, the ministry of health focuses on quantity rather than quality. it is preferred for a doctor to see as many patients as possible rather than providing best quality if medical treatment. The ministry of health only prefers the highest number of patients that are seen in a day. They will note only for example in [...] hospital that 1OO patient is seen in one department, another 2OO patients are seen in another department*."

A research conducted in Turkey (neighboring country of KRI) discussed similar issue whereby it was found that due to very limited time:

> *"There is no more an intimate and personal relationship between the doctor and the patient anymore. Doctors do not identify the names or faces of their patients but, rather, recognize them from their test results. The patient is now composed of the numbers and curves in and out of the "normal" and "healthy" intervals of the scores. There is no completeness or wholeness to the body anymore. It is, rather, fragmented into pieces into the quantifiable roles of both the doctor and the patient. The body is dissolved into pieces, becoming "post-human."*[470]

This supports the 'medical gaze' approach taken by the French philosopher (Foucault) whereby knowledge by doctors are used as a means to have power over human body and ultimately practitioners are seeing patients as a set of organs rather than human being.

Lack of Public Health Education: Participants 1, 3, 5, 6, 7, 8, 9, 13, 18, 19, 20, 23, 26, 29 and 32 are of the view that the lack of public health education is not only negatively impacting doctor-patient relationship, but also effects the safety of healthcare practice. For instance, participant 8 claims that as the result of the lack of educational background, patients are seeking medical assistance unnecessarily. He stated:

> *"I think the main reason is that education of the people, they are not educated enough about health issues. They sometimes come to the hospital just to ask question about how to use medicine. They may just come for a tablet or*

[470] Zeynep Balcioglu, *The Medical Gaze Between the Doctor, the Patient, and the State* (2012) E-International Relations https://www.e-ir.info/2012/10/11/the-medical-gaze-between-the-doctor-the-patient-and-the-state/ 18 December. 19

> *paracetamol. So, they will take your time. Eeh, you may miss emergency patients that are in serious conditions."*

This indicates that ineffective public health, filtering system, and sufficient resources can have the potential of causing serious harm to patients. Moreover, participant 29 is unsure about the reason of the absence of public health education:

> *"our patients unfortunately most of them do not have educational backgrounds and they don't have knowledge about health education. We don't know whether this is related to the patient's unwillingness to learn more about health education or is this the public authorities or the media that does not bring this into the attention of the patient."*

Under the empirical findings of the thesis, participants 3, 6, 13, and 23 claim that patients are not willing to understand the high workload on public hospitals and are neglecting the process of looking after their medical condition. As evidence, participant 13 stated: *"I was told by the security of the hospital that the prescriptions I wrote for the patient was thrown it in the bin outside my room"* Furthermore, participant 23 argued:

> *"The educational background of the patients is very limited...for example, I am being told by the patient that he or she is suffering from blood pressure for 5 or 10 years, when I ask what that is, the patient do not know it and does not know measures should be taken to reduce this illness."*

Participant 29 suggest that the combination of lack of public health background and lack of medical records database contribute to patient safety issues whereby practitioner are not aware about patient's medical history:

> *"most patients are not living in a healthy way to prevent illnesses; they don't have the understanding. Most patients are not keeping the test results, and don't bring their medication with them, in order for us to be aware what the patient is taking at home... this can have many side effects...we don't know whether the medication eeh we give in the hospital was already taken in the morning."*

The lack of patient's awareness about side-effects of excessive use of medications is further confirmed by participant 13:

> *"We have noticed that out 70 per cent of those that are coming they are not really patients ... But under our culture patients love medication... The best doctor in our culture are those who prescribe too much medications..."*

Patients and Families Dominance: Participant 13 as a doctor suggested the domination of patients within the healthcare providers, as he stated:

> *"patients that are playing the role of the doctor ... eeh they come to me tell me what I should prescribe for them and where I should refer them to. If I don't do what they tell me, I will be assaulted, and the patient will be psychologically suffering."*

According to participants 6, 10, 12, and 28, due to culture, lack of public health education, and political party's support, patients and their families are breaking the rules of the hospitals. For instance, participant 6 argued: "*it is the culture, ... eeh the main door of the hospital there more than one hundred family are outside and want to come inside to be with the patient…the patient is insisting to have two or three relatives at the same time."* This point is further confirmed by participant 28:

> *"Some patients have 10 family members ... eeh each patient should have one family member, if very tired two ... sometimes they have 5 family members…We used to have people from political parties, and we could not report this to the director assistant. We cannot, even the director cannot tell them."*

Participants 6 and 12 argue that breaking the rules of hospitals such as allowing families in the hospital wards has a negative impact on the infection control and it is a patient safety hazard. Additionally, participants 3, 6, 9, 16, 18, 27, 28 and 29 share the same opinion relating to the existence of verbal and physical abuse of healthcare practitioners by patients and their families. As evidence, participant 6 argued:

> *"One of the relative came and kicked the door of the operating room. They wanted fight with us. After doing a good job for the patient, but someone outside the operating room was not good with them, the family came back and kicked our door…"*

Further, participant 28 argued that the combination of workload on practitioners with the lack of educational background of patients and their families has led to assault:

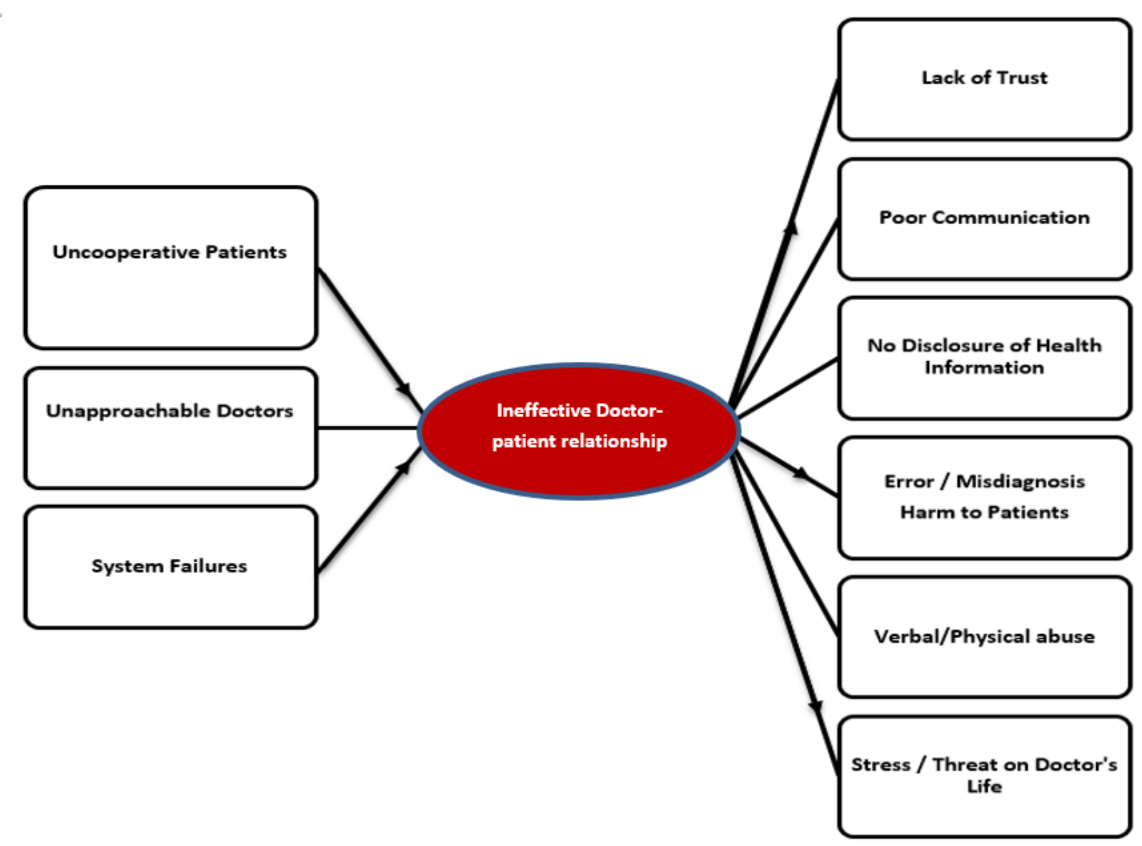
> *"Sometimes, we are being attached and assaulted for not treating the patient on time and we are being blamed for being careless about the patient…When our patient dies, the family start to attack us and one time they broke our computer. The security services by the entrance of the hospital cannot always control the situation on time. Some patients have quite a lot of family members with them and therefore it gets out of control. It is also a threat on our life."*

Most importantly, participant 29 suggest evidence of setting up, whereby doctors are allured to make mistakes:

> *"camera has been taken into the consultation rooms without the consent of doctors and have provoked doctors to act wrongly and was reported in the media."*

Figure 28 (below) illustrates the rationale behind in-effective doctor-patient relationship. This covers uncooperative patients as the result of lack of public health education patients or family's dominance as the result of political party's support. It also covers unapproachable doctors and system failures due to high workload. In addition to the reasons, the chart also displays the repercussion of in-effective relationship such as harm to patients and verbal or physical abuse by patients and their families against doctors.

Figure 28: In-effective Doctor-Patient Relationship



6.3.2 Systematic Barriers to Patient-Cantered Care

Informed Consent: Informed consent in healthcare is about the process of protecting patient's bodily integrity by providing the right of self-determination during the process of medical intervention. According to participants 1, 3, 6, 7, 12, 15, 16, 17, 18, and 21 under the KRI healthcare system, formalities such as consent form is in place. As evidence, the process of obtaining consent is clarified by participant 12:

> *"And consent is the most important part of our job. For children we need to have consent from father, mother, brother or sister… During this process, we inform the patient how serious the risks are, for example 1 in 10,000 patients do not wake up under general anaesthetics...*

Although participant 19 is indicating that patients are not forced to accept the medical treatment, participants 3, 7, 14, 18, and 28 share similar opinion and suggest that the existence of high workload and the lack of time is preventing professionals from obtaining informed consent. The table below provides examples of participant's perspectives:

Participant	**Critics on Informed Consent**
3(General Practitioner)	*"The problem is, especially in the public hospitals because it is so busy, the patient does not even read the information before signing the form."*
7 (Dentist)	"*There is no time to tell the patient the options and there is no option for the patient. Risks we mention it, but not that much to be honest."*
14(General Surgeon)	*"the number of the patients are more than the number of doctors, so they are seeing the patients in hurry. They don't have a lot of time to explain a lot of detail for each patient."*
18 (Nurse)	*"sometimes I have three patients that need medical assistance at the same time. So, none of them want to wait… I have difficulties explaining the facts that I have other patients which are also in medical need."*
28 (Senior Nurse)	*"Ooh no, we don't have enough time. Sometimes we have too many patients, and we don't have any time. Sometimes we get complaints about the lack of time for not spending enough time on each patient... Yes, sometimes I don't have time to explain the process and it is difficult for them to understand."*

Medical Paternalism: Participants 1, 2, 4, 6, 7, 17, 20, and 28 believe that medical paternalism is applied under the KRI healthcare system, where doctors are given discretion during medical decision making. For instance, participant 1 is suggesting the domination of doctors, as he stated: *"Yes in Kurdistan, challenging environment, the focus is on doctors and they are the main decision maker, the priority is not informing the patient"* Furthermore, participant 4 suggest that due to patient's lack of public health education, medical paternalism is applied during the decision-making:

> *"People there are very poor, and they will do whatever you tell them. They can follow, they are like a sheep they can follow you. As a doctor whatever you put guide, they will do it. The culture has an impact, and everybody see doctors like eeeh… that and give them all the power to act in the way they want."*

Additionally, according to participants 6 and 7 due to the lack of education and understanding patients are not paying attention to the information under the consent form and are usually giving the doctors the discretion to make the decision for them as they are not confident enough to exercise their right of self-determination. As evidence, participant 6 stated:

> *"Yes, we have consent form before the operation we are explaining everything for the patient, the risk and the process of the surgery…but the patient in the middle in our talking say doctor you are the doctor do what you want."*

Participants 17 and 28 provide that there are chances of refusal to consent following the revelation of medical information to the patients. For instance, participant 17 argued: *"the more information you give about the medical condition, the more problem you face."* Moreover, participant 28 stated:

> *"we disclose the risks, then after hearing the risks they decide to refuse the treatment…In cases where the patient refuses the treatment, I try to explain the process and convince them to undergo the treatment as it would be in their best interests."*

As such, it can be argued that the empirical findings suggest the existence of paternalistic approach under the KRI healthcare system as participants 6, 7, 17, and 28 suggest that doctors have the discretion to determine proposed medical treatment without specific reference to patient's wishes.

Patient Follow-ups and Family Medicine: Patient follow-up is the foundation of preventative healthcare whereby regular health checks leads to early diagnosis and prevention of chronic illnesses. Nevertheless, the empirical findings (including participants 3, 4, 7, 8, 14, 15, 17, 23, and 29) patient follow-ups does not exist under KRI healthcare system. As evidence, participant 4 stated:

> *"In Kurdistan, you only see the patient when they have problem. They don't come on regular basis for checking...we cannot detect the problem earlier in the first stages. We don't see patients on continues basis."*

Participant 23 exclaimed:

> *"When patients are discharged from the hospital, the contact will be broken, and we don't have a system that would keep the patient in contact. It is better to have this."*

The empirical findings further suggest various reasons for the lack of patient follow-ups including the absence of family medicine, health information system, and the existence of dual practice under the KRI healthcare system. According to participants 3 and 4, the rationale behind the lack of patient follow-ups is the absence of family medicine, which prevents close collaborative relationship between doctors and patients; comprehensive healthcare service; regular health checks; and the appropriate referrals to specialists. Participants 7, 17, 29 provide that the lack of health information system including electronic medical records contributes to the failure of patient follow-ups. As evidence, participant 29 stated:

> "*when patients are admitted, the medical information is not saved in a database. When the patient leaves, we don't see him or her again… after the discharge of the patient, the information of the patient will not be saved …*"

Additionally, participants 8 and 15 claim that healthcare professional's abilities to practice under both public and private health sector prevents patient follow-ups under the public sector. As considered above, issues relating to doctor's absence within the public hospitals is flagged up by the participants, meaning that doctors are not present to ensure after-care treatment and meet patients on regular basis. For instance, participant 15 stated:

> *"Unfortunately, as I told you we have problems with follow up of the patients. Because today I am in emergency hospital for example, tomorrow I am not in this department and will not be able to see the outcome of the operation I had performed...I may know by telephone or social media, but it is not like as you see the patient by yourself or seeing the patient after the patient is discharged."*

Although, participant 8 suggest that patients are receiving follow-up care by visiting doctors in their private clinic, which causes confusions for patients as not every individual doctor run a private clinic:

> *"in the town centre patient are admitted by one consultant, if they want to see their consultant again, they have to go to their private clinic in the afternoon. eeh the problem is you don't know which day which doctor have that clinic."*

Protection of Patient's Confidential Information: On the one hand, according to participants 17 and 30, patient's confidential information is recorded in files and kept at the hospitals: *"due to confidentiality we do not allow patients to take files out of the hospital. We only allow this in exceptional circumstances such as MRI. Some information is not suitable for patients to know, so it is also in their best interest."* Additionally, participant 30 (member of Forensic institute) stated: *"Because the report includes confidential information...We have the duty to protect confidential information...Sometimes our reports lead to serious family problems and the findings are not always welcome. This has the effect of causing further problems to us personally and maybe we are being threatened not to disclose the findings...Therefore, we deserve to have a better system, under which all of the functions are kept confidential. We should not be in direct contact with the public... So, you should be contacted directly through another authority."*

On the other hand, according to participants 3, 9 18, and 25, insufficient time and lack of facilities such as consultation rooms and data information system are preventing the protection of patient's confidential information. As evidence, participant 18 stated: *"In reality we do not have sufficient time, as our hospital have a major load at the moment…Sometimes we have about five patients admitted in one time…we don't have private room for them."* Participant 25 argue that the lack of examination rooms prevents confidence of patients in disclosing relevant information:

> *"I don't think there is any comfortabilities for the patient…we told them [hospital directors] that we need ... examination room eeeh even for the privacy of the patient, they told us that eeh he cannot manage that and make the situation."*

Additionally, participants 4, 6, and 16 suggest that interference by families is preventing the protection of patient's confidential information as participant 4 stated*: "there is always 5 or 6 people surrounding the patient."* Moreover, participant 6 argued: *"Believe me sometimes when we explain for a patient, next day the brother comes, and we should explain again and after another day another relative comes and we should explain it again."*

6.3.3 Limited Rights to Request Redress

Participants 2, 6, 10, 12, 16, and 23 claim that very often patients or families are complaining as they are not satisfied about many aspects under the KRI healthcare system including lack of communication due to high workload; low quality of health services due to lack of medical equipment; or unequal treatment due to political interference.

The Complaint Procedure: The empirical findings suggest that a number of steps are taken under the KRI healthcare complaint system. For instance, participant 27 provides that patients are made aware about the complaint process. According to participant 10, the complaints are firstly reported to either the receptionist or the management team of the healthcare provider. Participant 6 stated that under the second step *"if medical staff is not good, then manager calls the staff and they will have the meeting to solve the issue."* Subsequently, under the third step, according to participants 10 and 19, the patient and their family and the relevant practitioners are invited for a meeting. According to participant 10 the hospital management are *"Making the nurse / doctor to understand each other and to make an apology as soon as possible before more complain arise. And apology is usually accepted."* Although participant 20 argued: *"Unfortunately, under our society we don't have such a mentality where we find it easy to forgive or apologies."* Additionally, according to participants 19, 23, 30 and 31, in cases of death the police and the forensic institute will get involved in the complaint process and, potentially, the case is referred to the KRI DoH (Department of Health). According to participant 31 (a policy maker) such cases are referred to the KRI DoH, as he stated:

> *"we will have two another surgeon in the committee, we will appoint the experienced surgeons, this committee will also include a lawyer. This committee will have a meeting and make a decision... most of the cases are being settled before reaching the court."*

Notwithstanding, according to participants 3, 4, 5, 6, 9, and 30, the KRI healthcare system is subject to criticism for lacking effective complaint system; failing to take actions in cases of error; and avoiding accountability for those who are supported by political parties. As such, the rhetoric the above participants used about the existence of accountability under the KRI health system seem to be insincere.

As evidence, participant 3 attested: *"complaints do not have an effect because nobody will do anything. Some patients do not even know whether they have the right to complain. The process is not clear."* Moreover, participant 30 stated "Those cases that are taken against doctors are very uncommon." Contrary to participants 3 and 30, participant 31 (policy maker) stated:

> *"very often the patient complaints but it does not mean that the doctor was at fault and that we should take actions against the doctor. sometimes the patient doesn't understand. Out of ten committee meeting six meetings decides to close the case. Only four cases may include actions against the doctor..."*

As an alternative to the complaint system (according to participants 3, 6, 9, 16, 18, 27, 28 and 29) patients are using the medical, verbal and physical violence against the healthcare practitioners. As evidence, participant 3 stated: *"Sometimes, instead of complaint doctors are being physically attacked by patients and there are no involvements on the part of the directorate."* Further, participants 8, 10, 30 and 31 assert that KRI patients have no rights to request redress under the complaint system, unless they take a legal action and win the case in the courts. According to participant 31, the predominant reason for preventing patient's rights to request redress is due to the existence of free National Health Service:

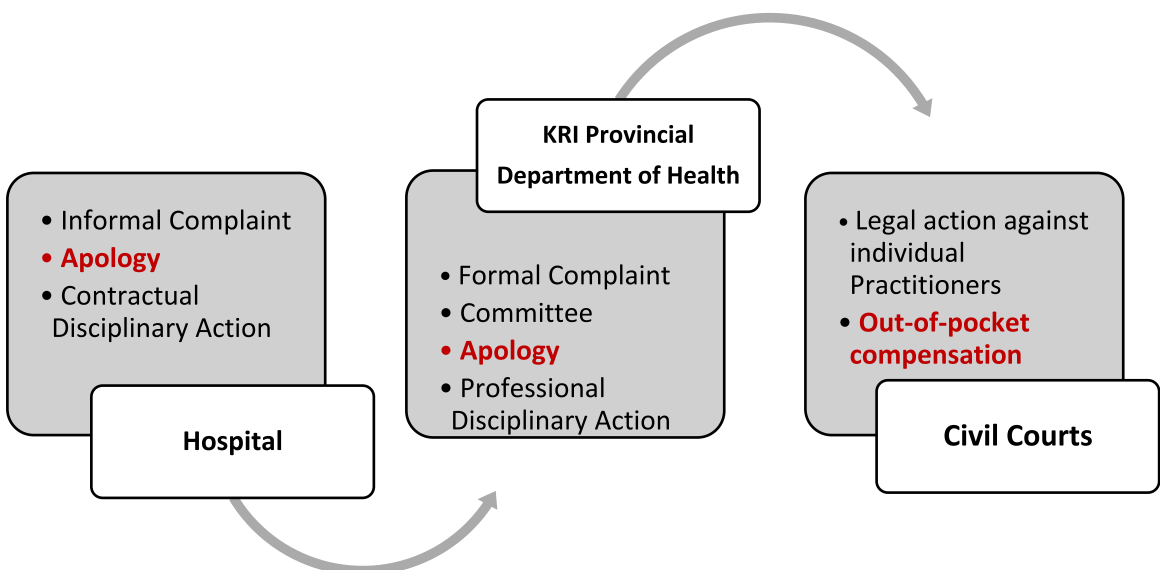
> *"because our hospitals are not private, and patients are not providing consideration in return for the services provided. We don't have the budged to pay for example 10.000 dollar to a patient. We don't have this. If the court decides, and enforces the doctor to pay compensation..."*

Legal Actions and Compensation: According to participants 3, 8, 12, 16, 23, 25, 27, 29, 30 and 31, legal actions are taken in the courts to obtain compensation. Although, participant 8 stated that it takes too much time for a case to go to the court..." Participant 23 stated that under successful claims, doctors have to pay compensation out of their own pocket, although no insurance exists to cover the costs. As indicated before, doctors are not being paid sufficiently and therefore, cannot cover the costs of compensation. Moreover, according to participants 12 and 31 although actions are taken against doctors, it is not taken publicly in order not to lose public confidence. As evidence, participant 12 argued: "*in the public eye we may still protect you as healthcare practitioners, internally, we do not accept any failure that will lead to a point where the media is involved."* Participant 31 also stated:

> *"We have referred doctors to the courts, we have had a doctor that was charged for 18 months. We do take actions, but we do not report it to the media...This is because we don't want to criticize our services. We don't want to make the people aware of what actions we are taking. This is why the public is complaining very often, the complaint about us that we do not take actions against our healthcare practitioners. I don't want to come out and tell the public that I have taken this action against my doctor."*

Figure 29 illustrates the avenues for KRI patients to request redress in cases concerning medical malpractice, which indicates that no compensation is available under the complaint process. Although, compensations can be granted within the courts following successful claims against individual practitioners, no insurance system is in place to guarantee the payment of compensation to victims within a reasonable time.

Figure 29: KRI Liability Framework



6.3.4 Synthesis and Discussions on Patient-centred Care

The empirical data of the thesis suggests that system failures are preventing patient-centred care whereby patients are not involved and informed in their care. As defined by the Institute of Medicine, patient-centred care is about *"Providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions."*[471] Nevertheless, the empirical findings suggests that system failures such as workforce; the absence of follow-up system and family medicine are the pre-eminent obstacles for obtaining informed consent.

As identified under chapter 2.4 of the thesis, the benchmarks of best practice for patient-centred care has eight dimensions including respect, coordination, information, physical comfort, emotional support, continuity and access of healthcare.[472] Unsurprisingly, the empirical findings of the thesis suggest that the above dimensions are not effectively applied under the KRI healthcare system. Due to societal culture (doctor's uncooperative attitude) and due to existence of medical paternalism, the dimensions of respect, coordination, physical comfort and emotional support are not guaranteed within doctor-

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[471] Institute of Medicine, "Crossing the Quality Chasm: A New Health System for the 21st Century" (2001) <http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf> 18 July 18

[472] Picker Institute, *Principles of patient-centred care* (1987) http://pickerinstitute.org/about/picker-principles/ 18 July 2018

patient relationship. This clearly indicates that the normative theory of culture outweighs the normative force of healthcare practice, as social and cultural norms influence healthcare professionals.[473]

It can be argued that the lack of public health education prevents patient's understanding about the disclosed medical information and the process of healthcare. The systematic failures such as high workload, no follow-up system and the lack of health information system can have the impact of preventing patients from accessing effective healthcare. The benchmarks of best practice for patient follow-up system includes the process of scheduling appointments to monitor patient's condition following medical intervention.[474] Nevertheless, the KRI system relating to patient follow-ups does not reach the benchmarks of best practice, as the findings suggest that no systematic plans are in place to ensure continuous treatment; medical service after discharge; and future referrals to relevant specialists for the purposes of early diagnosis and prevention of chronic illnesses.

6.4 Emerging Theme: KRI Risk Management Measures

Impact of Economic Crisis on Health Service Improvements: According to participants 1, 5, 10, 23, 24, 25 the economic crisis has prevented the continuation of a number of projects including the introduction of national electronic medical record; reporting system; medical research; clinical guidelines; advanced medical equipment; training opportunities; and research seminars. For instance, participant 10 provided an example of the impact of economic crisis on the implementation of clinical guidelines:

> *"My third plan was to write a mini protocol, what a nurse should do, how to receive a patient by paramedic, what the pharmacist needs to do and how we set for investigation and how it should be processed. But there are obstacles as I said from the beginning, obstacles ... and major obstacle is our economic situation of course. Eeehh the quality will be decreased, and the progress will be decreased."*

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[473] Gertrude Jaeger and Philip Selznick, *A Normative Theory of Culture* (1964) American Sociological Review, p653; Richard J Holden, *Social and personal normative influences on healthcare professionals to use information technology: Towards a more robust social ergonomics* (2012) Theoretical Issues in Ergonomics Science, p546

[474] AHRQ, *Health Literacy Universal Precautions Toolkit: Follow Up with Patients* (2015) 2nd ed. <https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2-tool6.html> 19 July 18

Participant 23 suggests that strikes by healthcare practitioners and closure of hospitals prevents the implementation of reporting system:

> *"I had plans to impose a duty on head of department to make a note of the failure and have a checklist of things that have gone wrong. I have plans to advise them not to include or identify any healthcare practitioner. I had plans to check this diary every month, if for example there are six crosses under dressing [cleaning the wounds] then I would think that I need to provide workshop. But actually, this plan did not go ahead due to the current situation."*

According to participant 31 (a policy maker), the implementation of electronic health record is costly, and the economic crisis prevents the implementation of such system:

> **"***it depends on our budget. It costs some hospitals about 30 million dollars. Yes, I am prepared to do it [Electronic Health Record]. We need to start step by steps. We have started with some hospitals now. Maybe even under this economic crisis we may be able to do this, but it takes time."*

6.4.1 Growing use of Health Information System

Unequal standards: Although participants 3, 13, 14, 17, 19, 23, 29, 30, and 31 are suggesting the existence of paper-based medical record, a national Electronic Healthcare Recording system does not exist across the KRI healthcare providers. As evidence, participant 31 (a policy maker) stated:

> *"in the emergency department we have electronic record system. We have this system in In3ash, thalassemia centre, [----] hospital ... But we have not implemented this computed system to all departments of all our hospitals. And we have not combined all of the data systems from different hospitals."*

Plastic Medical ID Card: according to participants 13 and 19, in order to become aware of patient's medical history and as a risk management measure, patients are provided with a plastic medical ID card which is for the purpose of alerting healthcare practitioners about the long-term medical condition of uneducated and unconscious patient. Nevertheless, participants 3, 17, and 29 are of the opinion that practitioners are not always able to uncover patient's medical history, as patients are not always wearing medical ID card. As evidence, participant 3 argued: *"some patients are not educated and*

cannot remember which medicine they are using at home and this can cause allergic reactions." Furthermore, participant 29 argued:

> *"Sometimes we ask the patient what medication he or she is taking the answer is too many medications, but we are not told which medications. So, at that moment we don't know whether the medication provided in the hospital was already taken in the morning. We don't know, and this is a major problem."*

In addition to the above, participant 29 is suggesting that the lack of health information system is the main reason for the failure to have a follow-up system in KRI as it is almost impossible to keep track of patient's medical history under the paper-based medical records:

> *"the medical information is not saved in a database ... When the patient leaves, we don't see him or her again…after the discharge of the patient, the information of the patient will not be saved. The patient takes the test results ... we will only have a hand-written file, but this goes directly to Baghdad and it will be burned after a few years."*

Participant 17 is also argued that the combination of dual healthcare practice (due to the unavailability of doctors under public health sector) and the absence of electronic health records increase the risk of harm to patients. As he argued: "*But our doctors are not here every day, then you will see that first doctors prescribe something and after the second admission the second doctor is prescribing something else."*

6.4.2 Insufficient Education, Training, and Research

Medical Degree: Education is the root for a high quality of healthcare as an effective medical educational system leads to valuable knowledge and skills. In KRI, a total of seven universities are established across different provinces, which consists of four years including the final two years practice in hospitals.[475] The empirical findings (including participants 9, 14, 15, 17, 19, 20 and 30) suggest that although medical students are given the opportunities to gain practical experience for two years, they are not competent enough to be put in charge of patients in critical conditions without appropriate

[475] KRG Cabinet, *Universities in the Kurdistan Region*, 2018 <http://cabinet.gov.krd/a/d.aspx?s=010000&l=12&a=18691> 20 July 18

supervisions. Additionally, participants 2, 3, 6, 9, 14, 15, 25, 26, and 29 suggest that the educational curriculum of college of medicine is subject to criticism for failing to provide knowledge about medical subspecialty. For instance, participant 14 indicates that operations are performed despite the lack of knowledge about the medical sub-specialty:

> *"Actually, under our responsibilities we have serious cases, we cannot decide on all... what we are performing, although there is no eeh research eeh there is no detail eeeh it is just a matter of opinion..."*

Participant 9 admitted that due to the lack of knowledge about the medical sub-specialty there is no guarantee of improving patient's condition:

> *"Sometimes I may be able to improve the condition but may not be able to totally treat the patient. This is because I am not an expertise in every type of heart condition...under the Kurdish system we have only doctors specialized in heart conditions generally and no more specific...in Kurdistan and all the responsibilities are on one individual doctor."*

As a result, participant 15 admitted that due to doctor's lack of knowledge in medical specialty, patients are seeking cross-border healthcare:

> *"We have so many patients having brain tumour, or other brain abnormality. But we don't know actually which cases are spine and which cases are neuron surgery. That is the problem...sometimes we refer the patient to other countries such as Turkey or India...* ***Do you mean that doctors in your department are not able to perform some types of operations?*** *They are able to do some operation but not all types of operation unfortunately. But it is not their fault."*

Nevertheless, for those patients who cannot afford cross-border healthcare, they are deciding to take the risk and undergo surgery under KRI public health sector:

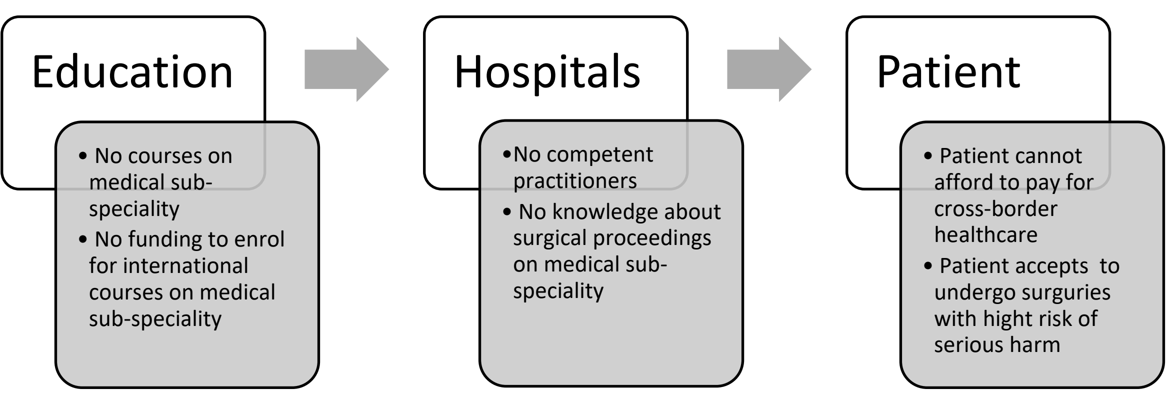
> *"I have seen doctors performing operations on conditions that they have not seen before, but I have seen the results of such experimental operations that was a total disaster to be honest...Training on patients."*

Due to the lack of knowledge about medical sub-specialty, doctors are losing confidence. For instance, participant 2 argued: *"It is impossible with the amount of information we have now for a doctor to know everything. You may have a nurse or a doctor who feels that they should know everything, but it is impossible, and it is wrong approach."* Participant 9 confirmed that the lack of knowledge increase risks of harm to patients substantially:

> *"as a general practitioner on heart condition you are required to treat every type of heart condition. This will put doctors in difficult situation because it is impossible for a doctor to treat every type of heart condition and therefore, as this is a serious condition sometime doctors have to go through difficult situation and eeeh can make medical errors."*

Although, participants 2, 6, 14, 25, 29, are members of Kurdistan Board of Medical Specialty, according to participant 29, the medical board does not focus on medical sub-specialty. Figure 30 illustrates the impact of lack of knowledge relating to medical sub-specialties on the risk of harm to patients:

Figure 30: Repercussion of Incompetency



Undergraduate Nursing Courses: Although, participant 26 (university lecturer) suggests that undergraduate courses enable nurses to gain practical experiences and knowledge about medical specialty, she does not suggest knowledge about medical sub-specialty as she does not indicate the type of medical surgeries. She stated:

> *"Our courses have been designed and it is in three parts, it includes theory, lab and practical experience. It is four years. During the first year they attend the lab*

> *and during the second year they are doing work experience in the hospitals. Those that are specialized in medical surgical will do work experience in medical surgeries. During the third year we have two courses maternity and paediatric. During the final year, we have another two courses eeeh mental health, and community health."*

This point is further confirmed by participants 2, 6, 20, 24, 25, and 26 as they are of the opinion that nursing degree does not educate nurses about medical sub-specialty. As evidence, participant 26 stated: *"our university degrees are general...They do rotation for two years. During the rotation the department they work for will be their specialty. But in reality, nurses are made work in different departments."* As a result, participant 25 (general practitioner) claims that due to the lack of experience relating to medical sub-specialty doctors are doing the job of nurses, which imposes additional workload on doctors which has a negative impact on the quality of healthcare. As evidence, she stated: *"we have just general nurses I think eeeh they should prepare everything for the doctor I think, but even we are doing everything for the patient, they are making our work harder..."* Moreover, participants 9, 20, and 26 stated that even though graduate nurses are better experienced when compared with college nurses, the number of KRI graduate nurses (particularly in rural areas) is substantially low.

Nursing College: Participants 9, 13, 15, 20 suggest that college nurses are not educated as they are not taught effectively under the KRI education system. Participant 9 explained:

> *"Nursing college is two years, During the first year they only attended the college for 3/4 months, because they get the results of secondary school in December and start with college in January and they finish the first year in April. This means that during the first year they only study for 3 months... During the second year they start from November and in January they will start with the preparation for party and graduations. This means that in total they not study for more than 6 months... You can ask themselves they will tell you that the time is not sufficient enough…We had no system and no structure to follow. This issue starts from the education system. Nurses cannot reach as good standard under the education system eeeh ... are not competent enough to practice in hospitals…"*

This point is further confirmed by participant 20:

> *"Last year we did teach the whole year, but when we calculated the total teaching period for nursing college is only 9 months. After this short period a student will be named nurse and they are looking after patients in critical conditions...We have a major gap between theoretical experience and practical experience."*

Medical Research: The empirical finding (including participants 14, 20, 23, 26, and 27) suggest that research (by medical students, training centre, forensic institute; and international health organizations) is conducted for the purpose of improving the KRI healthcare system. As evidence, participant 20 stated: *"I have many surveys that was conducted with the nurses about the relationship between management team with nurses, nurses with doctors and nurses with patients."* Moreover, participant 23 conducted surveys to identify patient satisfaction under the KRI healthcare system:

> *"In my public hospital, we have conducted two surveys in order to know whether patients were satisfied with the treatment of the doctors. In 2014/15 fortunately about 95% of the patients were fully satisfied. But then the second survey that was conducted in 2015/16 due to the economic issues in this country now the satisfaction rate came down to 85%. We were not happy with the result. But the points that was raised was mainly systematic issues rather than the scientific issues."*

It is submitted by participant 26 that under the educational curriculum, students are given the opportunity to conduct research studies, whereby the findings are published in the university magazine:

> *"Every student is given the opportunity during the final year in order to do a research project in a group supervised by one of the lecturers. This is one of the requirements for graduation. But in our country the projects conducted will not have an impact…We have university magazine for publication, this is published every three years."*

Contrary to the above findings, participants 14 and 26 stated that the KRI educational system does not include opportunities for medical students to conduct research in hospitals for the purpose of improving medical knowledge. Even though medical

students are given the opportunities to conduct research during the final year of medical school, the findings are not published online and are not accessible for the purpose of potential impact. Additionally, according to participant 20, over the last years, due to the political instabilities and economic crisis, the KRG has stopped funding international post-graduate students and lecturers, which has led to the closure of universities.

Barriers to Conduct Research: My findings (including participants 1, 19, 20, 22, 24, and 26) suggest that certain barriers, such as no allocated research funding due to economic crisis and the lack of advanced system of technology, are preventing medical research for the purpose of improving KRI healthcare system. Interestingly, according to participant 22, due to the focus on private clinics, healthcare practitioners are not committed to conducting research, as he banged on the table and explained whilst raising his voice: *"there is no research ... They are all busy making profit in their own private clinic."*

Conference Attendance: Participants 1, 3, 4, 7, 13, 14, 17, 20, 23, 26, 28, 29, 31 are confirming that KRI healthcare practitioners are provided with the opportunities to attend national and international conferences, research seminars, and workshops. For example, participant 3 stated *"we have conference about new drug for diabetes."* Furthermore, participant 13 argued: *"in October 2015 we attended a conference that lasted for three days, we had speakers from European countries, and we were given the opportunity to talk about our experiences."* Moreover, participant 20 confirmed that she was involved in the process of organizing national conference: *"We organized with international nursing association a workshop in Erbil it was about leadership and job description."* According to participant 23, healthcare practitioners are invited to attend conferences by private companies:

> *"recently we had invited the company called Heartland, eeeh focused on suicide cases eeeh…focused on the pressure on the healthcare professionals. To what extent do professionals have work pressure."*
>
> However, some participants pointed to caveats in the ability to attend. Participant 1 suggested that practitioners are not afforded time off to do so : *"International conference on diabetic and the new findings have been informed to the doctors in our hospital. Seminars are given to doctors. However, due to my duties I have*

not been able to attend all of the seminars.". Participant 14 suggested that attendance was not government funded: *"Eeh in our department doctors go outside for workshop with their money. It is not eeh government that will pay for it."* Participant 20 also pointed to cost issues as well as political party interference: "*We also had plans to organize national conference, but we did not have sufficient budget and political parties were also as an obstacle in our way.* "Participant 4 pointed to political parties also being an obstacle to equality of access (specifically to international conferences): *"There are always priorities for someone else that is very close to political party and those close to the management services. That is how the system is working down there."*

KRI Health Professional Training Opportunities: Participants 7, 8, 17, 19, 20, 24, and 26 confirm the existence of training contracts under the educational system and suggest that healthcare practitioners are entitled to undertake training courses, which is funded by the KRG. As evidence, participant 24 argued: "*under this healthcare system we have about 12000 healthcare practitioners. I can say that since 2004 we have had about 9000 healthcare practitioners in this training centre."* Moreover, participants 20, 24 and 26 confirm the existence of training centres under the KRI healthcare system and the image below provides an example of KRI training centres for nurses in the province of Sulaymaniyah:

Figure 31: KRI Training Centre

Further, participant 20 explained the aim of the nursing training centre in the province of Sulaymaniyah:

> *"this centre has been established in order to refresh the knowledge of our nurses and other healthcare practitioners. This is in order to provide more information on how to provide sufficient care to our patients."*

For instance, participant 24 (assistant director of training centre) explained the facilities the training centre he was directing:

> *"in our centre we have different rooms, including computer rooms (about 30 computers) and English language classes. The scientific subjects that were discussed during the training course were, atomy, sociology, human body, paediatric, mental health, laboratory and many other subjects."*

The process of designing in their centre, was explained by participant 26, who stated that:

> *"we were setting up the project we used to identify the participants at the same time. For example, if the course was for those nurses working with premature nurses, no other nurses outside this area could participate in this training. We used focus on different specialties… Another example was the training course for those nurses working in maternity department on breast feeding, so only nurses within this area was allowed to participate."*

To ensure the participation of practitioners, participant 24 confirmed the communication of the courses with the hospital directors and also argued that the majority of healthcare practitioners under the KRI healthcare system have undertaken training courses.

Training by International Bodies/Organizations: According to participants 24 and 26, specialised trainers from abroad (such as Iran, Jordan) are invited to provide training to existing healthcare practitioners. As evidence, participant 26 argued:

> *"Sometimes, not always we used to have international professionals from Europe. At the same time, we also had national medical trainees. So, it depended on our needs. We also have trainees from the universities. We used to call them facilitators and we used to set up the training programs for them, we also used to pay the participants."*

Additionally, participants 24 and 26 stated that international health organisations such as the Red Cross, UNICEFF and the WHO are also present to provide training and ensure KRI healthcare practice at international level by making them aware of new knowledge. As evidence, participant 26 exclaimed:

> *"We benefitted from the WHO in two ways, first the financial side, second the training side. We were assisted with immunizations, we were also made aware of new knowledge and new developments in the area of medicine."*

International Training Opportunities: Participants 4, 6, 9, 15, 20, 22, 27 and 28 confirm that KRI healthcare practitioners are entitled to undertaking international training courses in other countries such as Iran, Germany, Egypt, Jordan, Turkey, UK, South Africa, and Korea. However, participant 28 opined that the process of selecting and funding healthcare practitioners is based on personal bias:

> *"two years ago, where two doctors went to Jordan for medical training. But not everyone will get this chance and those that attended the conference was nominated by the hospital director. It was in accordance to their preferences."*

Additionally, participant 15 claim that some practitioners are going abroad for training at their own expenses:

> *"From then up to now there is a good progress actually in doctor's skills. But they are doing at their own expenses and costs. We have doctors going on training course in India we have doctors going to UK, to Egypt. Anywhere and any place if they can find a place for themselves, they will go for months and years. Even without diploma they are just going to see to find out how they can get more experience. This is all personal ability. But actually, this should be systematic."*

Challenges and Limitations: Participants 2, 5, 10, 14, 15, 19, 20, 28 suggest that the existing KRI training programs are subject to criticisms. For instance, according to participant 20 (a training manager) no authority is in place to oblige practitioners to participate in or provide training courses. He argued: "*Eeh under this healthcare system I am not under the control of any authority that would oblige me to provide training. This is our own initiatives ... we don't provide sufficient training."*

Additionally, participants 5, 9, 19, 20, 24 indicate that the current economic crisis has a negative impact on the provision of training and the availability of equipment relevant to training programs. For instance, participant 5 argued: *"Lack of money have a negative impact on the system. Money is needed to provide better equipment and to train the staff for better performance."* participant 24 stated: *"But this year our plans are very limited due to this critical situation. Now nurses are not being paid and they are not prepared to attend our training course five days a week without payment."* Due to the economic crisis, participant 9 suggest that *"doctors are prevented from improving their knowledge by going abroad and have training."* As a result, participant 20 indicated that as a training manager she has sought external funding from health organisations for the purpose of the provision of training.

No Leadership Cooperation: according to participants 20, 24, the additional criticism relates to the failure of hospital directors to collaborate with training managers whereby not all practitioners are being referred for training. As evidence, participant 20 is suggesting the dominance of hospital directors:

> *"But sometimes we have had course and asked the hospitals to refer the healthcare practitioners ... but very often the hospital director does not refer the healthcare practitioner I am looking for, sometimes they refer someone that is not very active or someone that is close to them either politically or personally such as a family member. There is not a specific criterion that would oblige… I can ask or recommend the hospital director ... but I cannot order or oblige within this process. The hospital director is free to decide whether to refer or not to refer the healthcare practitioners."*

Further, participant 20 continued as she provided an example:

> *"For example, if you are very active in the theatre room, the director does not want to refer you for training because during the training time you are needed, and your place will become empty... So, over the last four years in this training centre, I have not been able to train all the nurses that are active in the hospitals…Believe me sometimes I have participant that have fallen asleep*

> *during the seminar. This was mainly because of the age as he should have been actually a pensioner and not referring for training."*

As a result of hospital director's decisions relating to referrals for training, participant 28 argued: *"since 2005 and before this I have been working outside the city since 2002. Since then I have only attended one training course."* Due to the criticism relating to the training system, participants 9 and 10 are of the opinion that it has a negative impact on the quality of healthcare including patient safety, as participant 10 argued:

> *"the quality to me let us say is poor.* ***Yes,*** *if you compare it to international emergency medical hospital. The reason for this maybe the resources, the training of the doctors who work here, the availability of staff..."*

Additionally, participant 9 stated:

> *"Without any training and having not previous practical experience and treating patients in emergency department is serious. In emergency department, time is limited, and patients are in life-threatening conditions. In order to treat the patient successful as a medical doctor you need sufficient experience."*

6.4.3 Barriers to Implementing Medical Knowledge in Clinical Practice

Methods of Implementing Medical Knowledge: Following the successful completion of the training course, participants 19 and 24 suggest that a number of practitioners are appointed by training managers within the healthcare providers to ensure the successful application of new knowledge:

> *"in each department of the hospital we have experienced and trained practitioners that have had more than 9 months training. For example, in the antenatal department we have about 7 trained healthcare practitioners there... we don't have accountability under this system and therefore we don't have follow up. The final stage of a training course is following up but since we don't have follow up system, we don't have a complete training course and therefore we cannot say we are successful…"*

Participant 26 added:

"But we were making the managements and the head nurses aware of the new practice after the training and were asking them to make sure that the nurses following the new points under the course."

The empirical findings (including participants 1, 3, 8, 10, 12, 13, 17, 18, 23, 24, 25, 26, 28, 29, 31) suggest different methods of bringing new knowledge into the attention of medical practitioners. The methods include informal discussions between medical staff and management teams; post-call meetings, lectures, seminars, workshops by presentations of data show; providing guidelines; and notification through verbal warning, posters, magazines, and social media whereby a research group is created on Facebook. As evidence, participant 31 stated:

"all of the guidelines are made available from us to the hospitals. The guidelines are based on the program of work, new knowledge. If we get new information about certain medication, we put that into writing and refer it to the hospitals to make them aware of whether this medication should be used or should not be used."

More specifically, participant 8 added:

"In the morning, there is like seminars and workshops every day in some hospitals. They will discuss every case that was admitted to the hospital. They will discuss significant cases. From time to time there is workshops and seminars about new medications, but because of the crisis here no many eeh no may up to date medications are available in the hospitals."

Barriers to Implementing Medical Knowledge: although various methods are used to bring new knowledge into the attention of medical staff, the empirical findings do not suggest equal standards across KRI healthcare providers. Specifically, participants 3, 9, 14, 18, 19, 20, 22, 24 and 29 suggest that due to the lack of follow-up and due to the failure to assess doctor's practice, the implementation of new knowledge cannot be justified. As evidence, participant 20 argued:

"I put my findings and distributed amongst hospitals, but I was not taken seriously, and it is not having any impact. This finding was about nursing care…I

> *put all the fundamental nursing factor in points and identified them…We don't have system that would check whether the healthcare professional is following the instructions provided during the training. We don't have follow up…Even if training is provided, knowledge is not successfully implemented due to the lack of follow-up by the training providers."*

Further, participants 13, 19, 24 and 29 suggested that the lack of accountability has led to the domination of doctors within the healthcare providers and to the prevention of successful implementation of new knowledge. As evidence, participant 13 argued:

> *"No, there is no accountabilities, most of the doctors are following an outdated system. Doctors are doing what they want. Although doctors are made aware of some developments, there is not a follow up system that would make sure that doctors are following the new findings."*

Participant 29 is of the opinion that due to the lack of law, practitioners are not held accountable for failing to apply new knowledge:

> *"But there is no law to prevent you from using certain medications. So, it depends on the characteristics of the doctor. Even after the workshop you can decide not to follow the new knowledge."*

The issue relating to the lack of accountability is further explained by participant 24:

> *"we don't have accountability under this system and therefore we don't have follow up. The final stage of a training course is following up but since we don't have follow up system, we don't have a complete training course and therefore we cannot say we are successful."*

Due to the lack of regulatory authority to impose a duty and ensure the implementation of new knowledge, participants 4, 15 19, 20, and 29 claim that KRI practitioners are following outdated knowledge. As evidence, participant 15 argued:

> *"Well the system should first of all oblige to me to bring my knowledge into the attention of other medical staffs on my return and the staff should be obliged to come and listen to me. But this is the point there is no obligation under our system in this area."*

Participant 29 added that there is a tendency on the part of the practitioners to remain unchanged:

> *"for other doctors there is nothing that would impose a duty to be aware of new knowledge. No, we don't have it, no. We have doctors that are practicing in a way that they used to practice 20 years ago, and they are not up to date with new knowledge. They even think that they know better than anyone else."*

In addition to the above issues relating to inertia, participants 4, 6, 7, 9, and 20 suggest that although practitioners are allowed to register for training abroad, due to system failures, they are not equipped to apply new knowledge:

> *"We have been sent to Germany to have a course for implant…when we came back home, they did not let to practice our know knowledge… So, what was the point for us to go there? Its shit and it was a waste of time. Even because of the workshop someone else took over my place and I lost my job."*

Participant 20 (a training manager) is also from the opinion that special skills need special equipment which is not available:

> *"I cannot say we are very important, and our training course are 100%. No that is not the case… I don't believe that even our courses are sufficient enough to improve the quality of healthcare. It is not professional … I do not have all the equipment so to make it clear for the practitioners…For example, eeeh when I am training a nurse and explain that during the injection you need this and that … eeh then the nurse starts to complain that the equipment I am talking about is not available in the hospital."*

Most importantly, participant 9 suggested that no time is allocated to implement new knowledge: *"The Kurdish healthcare system is preventing the healthcare professionals from following new updates. It is difficult for healthcare professionals under a busy environment to find most recent book and they will only follow the outdated book that is reachable."* As such the chart below, lists the potential challenges to implementing emerging medical knowledge under the KRI healthcare system:

Figure 32: Challenges in Implementing new Knowledge

Benchmark of Best Practice

Enhancing Practitioner's Knowledge through
- Research
- Conference
- Training

KRI Healthcare System

Challenges to implementing new knowledge:
- Inertia
- Funding
- Allocation of Hours
- Relevant Recourses (Staff & Equipment)
- Relevant Authority to regulate the process
- Colaborative Leadership
- No Follow-ups / No Accountability

6.4.4 Synthesis and Discussions on Risk Management Measures

The introduction of health information system; the existence of effective medical education program; and the implementation of medical knowledge at the level of patient's care are regarded as the pathways to a safe healthcare environment for patients. The integration of health information system enhances the risk management measure of reporting system whereby the reported medical errors are recorded under the information system for the purposes of identifying, analysing, and preventing potential risks of harm. As indicated under chapter two, the benchmarks of best practice for reporting system consists of three steps. Firstly, the promotion of an open culture whereby practitioners are encouraged to report errors. Secondly, the introduction of health boards to investigate the reported failures. Finally, it involves the process of analysing the reported data in order to learn lessons from mistakes.

The finding of my empirical research suggest that improving the healthcare system by learning from mistakes is not a priority under the KRI healthcare system. Although paper-based medical records exist and in some hospital departments electronic healthcare records are in place, a national health information does not exist, and the empirical findings suggests that the information from the paper-based medical records are not utilised for the purpose of improving the healthcare system. Even though, participant 23 recognised the importance of risk management plan by making and reviewing notes

relating to the failures at the level of patient's care, it did not suggest the implementation of such plan.

It is submitted by *Thamer Kadum* that the above issues relating to health information system are common under the Iraqi healthcare system.[476] In 2010, *RAND Corporation* found that in the KRI health information system was not integrated at all levels of patient's care and that no evidence suggested that the recorded information were utilised to improve health policy making process.[477] Confirming the above findings by RAND Corporation, the present empirical study provides that the KRI information system is not standardised across KRI healthcare providers. Even though some department have started implementing *Electronic Health Record*, yet no evidence suggest that the recorded information are taken into account within the process of improving healthcare quality.

In addition to the issues relating to health information system, the empirical findings suggest that professionalisation of KRI healthcare practitioners is not a priority. As indicated above (chapter 2.5.2) the benchmarks of best practice for professionalisation consists of three pillars 1) the expectation of the public in healthcare professionals acting in patient's best interests. 2) Having the knowledge and skills to act in accordance to the expected standards. 3) Effective interpersonal skills within doctor-patient relationship.[478] With regards to the first pillar, the empirical findings of the thesis suggest that initiatives need to be taken to increase the role of medical professionalism in the KRI and to maintain public trust. Although there is an attempt of covering up negligent actions to maintain public trust, the public are nowadays becoming increasingly aware about health service failures, whereby a culture of cover-up in the KRI has led to further distrust. In terms of healthcare regulations, the empirical findings indicate that ineffective education and training; lack of follow-up system; and due to scarce resources, healthcare practitioners are not always acting in accordance to the standards expected and often healthcare practice is not in patient's best interests.

[476] Thamer Kadum Al Hilfi et al, Health Services in Iraq (2013) 944 https://www.ed.ac.uk/files/imports/fileManager/Lancet%20paper%20Thamer.pdf 18 July 2019.
[477] Melina Moore et al (n36) 121.
[478] American Board of Medical Speciality, *ABMS Definition of Medical Professionalism* (2012) https://www.abms.org/media/84742/abms-definition-of-medical-professionalism.pdf 12 July 2020

Further, my empirical findings suggest that a number of factors are contributing to medical professionalism failures. Examples of such factors are in-effective educational system; the failure to allocate research funding and research hours; the non-existence of relevant staff, resources, and regulatory authority to ensure follow-up and accountabilities. In 2010, a research was conducted on the satisfaction level of medical practitioners in the province of Erbil. The results of the study are listed below, which clearly indicates that the health practitioners in Erbil are not satisfied with health education activities and the role of research in health system.[479]

Variable	Scale [No. (%)]						
	Negative view			Positive view			
	Very weak	Weak	Total	Satisfactory	Good	Very good	Total
Health institution aspects							
Offered services	45 (21.7)	90 (43.5)	135 (65.2)	51 (24.6)	21 (10.1)	0 (0.0)	72 (34.8)
Availability of required quantity and quality of medicines	67 (32.2)	76 (36.5)	143 (68.8)	47 (22.6)	16 (7.7)	2 (1.0)	65 (31.3)
Medical equipment and investigation tools	61 (29.3)	82 (39.4)	143 (68.8)	47 (22.6)	17 (8.2)	1 (0.5)	65 (31.3)
Availability of sufficient number of nurse and other health care workers	25 (12.1)	49 (23.7)	74 (35.7)	67 (32.4)	50 (24.2)	16 (7.7)	133 (64.3)
Health system aspects							
Overall health system	50 (24.0)	100 (48.1)	150 (72.1)	47 (22.6)	11 (5.3)	0 (0.0)	58 (27.9)
Government fund allocation for health	38 (19.6)	92 (47.4)	130 (67.0)	43 (22.2)	20 (10.3)	1 (0.5)	64 (33.0)
Salary of medical professionals	25 (12.1)	64 (31.1)	89 (43.2)	66 (32.0)	48 (23.3)	3 (1.5)	117 (56.8)
Role of private sector compared with public sector	34 (17.2)	76(38.4)	110(55.6)	56 (28.3)	31 (15.7)	1 (0.5)	88 (44.4)
Health education activities	83 (40.5)	91 (44.4)	174 (84.9)	26 (12.7)	5 (2.4)	0 (0.0)	31 (15.1)
Role of professional associations in controlling health system and private practice	116 (57.4)	60 (29.7)	176 (87.1)	19 (9.4)	6 (3.0)	1 (0.5)	26 (12.9)
Role of medical research in health system	112 (54.4)	69 (33.5)	181 (87.9)	17 (8.3)	8 (3.9)	0 (0.0)	25 (12.1)

Although the empirical data revealed considerable amount of information relation to the training of medical practitioners, particularly nurses, no data revealed the focus on leadership training. Measuring the above findings against the benchmarks of best practice on risk management initiatives (chapter 2.3), it can be argued that the implementation of health technology is not consistent across the KRI healthcare providers. Due to the issues relating to effective laws and professional regulatory authorities, it can be averred that under the KRI healthcare system professionalising healthcare practitioners and health service leaders through education and training is not a priority.

[479] Nazar P Shabila et al (n32) 4.

6.5 Summary

This chapter provided detailed description and analysis of the KRI healthcare quality. Following the presentation and the discussion of the empirical finding of the thesis relating to the quality of healthcare in KRI, it can be argued that there is a major gap between the benchmarks of best practice and the KRI healthcare system. As categorised above, the main areas for improvements are patient safety, patient-centred care, health information system, and relevant knowledge of healthcare practitioners through education, training and research. Although the majority of the failures are identified under existing researches by academic and health organizations, the empirical study of the thesis provide a detailed overview of the failures and confirms the continuance of such failures under the current healthcare system. In response to the identified healthcare quality failures, chapter 7 of the thesis aims to recommend potential solutions for KRI healthcare governing authorities in order to improve the quality of health at the level of patient's care.

PART 3:
RECOMMENDATIONS FOR POTENTIAL SOLUTIONS

Chapter 7: Recommendations and Conclusion

7.1 Introduction

Chapter seven brings the thesis to a close by making recommendations for developing effective governance to foster healthcare quality in the KRI. It starts by discussing the roles of hard laws in advancing the KRI healthcare quality. It provides a brief overview of the process of developing health laws in the KRI health sectors. Subsequently, this chapter discusses the development of governance in the KRI through the development, implementation and enforcement of professional regulatory laws. To introduce the KRI to the modern ideas of healthcare systems governance operating around the world, this chapter recommends the setting up of a *Professional Medical regulatory Authority (PMRA)* in KRI. It will suggest what the core values and, key functions of the PMRA should be and how it might be implemented. The final part of this chapter summarises the research project and recommends future research.

7.2 Roles of Health Law in Advancing Healthcare Quality in the KRI

This part of chapter seven outlines the respective potential roles of hard laws and soft laws in advancing healthcare laws in the KRI. As indicated above (Chapter 4.2) laws are one of the essential tools for advancing healthcare quality in health sector. Effective laws can potentially lead to the clarification of healthcare standards, increased accountability; equalisation of resource distribution and better public health protection.

To guarantee effective health laws in the KRI, the existing Acts of Parliament need to be comprehensively reviewed. The existing Acts need to be developed in a way that would provide powers to professional regulatory authorities. Although such process can prove challenging and can lead to resistance by both leaders and practitioner, the imposition of a statutory duty can ensure successful enforcement of powers. The rationale behind such proposition is that breach of statutory duties can lead to legal challenges in the courts. Due to fears of liability, the level of compliance with accepted standards will likely to increase by health policy makers and professional regulatory authorities.

Developing KRI Hard Laws: The process of developing an Act of Parliament in the KRI involves a number of steps. Namely, the communication of recommendations to

health standing committee in the KRI Parliament. Such committee is part of *Kurdistan National Assembly*, which has the powers under the *Iraqi Federal Constitution* to debate, legislate, and amend Acts of KRI Parliament.[480] In cases of developing clauses under an existing Bill, prior to the incorporation of such clause in pertinent Act(s) of Parliament, the proposal has to be approved by the majority of KRI Parliament. Essentially, the consolidation of the KRI Acts of Parliament potentially outwit discrepancies in the legal order and ensures that the emerging laws have legal value. The initiative of developing and consolidating existing laws builds upon a transition report by the *World Bank Governance Global Practice* entitled as *'Strengthening Public Financial Management Oversight and Accountability Institutions in Iraq*.'[481] Predominantly, such initiative also responds to a recent *KRG Cabinet* agenda on comprehensively reviewing the regulatory framework and reforming governance.[482]

7.3 Developing Governance in KRI

Professional Medical Regulatory Authority (PMRA): Following the development of existing hard laws, the subsequent measure is to recommend an effective regulatory authority in the KRI. Even though the *Professional Medical Syndicate (PMS)* was established under the KRI healthcare system, the functions of such syndicate are subject to criticism. As discussed before (Chapter 5.2.3), the *KRI PMS* fails to provide effective guidelines; set standards of care; assess doctor's practice; avoid political parties' interferences; and regulate a system of licence revalidation for the KRI healthcare practitioners. The existence of the above criticism necessitates the reform (most preferably the abolition) of the *KRI MPS*. In response to the failures by the *KRI MPS*, the proposed *PMRA* can typically hold a number of functions, including the development of professional regulatory law, the clarification of healthcare standards, and the licensing of healthcare professionals.[483] As such, this part of the chapter starts by discussing the

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[480] Iraqi Federal Constitution Art.114; World Bank Governance Global Practice, *Comprehensive Review of Legislation: Transition Report* (2018) World Bank Governance 39.

[481] World Bank Governance Global Practice, *Comprehensive Review of Legislation: Transition Report* (2018) World Bank Governance 3.

[482] World Bank Governance Global Practice, *Strengthening Public Financial Management Oversight and Accountability Institutions in Iraq* (2019) 8

[483] Professional Standards Authority, *A closer look at each regulator* (2018) https://www.professionalstandards.org.uk/what-we-do/our-work-with-regulators/find-a-regulator 10 September 2018; Charles Foster, Institute of Medicine The Future of Nursing Report, lifelong learning, and certification (2012) Medsurg nursing, 115

functions of PMRA, including the process of introducing and implementing professional regulations, as well as the process of enforcing regulations through disciplinary actions.

7.3.1 Strategic Direction of Policy Development

Regulations are regarded as a significant tool for setting up and clarifying healthcare standards. The introduction of healthcare related legal rules is paramount as under the empirical study of this research, 53% of the practitioners (including participants 2,3,4,5,6,8,9,10,12,14,15,20,22,24,25,26, and 32) claim that there is an urgent need for effective guidelines and regulations. Based on the existing literature, the benchmarks of best practice for developing regulations involves the process of setting up standards of care, formulating policy agenda, and codifying rules.[484] Each stage is critically discussed below.

Stage 1: Setting up Standards of Care: To set up standards of professional and ethical conduct, this stage involves the process of adapting a pragmatic approach, whereby relevant social norms, principles and values are formalised.[485] The codification of the rules will have the effect of ensuring consistencies of healthcare practice across the KRI healthcare providers. Such measure would respond to the existing issues of lack of consistency of healthcare practice in the KRI. For instance, the empirical findings under the thesis indicates that the failure to consistently apply rules has precipitated issues for those practitioners who are working in different healthcare providers. Predominantly, the codification of healthcare practice does not only lead to consistent healthcare practice, it also clarifies the expected standards of care, justifies healthcare practitioner's decisions in critical cases, and can lead to cost-effective treatment. Whilst clarifying the expected standards of care can be in patient's best interests, supporting decision-making processes can be in the best interests of healthcare practitioners' and ensuring cost-effective treatment can be in the best interests of healthcare providers.

Stage 2: Formulating Policy Agenda: To avoid overregulation, the process of formulating policy agenda involves the critical examination of the proposed healthcare standards. The process of setting up healthcare standards and formulating policy agenda will not be straightforward, as this process requires well experienced policy makers to

[484] Tingle and Foster (n73) 27-29.
[485] Allyn L. Taylor, *Global governance, international health law and WHO: looking towards the future* (2002) Bull World Health Organ.

ascertain the aims and the objectives of the proposed regulations. It is anticipated that well experienced policy makers are knowledgeable about the essential characteristics of transparency and proportionality. Such characteristics are essential, as proportionate regulations are less excessive and transparent regulations are less complicated.

Stage 3: Codification of Proposed Rules: Following the stages of setting up standards and formulating policy agenda, the subsequent stage involves the codification of the proposed rules. As suggested by *Dickson*, policy makers can elaborate a number of approaches such as proceeding downward, whereby more specific rules are developed from general rules; or proceeding upward through the process of developing general rules from specific rules or instances.[486] To respond to the existing failures of the KRI healthcare providers, it is essential to take an upward approach through the process of identifying root causes of healthcare quality issues. Nevertheless, this can be regarded as a challenging process under the KRI healthcare system, as substantial number of researches need to be conducted under each medical specialty. Such initiatives of identifying root causes would respond to the failures identified in the empirical research I have conducted. As the need for research under the KRI healthcare system is recognised as a priority by 37.5% of the participants of the present empirical study (including participants 1, 2, 10, 12, 14, 15, 19, 20, 22, 24, 26, and 32).

Due to the lack of an effective system for research and innovation, participant 14 has taken personal initiative by creating a research group (known as *Medical Research in Kurdistan*) in the social media. The members of this research are communicating the emerging practices in the healthcare and discussing the application of such practices at the level of patient's care. Nevertheless, the work of such group does not suggest consistency in applying emerging practices and this measure has not yet been extended to the process of identifying root causes of medical errors. As such, it can be attested that conducting research under the KRI healthcare system and identifying root causes of medical errors can lead to effective professional regulatory laws.

[486] John Dickson, *Legal Rules: their application and elaborations* (1931) 1058 University of Pennsylvania Law Review and American Law Register.

7.3.2 Implementing Professional Regulatory Laws

As discussed before (Chapter 2.3.2), the implementation of regulations at the level of patent's care is the foundation of a strong and resilient healthcare system that can lead to a well-structured healthcare system. To avoid bureaucratic regulations, the PMRA will have three main functions under the process of implementing regulations in the KRI healthcare providers.

Communication of Emerging Rules: Under this process, the PMRA is expected to communicate the introduced legal rules to the healthcare practitioners in the form of guidance through training courses, workshop, seminars, social media, and conferences. At this stage, it is expected for the PMRA to build strong relationship and work closely with the existing training centres, senior practitioners, members of online research groups and conferences organisers. Although, medical journals are one of the main tools for communicating emerging knowledge, according to the empirical study and the existing literature, sharing new knowledge through medical journal is not common practice in the KRI.

The communication of emerging rules and the clarification of responsibilities have numerous positive impacts on the quality of healthcare.[487] First of all, the clarification of responsibilities enhances team performance.[488] Such initiative would also respond to the failures disclosed by the participants of the empirical study. As the findings indicates that the lack of job-description has caused disagreements between healthcare practitioners and nurses. The enhancements of doctors' knowledge through the clarification of responsibilities, can also prevent issues relating to the domination of doctors within the KRI healthcare providers. It can be argued that the clarification of nurses' responsibilities is not only improving doctor-nurses' relationships, but it can also improve the relationship between graduate and college nurses. Figure 33 illustrates the positive impact of successfully introducing and implementing professional regulatory laws.

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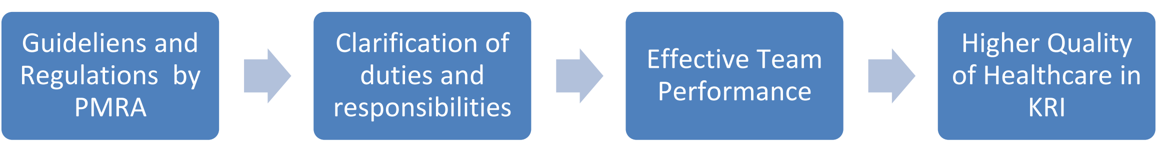
[487] Mathilde M.H. Starting, Anna P. Neiboer (n435) 276.
[488] Melina Moore et al (n36).

Figure 33: Impact of Regulations on Quality of Healthcare



Application of Emerging Rules: Following the communication of emerging rules, the subsequent step is to apply emerging rules during daily healthcare practice. Predominantly, transparency plays a crucial role under the process of applying emerging rules. As under this process professional regulators are expected to provide a discretion to health service leaders to implement the regulations in accordance to the local conditions of the individual hospitals.[489] Under such process, the PMRA has a duty to ensure the application of such rules through the provision of pertinent resources, including medical equipment and funding training courses. Although, due to the economic crisis in the KRI, it is a challenging process to secure funding for relevant training, equipment, and for the recruitment of relevant professionals.

The most cost-effective way is to provide training to senior practitioners whereby such knowledge is then passed onto healthcare practitioners through workshops and seminars. Such knowledge could also be passed on through practical guidance in the course of daily medical intervention. Essentially, training courses are not only designed to communicate knowledge to healthcare practitioners, but also to train members of PMRA. Such training is paramount as it can have the effect of enhancing leadership and can promote regulatory authorities' competences to implement aligned legal rules and strategic policies.

Ensuring Consistency: To ensure common standards and consistent practice, under this role, it is expected for PMRA to regulate the functions of healthcare practitioners across KRI healthcare providers. The empirical research I conducted suggests that introducing and implementing legal rules in one hospital will not improve healthcare practice. Often, doctors and nurses are working across a number of KRI hospitals and the inconsistent standards of care could prevent a good quality of healthcare. Due to the imposition of duty on (self-regulatory) PMRA to ensure consistency in implementing legal rules, it can

[489] Richard E Matland, *Synthesizing the Implementation Literature: The Ambiguity-Conflict Model of Policy Implementation* (1995) 148 Journal of Public Administration Research and Theory http://orion.luc.edu/~rmatlan/pdf/1995SynthesizingtheImplementationLiterature.pdf 4 July 2017.

be argued that horizontal implementation is mostly applicable within the KRI healthcare providers. In addition to horizontal implementation, vertical implementation is also applicable to the KRI healthcare system, which is similar to top-down approach whereby the superior authorities are accountable for ensuring an effective system.[490]

Moreover, an effective implementation process exists through the avoidance of political interferences and nepotism. Although political parties are in charge of KRI healthcare system,[491] under the process of enforcing legal rules, there is a need to ensure that the rules are applicable to all practitioners and healthcare organisations equally without differentiations. Predominantly, such practice of equal treatment is also in accordance to biomedical ethics, more specifically the theory of principlism initially introduced by *Beauchamp* and *Childress* (2001).[492]

7.3.3 Enforcing Professional Regulatory Laws

Assessing Healthcare Practice: Under this process, the role of the PMRA is to put the rules into effect by employing relevant bodies to oversee the functions of healthcare practitioners and to assess KRI professional's healthcare practice (Chapter 7.4). Further, the additional duties of the PMRA is to assess the effectiveness of codified rules and hold those practitioners accountable who are failing to take the codified rules into account.[493]

Holding to account: As indicated before (Chapter 2.2.3), one of the primary functions of professional authorities is to enforce regulations through the imposition of a duty on healthcare practitioners to take responsibilities for their actions. Such initiative can respond to the existing issues relating to the lack of accountability in the KRI. As the empirical findings of the thesis suggest that healthcare practitioners are not aware about healthcare-related legal rules (Chapter 4.3). The existence of accountability through professional disciplinary process in the KRI can have a deterrent effect on healthcare practitioners, whereby fears of accountabilities can lead to better practice of healthcare. The additional impact of enforcing rules in the KRI is the avoidance of political parties' interferences. Just as suggested by *Ala'din Alwan*, the enforcement of legal rules prevents

[490] Angela Yu (n74) 23.
[491] Ali Towfik-Shukur, Hiro Khoshnaw (n2) 3.
[492] Beauchamp T L, Childress J F. *Principles of Biomedical Ethics* (Oxford University Press, 5th edn 2001) 454.
[493] Morgan, Yeung, and Twinning (n72) 106.

domination of those practitioners and patients supported by political parties. As such it can be argued that the enforcement of legal rules not only increases chances of equal treatment, but also strengthens the management of health sector and ameliorates the problem of corruption.[494]

Responsive Governance: The enforcement of regulations and the application of emerging rules is in accordance to *Transformational Leadership Theory.* The KRI healthcare system can benefit from this type of leadership as effective enforcement of emerging rules can have a positive impact on work-life balance, staff well-being, and patient/staff satisfaction.[495] Additionally, the KRI healthcare system can also benefit from the *"Authentic Leadership Theory,"* as it emphasizes the importance of leadership through honest relationships; ethical and transparent behavior. Essentially, the application of honest relationship under this theory can also have the effect of preventing clientelist approach in the KRI. The latter has the effect of building greater level of trust and work engagement, which according to *Wong, Laschinger, and Cummings (2010)* ultimately leads to a higher quality of healthcare.[496]

Implications on KRI Quality of Healthcare: The PMRA's duties to introduce, implement, and enforce professional regulations has certainly a positive impact on improving the quality of healthcare. The first stage of introducing professional regulations involves the process of codifying existing norms, setting up policy agenda, drafting and finalising regulations. The codification of essential norms relating to patient centred care and health and social care can result into a consistent practice, which has the potential of increasing the chances of acting in patient's best interests (Appendix 5).
Under the second stage, the introduced regulations are communicated to healthcare providers (which is known as promulgation of regulation). This stage also involves the imposition of a duty to make those resources available that are essential to the successful implementation of the regulations. As seen, the third stage of developing governance, involves successful implementation through the assessment of healthcare practice; accountability; and follow-up system. The assessment of healthcare practice under the third stage of enforcing regulations can lead to the identification and the prevention of

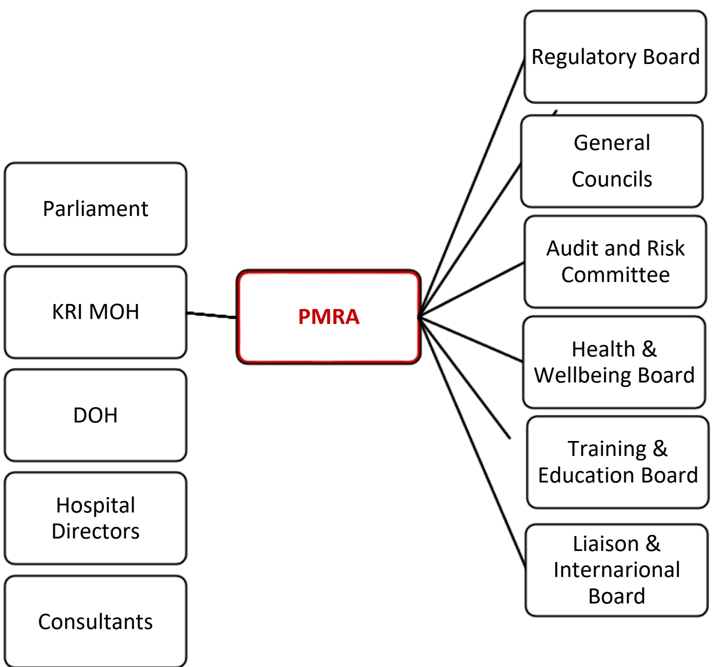
[494] Ala'din Alwan, *Health in Iraq: The current Situation* (2004) 50 WHO.
[495] Faculty of Medical Leadership and Management, *Leadership and Leadership Development in Health Care: The Evidence Base* (2015).
[496] Ibid 11.

potential risks. The additional example is that the existence of accountability, can lead to a process whereby leaders are taking responsibilities for their actions and therefore, increasing the number of competent leaders within the healthcare providers.

7.4 The Proposed PMRA Framework for KRI

Although, the overall structure of health professional regulatory authorities varies from one country to another, to develop governance and guarantee responsive governance, the proposed PMRA structure for the KRI is illustrated below:

Figure 34: PMRA Framework



As illustrated under chart 34, the PMRA will work best as an independent regulator with decision making powers at the ministerial level. The underlying reasons for such power is to avoid political parties interferences (clientelism). To address different aspects of health system governance, the purpose of the PMRA is to adopt a mix of regulatory instruments by a number of professional bodies. Such bodies include regulatory board; medical councils; audit and risk committee; health and wellbeing board; training and education board; liason and international board. The proposed roles and responsibilities of the professional bodies are discussed below.

7.4.1 Regulatory Board

Guaranteeing Responsive Governance by Taking Systematic Measures: In addition to the process of establishing and implementing regulations, one of the main functions of the regulatory board is to respond to the existing systematic failures. According to the empirical research I conducted, there is an urgent need to take a number of systematic measures to improve filtering system of emergency hospitals; dual healthcare practice; family medicine; and healthcare finance. In response to such failures, this part of chapter seven critically discusses the role of the PMRA in governing the hospital filtering system; the regulation of dual healthcare practice; the introduction of family medicine; the regulation of healthcare finance.

Governing Emergency Hospital's Filtering System: Whilst, under the benchmarks of best practice, patients are first expected to be seen by nurses, and consultants are supposed to respond to critical cases, my empirical findings indicate that as the result of ineffective filtering system (instead of nurses) doctors are the first body to see patients. The existence of free health services has led to a culture of overtreatment whereby patients are visiting local primary health services almost every day. The empirical finding suggested that the majority of the patients are not in medical need, which is regarded as a waste of limited medical resources.

Such an approach is also against the notion of safe practice as it imposes additional work pressure on the medical practitioners and can lead to acquirement of bacterial infections from the hospitals. In order to limit the number of unnecessary admissions within the KRI healthcare providers, the PMRA need to regulate the admission process by imposing restriction through guidelines and make the patients pay a small amount for medical intervention. An effective filtering system has a positive impact on the limited medical resources as it will prevent the admission of those patients who are not in crucial conditions, which also has a positive impact on patient safety as it prevents further illnesses due to the bacteria's that could be acquired from the healthcare providers.

Regulating Dual Healthcare Practice: Having previously discussed the negative impacts of the phenomenon of dual health practice (chapter 5), the potential solution is to strictly regulate both public and private sectors. Under this process, specialised doctors

are obliged to be present and to effectively supervise graduate and unexperienced medical students under the public health sector. Although, it is preferable to separate public and private sectors, due to the financial issues it is unfavourable for physicians to work under the public health sector only.

As a result, the regulation of private health sector by PMRA can lead to better engagement by physicians under the public health sector. Moreover, ensuring effective collaboration and partnerships under the coexistence of public and private sectors can have a positive impact on the quality of healthcare. This is mainly because the existence of private health sector enhances patient's access to healthcare. As such it can be attested that regulating healthcare practice and overseeing functions can prevent the domination of healthcare professionals. Due to underpayment within the public health sector, the alternative way is to charge patients with a reasonable amount under the public hospitals and increase doctor's monthly salary.

Introducing Family Medicine: My empirical findings suggest that due to the lack of family medicine under the KRI healthcare system, patients are not seen by local general practitioners.[497] The existence of family medicine advocates a follow-up system whereby patient's health condition is assessed on regular basis to ensure the detection of early stages of patient's medical condition. Although, KRI patients have access to primary care, my findings suggest lack of interpersonal connections between doctors and patients. Therefore, the promotion and regulation of family medicine by PMRA will have a positive impact on doctor-patient relationship through regular health checks and correct diagnosis of illnesses.

Taking a Patient-centred Approach: the role of the health and wellbeing board, under patient-centred approach, consists of the imposition of a legal duty on clinical leaders to operate in the best interests of patients rather than in the best interests of the institution. The additional role of the regulatory board is to establish guidelines and regulations relating to the consultation process between doctors and patients. Such duty needs to be imposed on the healthcare professionals to pay respectful attention to patients during the process of medical interventions. Respecting patient's decisions and acting in the best

[497] Nazar P Shabila et al (n32).

interests of patients is in accordance to the theory of principlism, more specifically autonomy and beneficence.[498]

Regulating Healthcare Finance: My empirical research findings found that the healthcare system of KRI is currently financially dependent on political parties, and the implication that the system is subject to interference by such political parties was also borne out by some specific participant comments. To avoid such interferences, it is paramount for KRI healthcare system to be financially independent. As such, the role of the regulatory board would consist of introducing and implementing relevant guidelines to oversee the functions of those authorities who are in charge of healthcare budget. More specifically, the regulatory board would also need to consider alternative funding methods such as privatisation of healthcare system through health insurance and the publication of guidelines on cost-effective treatment. This type of governance will mostly fit with directive governance identified by *Leeuw* (discussed under chapter 2.2.1) which is concerned with the distribution of essential sources.[499]

Specialist/Consultant Clinic: The additional method of funding healthcare would be to regulate a system of specialist / consultant clinic under the KRI public health sector. Under this process, the role of the regulatory board would be to reiterate the need to increase the number of consultant in the public health sector; set up reasonable price for the general public to afford; standardise such prices through effective guidelines; and utilise the income to improve the quality of KRI healthcare. Although, there is a need to research and explore the impact of this measure on the quality of healthcare, the proposition is that more budget means more the resources, which ultimately can lead to better quality of health services.

Regulating Tax Collection System: The additional initiative which is already negotiated by the KRI policy makers is to boost the healthcare budget through the increase of taxes of alcohol and cigarettes. [500] Under this process, the PMRA has the function of regulating

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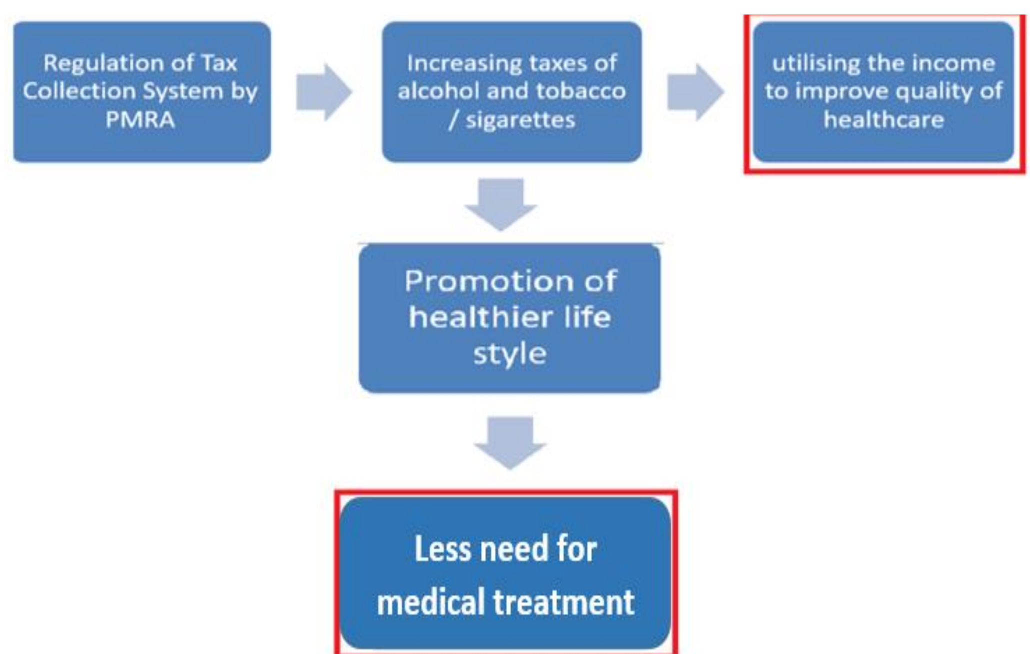
[498] Beauchamp and Childress (n477).

[499] De Leeuw,E. *Engagement of Sectors Other than Health in Integrated Health Governance, Policy, and Action* (2017) Annual Review of Public Health, 337 http://www.annualreviews.org/doi/full/10.1146/annurev-publhealth-031816-044309

[500] Melina Moore (n36) 179.

the national tax collection system, whereby the money is utilised to improve the quality of healthcare. Additionally, such measure advocates healthier lifestyle as the increase of taxes, means higher prices, which has the potential of discouraging the purchase of alcohol and cigarettes. Essentially, the promotion of healthier lifestyle means less need of medical care and less pressure on the KRI healthcare system. Such an initiative can also be dovetailed with global strategies for promoting healthier lifestyles. Figure 35 illustrates the impact of the tax collection system:

Figure 35: Implications of Regulating Tax System



To ensure cost-effective treatment it is essential for the regulatory board to regulate KRI healthcare budget by way of clear and transparent guidelines on the allocation of healthcare resources (similar to the UK NICE guidelines). In addition to guidelines on the process of medical intervention, the regulatory board can also benefit from international health regulations by the WHO and the WMA. Such guidelines are particularly useful during the critical times of political instabilities, unexpected need of medical care by refugees, and the outbreak of global health decease (COVID-19).

7.4.2 Medical Councils

Registering and licencing healthcare professionals: Unlike the UK, the KRI is not yet ready for the introduction of numerous medical councils on specific medical areas. As such, it can be recommended that the KRI can start by introducing general medical council. The proposed functions of such council are the registration of qualified, experienced and competent healthcare professionals on the medical register; and the provision of a fitness to practice licence to practice within the healthcare providers. Providing fitness to practice licence and ensuring periodic re-validation process by evaluating doctor's practice on a regular basis has the effect of guaranteeing responsive governance by continuingly developing medical and professional practice. Although, the KRI healthcare system consists of *Professional Syndicates*, which provides certification for practice, my empirical findings indicate the ineffectiveness of such authority due to the fact that no duty is imposed to assess doctor's practice and hold negligent doctor's accountable for their error.

In this context, the introduction of Medical Council with the function of registering and licencing healthcare professionals underpins the quality of healthcare which can minimise chances of medical errors. Predominantly, the introduction of such council can lead to effective governance through the periodic evaluation of healthcare practice at the level of patient's care whereby competent practitioners are certified and registered under medical register. Further, the certification of competent medical practitioners by PMRA, can have the effect of preventing medical intervention by incompetent practitioners. Such practice of being treated by competent practitioners can decrease the risks of medical errors and ensures a high quality of healthcare. Potentially, whilst this can lead to the intervention by competent and experienced medical practitioners, it also enables healthcare practitioners to act within their duties.[501]

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[501] Shelly A. Jeffcott, Colin F. Mackenzie, *Measuring team performance in healthcare: Review of research and implications for patient safety* (2008) 190 Journal of Critical Care.
[501] Rang Nouri Shawis, *Medical Registration and Licensing Body is a pre Requisite for Good Medical Practice* (2011) http://www.duhokhealth.org/files/Lecture%202-%20Rang%20shawis-GMC%20PresentationNew%20Microsoft%20PowerPo.pdf 7 September 20

Disciplinary Process: Similar to the UK system, under this process the Medical Council needs to be empowered to undertake certain measures, such as: issuing a warning, suspending, and removing incompetent practitioners from the medical register. Moreover, the registration and certification by such council enables healthcare practitioners to uphold their professional reputation which improves doctor-patient relationship. Under an effective interpersonal connection, the patient has trust in the practice and feels confident in disclosing pertinent information which decreases the chances of misdiagnosis. The need for a licencing body to promote good medical practice was also previously recognised by Dr Shawis.[502]

7.4.3 Audit and Risk Committee

Governance of Incident Reporting System: As discussed above (chapter 2.3.1), reporting failures to learn from mistakes is one of the benchmarks of best and safe practice. The disclosure of failures leads to the identification of mortality rates and common diseases as the result of medical errors. The establishment of audit and risk committee in the KRI has the impact of ensuring a safe environment and a better quality of healthcare through the governance of incident reporting system. The introduction of such a system responds to the failures identified within my empirical research study as it is suggested that no system is in place under the KRI healthcare system to prevent failures from reoccurring in the future.

Strategies for implementing incident reporting system in KRI: As suggested by the WHO (chapter 2.3.1) an incident reporting system consists of three stages: 1) promoting practitioners to report failures, 2) analysing the reported data; and 3) learning lessons from the failures. The main function of audit and risks committee under the first stage is to impose a duty of candour / legal duty on healthcare practitioners to report failures. Nevertheless, due to the lack of professional regulations and guidelines, healthcare standards are not clearly defined at the level of patient's care under the KRI health system. Therefore, it can be argued that it would be a challenging process to implement incident reporting system prior to the implementation of regulations and guidelines.

In order to promote the process of reporting failures, lessons can be learned from the reporting system of UK (safe space) whereby practitioners are made aware of the fact that no disciplinary actions are taken, and that the information is kept confidential without impact on professional's reputation. Incident reporting system is applicable to KRI healthcare system as the lack of accountability encourages openness and honesty, whereby it is more likely for healthcare practitioners to report medical errors to relevant authorities. Although, the empirical finding suggested resistance about whistleblowing fellow practitioners' failures due to its negative impacts on the doctor's relationship under team performance, the protection of confidential information prevents such impact.

Under the second stage, the committee regulates and oversees the functions of data analysis team during the process of recording and analysing the reported failures under specific database of *Electronic Health Record System (EHRS)*. Although, as indicated in my empirical findings, the *EHRS* does not operate across the healthcare providers of KRI, the committee can impose a duty on team to make notes of the reported failures and analyse the most frequently reported failures for the purposes of identifying tangible information about the root causes of healthcare quality issues. The use of technology by governing authorities to oversee the functions of healthcare practitioners is also known as 'e-Governance'[503]

Under the third stage the committee regulates Local Health Boards within the process of learning lessons from the root causes of the reported failures by setting up a strategic plan. In order to prevent the reoccurrence of reported failures, the PMRA imposes a duty on Local Health Boards to put strategic plans into action by allocating pertinent resources and funding such as negotiating potential solutions; introducing effective guidelines / job description; and imposing a duty on healthcare practitioner to act in accordance to the standards set under the guidelines. As indicated above (chapter 6.1.3), the subsequent function of PMRA is to assess doctor's practice on regular basis to ensure that the standards are implemented and followed at the level of patient's care.

[503] Bob Roberts, Graham Alsop, *Public Services: E-Governance and E-Health-What are we really talking about? 'A Cure All for all Ills?'* (2003) International Federation for Information Processing 513

The Impact of Effective Incident Reporting System on KRI Healthcare Quality: The introduction of Incident reporting system has certainly a positive impact on the quality of healthcare in KRI as it leads to the identification of root causes and the prevention of medical failures in the future. The additional advantage of the reporting system is actively engaging healthcare practitioners in the process of patient safety initiatives and the improvement of KRI healthcare system through the process of disclosing medical errors to the managing teams for the purpose of learning lessons from mistakes. The prevention of medical failures increases the chances of safe practice to future patients and minimises the risks of medical errors.

Such a practice is also in accordance to the theory of 'principlism' whereby the creation of a safe practice is in accordance to the ethical principle of non-malfeasance.[504] This system has also the impact of developing communication between healthcare practitioners, clinical leaders, and members of the committee. Moreover, the incident reporting system also assist policy makers in identifying failures under the process of designing health law which is compatible with the most significant factor of agility that policy makers are required to take into account during the process of designing healthcare-related legal rules.

7.4.4 Health and Social Care Board

To promote healthy lifestyles and oversee community based healthcare and social services, the health and social care board will have an important role under the KRI healthcare system. Similar to the independent regulators of the UK (known as *Care Quality Commission*) [505] and the USA (known as *Centre for Disease Control and Prevention*)[506], and the proposed health and social care board can regulate the process of protecting the population from health and safety threats. Under this process, the board directs and controls the functions of individual healthcare practitioners to conduct regular assessments of the practice by individual institution. Such assessment involves a number of stages including setting up strategies and objectives. Through the dissemination of

[504] Beauchamp and Childress (n477).
[505] Care Quality Commission, *Regulation 17: Good Governance* (2014) https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-17-good-governance 5 September 2019
[506] Centre for Disease Control and Prevention, *CDC Regulations* (2016) https://www.cdc.gov/regulations/index.html 6 September 2019

national audit check list in the form of self-assessment tools to each institution, the board can assess whether the institutions are achieving their objectives. The most common objectives are the assistance of the vulnerable with their primary needs by guaranteeing free and effective board would involve the regulation of public health education.

Regulating Public Health: to ensure an effective follow-up system in KRI, it is essential to regulate and integrate a public health. Under the latter, the role of the proposed board is to promote healthy lifestyle by educating the general public on how to prevent illnesses and avoid unnecessary medical intervention. My empirical findings suggest, KRI patients are often not educated enough to understand that the consumption of excessive amount of medications can have a major adverse effect on their well-being. Under this process, the board will have the duty to provide guidelines relating to self-management support for patients to deal with long-term illnesses. The board would also have the function of regulating preventative measures such as providing vaccination programmes and promoting of healthy lifestyle through public health education.

The regulation of public health education does not necessarily have to be costly; it can involve a peer dissemination model as used in Cuba to rapidly improve literacy rates and reduce chronic health diseases. Establishing health promotion policy and implementing through campaigns against causes of health issues such as obesity and smoking. It is arguable that in the modern society such campaigns can raise awareness about healthy lifestyles through the media (more specifically social media). From the experience of Cuba, such measures can have the effect of encouraging individuals to take responsibilities for their own health.

7.4.5 Training and Education Board

Innovation and Continues Improvements: The duties of the training and education board involves the process of continuously improving healthcare practitioner's knowledge through the governance of effective education and training system. As indicated under chapter two of this thesis, under the benchmarks of best practice, innovative measures are assured through incentives to conduct research within university hospitals. Research is the key tool to identify new findings and improving the quality of healthcare at the level of patient's care. Under this process it is crucial for the KRI MoH

with the assistance of the board to convert KRI hospitals into teaching hospitals whereby essential medical equipment are made available and researchers are encouraged to actively engage in the process of discovering emerging medical knowledge. This would also have the effect of engaging medical students in the process of improving the healthcare system. As suggested by *Jo Samanta*, and *Ash Samanta*, it is essential for governing authorities to regulate by means therapeutic protocols on the process of balancing innovative treatments against patient safety considerations, whereby innovative treatment is only accepted when it is applicable to patient's unique circumstances.[507]

Professional Trainings and Accreditation Programmes: The proposed *Training and Education Board* will have the duty to enhance practitioner's skills by applying new findings through professional training courses and accreditation programmes. The main duty of the board under this process is to introduce research and training programmes; impose a duty on practitioners and leaders to participate in enhancing their competences; and oversee healthcare professionals' practice to assess the implementation of new knowledge.

Application of New Knowledge: Although, the empirical findings suggest that practitioners are becoming aware of emerging medical knowledge through training, workshop, research seminar, and national and international conferences. However, due to the lack of accountabilities no evidence suggests the application of new knowledge following the completion of training course. As a result, it can be argued that in order to ensure the application of up-dated regulations and guidelines at the level of patients care in KRI, research budget need to be allocated to oversee the functions of practitioners following the completion of training courses.

Updating Teaching Curriculum: Moreover, the role of the proposed board will include the governance of quality assurance programs under the education system. Such process involves the imposition of a duty to include modules within the teaching curriculum on communication, teamwork, accountability, and most importantly patient safety

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[507] Jo Samanta, Ash Samanta, *Quackery or quality: the ethicolegal basis for a legislative framework for medical innovation* (2015) Journal of Medical Ethics, 474.

measures. For instance, the modules on standards of healthcare would focus on healthcare practitioners' expectations are clarified in terms of the right attitude with patients and fellow doctors. Such measure is essential for the KRI, as the empirical findings and the existing literature suggest the lack of quality assurance programmes for both undergraduate and post-graduate courses has led to healthcare practice by incompetent medical students without appropriate supervision.

7.4.6 Liaison and International Board

Collaboration with International Health Organizations: The existence of the liasion by international board with international health organisations fulfills the reguirements of article 14 of the *Iraqi Constitution 2005* on the cooperation with non KRI organisations. As such the empirical findings and the existing literature suggest that the KRI MoH is liasing with a number of international health organisations. An example of this is the provision of guidance on national diseases by the WHO.[508] Nevertheless, the proposed board can promote cooperation with wide range of international healthcare organisations such as *Patient Safety Friendly Hospital Initiatives (PSFHI),* and *World Alliance for Patient Safety.*

Implementing International Regulations: To reach international standards, the proposed board will have the duty to implement international regulations such as *International Health Regulations (IHR)* established by international health organisations including the WHO and the *World Medical Assosciation (WMA)*. The implementation of international regulations will have the impact of applying evidence-based practces, reaching higher standard of care and promoting a higher quality of healthcare.

Keeping Knowledge Up-to-date: The *Liasion and International Board* can also promote higher quality of healthcare through the communication of new findings, whereby healthcare practitioners are funded to attend international conferences and workshops. Under this process, the role of the proposed board is to encourage healthcare practitioners to become members of international health organisation and complete online courses. The function of the board is to provide individual praise or offering

[508] WHO, *Iraq: WHO intercountry cooperation yields rich health dividends* (2018) http://www.emro.who.int/irq/iraq-news/who-intercountry-cooperation-yields-rich-health-dividends.html 7 August 2019

reward for completing certiain international workshops and offering reward to those healthcare providers for successfully completing accreditation programmes. Although the empirical findings and the existing literature suggest that healthcare pracititioners are attending international conferences and workshop, the additional duty of the proposed board is to ensure the implementation of new knowledge by encouraging pracititoners to hold seminars and communicate new knowledge.

7.5 Strategies for Introducing and Implementing PMRA in KRI

The applicability of PMRA in KRI: Due to the existence of the above issues under the KRI healthcare system, the introduction of PMRA is perceived by the participants of the empirical study as an important tool for effective governance. The empirical findings and the literature indicate uncertainties relating to the role of health service leaders, as the existence of unqualified leaders within the KRI healthcare providers has the effect of preventing the imposition of responsibilities on healthcare practitioners and responding to failures. Although, the empirical findings indicate that initiatives are taken to introduce relevant committees within the public hospitals, no regulatory authorities are in place to prevent the import of low-quality medications; oversee the functions of pharmacists; regulate the storage of medications; prevent the provision of expired or counterfeit drugs within the KRI healthcare providers.

The inception of PMRA and the exertion of influence on the application of regulations at the level of patient's care responds to the issues under the KRI health system governance.[509] Similar to the UK healthcare system, self-regulation is the most preferable method of PMRA, as the inclusion of medical professionals with medical knowledge increases the chances of meeting the proposed regulatory goals in the healthcare.[510] Additionally, the introduction of independent regulatory authorities without political parties' interference has the effect of ensuring higher equality of healthcare and effective peer support amongst the healthcare professionals.

[509] Morgan, Yeung, and Twinning (n72) 93.
[510] Ibid.

The Process for Introducing and Implementing PMRA: The process of introducing an effective regulatory authority under the KRI healthcare system involves a number of stages. Firstly, identifying the underlying issues resulting from the lack of PMRA in KRI through qualitative and quantitative research projects. Secondly, analysing the issues for the purposes of justifying the objectives of introducing PMRA in KRI. Thirdly, communicating recommendations for introducing PMRA to the healthcare leaders and policy makers in KRI including the KRI MoH. The fourth stage involves the process of approving the recommendation and appointing relevant committee members in the Ministry of Health to exercise autonomous authority and employing qualified individual regulatory agencies without political interferences.

Learning from the system in the UK, it is essential to employ self-regulatory authorities such as consultancy teams in association with senior doctors within the KRI healthcare providers. Instead of the involvements of members of political parties, it is essential to get members of the community involved in this process. Under the fifth stage of the strategies for introducing PMRA in the KRI, it is essential on the members of the ministry to clarify duties and responsibilities of members of PMRA. As suggested above, such duties involve the introduction of regulations and guidelines. The sixth stage involves the process of successful implementation of PMRA by assessing their effectiveness through regular assessment of their duties and enhance the knowledge of members of PMRA by providing relevant trainings. Under this stage it is important for KRI to test the applicability of PMRA in KRI by piloting it within those hospitals where managers are not politically directed. Once it has proving to be successful, then it could be spread across the remaining healthcare providers of KRI.

Overcoming Potential Challenges to Introducing and Implementing PMRA in KRI: The introduction of PMRA and successful implementation of rules and practices by it could both encounter certain difficulties. The PMRA would restrict the practice of medical professionals and impose greater accountability upon them. Many participants in my empirical research suggested that many medical professionals would resist such interferences with their professional freedom (including participants 2, 3, 4, 5, 6, 7, 8, 13, 14, 15, 18, 20, 22, 24, 26, 29) . Some of the older generation of medical professionals were suggested to be particular resistant.

Notwithstanding this, implementing the PMRA is a necessary step for fostering much needed improvement in healthcare quality.

Following the successful introduction and implementation of PMRA without political parties' interferences, healthcare practitioner has no choice but to accept such authority. Although the requirements of pertinent resources, including employment of regulatory authorities under PMRA can be costly, the application of self-regulatory authority can be cost-effective as the members are already employed and can contribute as part of their existing duties.

7.6 Overall Conclusion

This thesis critically explored the role of the KRI health system governance; provided an overview of the impact of KRI health system governance on the quality of healthcare; and recommended ways to develop governance in the KRI health sector. It was divided into three parts. The first developed benchmarks of best practice for health system governance. The second explored healthcare quality issues in the KRI against the backdrop of these benchmarks and the third has put forward proposals for reforming healthcare governance in the KRI, centered on the implementation of a PMRA.

Strengths of the PhD Process: It was an extraordinary journey to complete the present PhD. Reflecting on the strengths of the research, it can be attested that the research design increased the chances of achieving the overall aims of the research. More specifically, measuring the findings relating to the KRI health system governance against benchmarks of best practice and recommending PMRA have the potential of developing governance to foster healthcare quality in the KRI. Dividing the entire research into three parts of benchmarking components of health system governance, exploring KRI heath system governance through empirical study, and making recommendation for potential solutions.

The additional strengths of the thesis are related to its contribution to the existing literature. The KRI health system governance and the role of law under the health sector is mostly under-researched as much focus is on business governance rather than health system governance of the KRI. Nevertheless, the thesis draws on a system of benchmarking derived from a critical examination of the measures taken under different jurisdictions. The novelty lies in the process of measuring the KRI healthcare standards

against the benchmarks of best practice as this enabled a critical assessment of KRI health system governance and the identification of areas for improvement. Building significantly on limited existing scholarly analysis, the thesis indisputably demonstrates originality as it explores the KRI health system governance from a critical angle.

Whilst other researchers, including John Quinn, are facing defensive participants in the KRI, one of the major strengths of the thesis is getting hold of sensitive information relating to nepotism, antagonism, and exoneration under the KRI health sector. Being originally from Kurdistan region, as a researcher, it was an advantage to be a native speaker and have the linguistic abilities during the empirical study. The thesis illuminates in its findings not just through a robust use of existing work, but also a significant programme of original empirical research consisting of a total of 32 semi-structed interviews with KRI policy makers, health service leaders and healthcare practitioners. To ensure broader impacts of the thesis under the KRI healthcare system, an action plan focused on the implementation of Professional Medical Regulatory Authority framework will be communicated to the KRI health policy makers and health standing committees.

Whilst the reports published by *RAND Corporation* provides an overview of healthcare quality issues of the KRI, the thesis adds to such findings and clarifies the link between health system governance and healthcare quality issues. More specifically, the thesis critically discusses the KRI healthcare system from a legal perspective and assesses the impact of ineffective health system governance on healthcare quality issues in the KRI. For instance, in the report published by RAND corporation it was found that ineffective distribution of healthcare resources, measurement of healthcare quality, health information system, and financing system lead to a low quality of healthcare. [511] Notwithstanding, the thesis takes a step further and discusses the role of KRI governing bodies within the process of distributing healthcare resources, assessing risks, managing health information and financing system. Predominantly, the thesis not only illustrates a connection between the KRI health system governance and the quality of healthcare, but it also provides a comprehensive overview of the role of law under the KRI health system. Further, such findings have the potential of contributing to a number of stake

[511] Melina Moore et al, *The Future of Health Care in the Kurdistan Region — Iraq: Toward an Effective, High-Quality System with an Emphasis on Primary Care* (2014) https://www.rand.org/pubs/periodicals/health-quarterly/issues/v4/n2/01.html 6 July 2020

holders, including academics, health policy makers, and not only law students but also medical and law students.

Challenges to the PhD Process: Reflecting upon the challenges faced during the PhD journey, it can be argued that it was not a straightforward process. The difficulties started under step one which was concerned with benchmarking healthcare practice, which involved a critical discussion of European benchmarks. The potential drawbacks for focusing on European benchmarks lies in the process of measuring KRI healthcare standards against such benchmarks. Essentially, healthcare practice of developed countries cannot be copied and pasted in Kurdistan region which is based in low/middle income and which is dissimilar in terms of socio-economic background. To deal with this challenge, specific reference is also made to the Middle East countries (including Turkey, Egypt and Jordan) under the synthesis and discussion part of the thesis. Furthermore, under part three of the thesis, the recommended benchmarks are adapted in a way that is most suitable for the KRI.

The second challenge faced under the thesis, was concerned with the process of accessing reliable data on the role of KRI health system governance, which necessitated the need to conduct empirical study. Although the empirical study made the PhD more interesting and original, such study was also a challenging process. More specifically, the study required the submission of ethical application, which was not a straightforward process. Due to political instabilities in the region, the safety of the participants was the main concern of the ethical committee. Essentially, the steps taken to mitigate such challenge was to resubmit the application and act in accordance to the guidance provided by the ethical committee. Furthermore, the institutional support including training on qualitative research method, NVIVO data analysis software, and guidance on thematic data analysis made such empirical study possible.

Recommendations for future research:

Following the completion of the thesis, several areas have been identified that require further research. One of the key areas identified is the need to access and analyze data on reported incidents within the KRI healthcare providers. This would provide an objective overview of the KRI quality of healthcare. The additional area for future research

includes the assessment of the implementation process of PMRA. The additional recommendation for further development of the KRI health system governance is to fund future researches on the impact of the implemented PMRA in the KRI.

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Appendix 1: Benchmarks of Best Practice

Benchmarks Numbers	**Components of Health Service Governance**	Benchmarks of best practice
Benchmark 1	Developing Professional Regulations	Avoiding over-regulation by developing existing the professional regulations through the stages of setting up policy agenda, formulating the agenda, designing and submitting the proposed regulations; and ensuring that the developed regulations have distinct characteristics of proportionality, transparency, focus, and agility.
Benchmark 2	Implementing Professional Regulations	Vertically and horizontally implementing professional regulations, whilst complying with the adaptation and communication under the implementation stages.
Benchmark 3	Supplementary to Professional Regulations	Clarifying the roles and responsibilities of health service leaders and healthcare practitioners; and enhancing the implementation of the developed regulations by means of supplementary statutory instruments and non-legal rules.
Benchmark 4	Health Service Leadership	Ensuring effective leadership through the process of working closely with healthcare practitioners at the level of patient's care; and developing practitioner's capability by engaging them with health service improvements under the traditional approach of 'collective leadership.'
Benchmark 5	Professional Medical Regulatory Authorities	Establishing not excessive, but diverse self-regulatory authorities with non-political interventionist and non-repressive powers by governmental bodies.
Benchmark 6	Accountability Mechanisms	Ensuring transparent and effective accountability mechanisms at both leaders and practitioners' level, through well founded support to avoid blame culture and defensive medicine.
Benchmark 7	Patient Safety and Risk Management	Acting in accordance to international health law and ensuring a safe environment by reducing the risks of harm through the process of reporting failures and learning from mistakes; proposing protective factors to reduce medical misadventure.
Benchmark 8	Professionalisation of Healthcare Practitioners	Professionalising healthcare practitioners through education, training courses, accreditation programmes, regulation, implementation of national and international health organisation initiatives.
Benchmark 9	Developing Health Technology	Developing health technology and electronic health records to protect confidential information and ensure design-based regulations.
Benchmark 10	Interpersonal Connections	Ensuring effective interpersonal connections by taking patient-centered approach and supporting patients during decision-making process.
Benchmark 11	Access to Healthcare	Ensuring cost-effective treatments to providing patients equitable and equal access to health services.
Benchmark 12	Patient's Rights to Request Redress	In cases of harm, allowing patients or their families to request redress under a number of avenues including: a local complaint procedures, Criminal Law, Medical Negligent system, and NFCS. Allowing access to information relating to negligent actions to learn lessons from failures.

Appendix 2: KRI Health Ministry Certificate

اقليم كوردستان - العراق
مجلس الوزراء
وزارة الصحة
المديرية العامة لصحة السليمانية
- قسم الامور الفنيه -

هەرێمی کوردستان
ئەنجومەنی وەزیران
وەزارەتی تەندروستی
بەڕێوەبەرایەتی گشتی تەندروستی سلێمانی
-کاروباری هونەری -

Kurdistan Regional Government
Council of Ministers
Ministry of Health

No :
Date :

ژمارە/
بەروار/ ٢٠١٦/ ٤/
بەروار/ نەورۆز ٢٧١٦/

((پێشمەرگە پارێزەری ئاشتی و خاکە بە پشتیوانی پێشمەرگە ئارامی دەپارێزرێت))

بـۆ / سەنتەری نەخۆشیەکانی دڵ
بابەت / هاوکاری

ئاگادارتان دەکەین بە هاوکاری کردنی خوێندکاری باڵای دکتۆرا ((د. ئەژین عمر محمد)) کە خوێندکاری زانکۆ ((نوتینگهام))
لە وولاتی بەریتانیا بە مەبەستی شارەزا بوونی لە سیستەمی کار کردنی لە تەندروستی کوردستان تکایە .

د.میران محمد عباس
بەرێوەبەری گشتی
٢٠١٦/٤/

وێنەیەك بۆ//

- کاروباری هونەری / کامل .
- دۆسیەی تایبەت .
- دۆسیەی کەسێتی / لە گەڵ بەرابیەکان .

دکتۆر
شەوا یاسین حمە
بەرێوەبەری شارەزای هونەری
کاروباری هونەری / کامل
٤١٤

شیلان //

E – mail : - Doh – suli @ yahoo . com

Appendix 3: Table of Samples

Table 1: Healthcare practitioners

Participant Male/Female	Public/ private	Profession	Date	Method	Language
P1 - M	Public Hospital	Senior Doctor:	November 2015	Telephone Interview	English
P3 - F	Public Hospital	General practitioner: resident doctor	December 2015	Telephone Interview	English
P4 - F	Public Hospital	Oral surgeon	January 2016	Telephone Interview	English
P5 - M	Public Hospital	Dentist	January 2016	Telephone Interview	English
P6 - M	Public Hospital	General Surgeon	January 2016	Skype Interview	English
P7 – F	Private Clinic	Dentist	January 2016	Telephone Interview	English
P8 - M	Public Hospital	General Practitioner	February 2016	Telephone Interview	English

P12 – M	Public Hospital	General Anesthetic	March 2016	Telephon e Interview	Kurdish
P13 – M	Public Hospital	Dermatologis t	March 2016	Skype Interview	Kurdish
P14 – M	Public Hospital	General surgeon / medical board	March 2016	Telephon e Interview	English
P15 – M	Public Hospital	Neurosurgeon	March 2016	Telephon e Interview	English
P16 – M	Public Hospital	Senior Nurse	March 2016	Face-to-face	Kurdish
P17- M	Public Hospital	Nurse	March 2016	Face-to-face	Kurdish
P18 - M	Public Hospital	Nurse	March 2016	Face-to-face	Kurdish
P22 - M	Private clinic	Children's Health Doctor	March 2016	Face-to-face	Kurdish
P23 – M	Private clinic	Plastic Surgeon	March 2016	Face-to-face	Kurdish
P25 – F	Public Hospital	General Practitioner / medical Board	March 2016	Face-to-face	English

P26 – F	Public university	Lecturer in Nursing School/ former nurse & WHO associate	April 2016	Face-to-face	Kurdish
P28 – F	Public Hospital	Senior nurse / Heart Department	April 2016	Face-to-face	Kurdish
P29 – M	Public Hospital	Heart Surgeon	April 2016	Face-to-face	Kurdish/English

Table 2: Legal Practitioners, Policy and Decision Makers

Participant	Public/ private	Profession	Date	Method	Language
P2 - F	Public Hospital	Head of healthcare quality	November 2015	Telephone Interview	English
P9 – M	Public Hospital	Hospital Director/ Heart Surgeon	February 2016	Skype Interview	Kurdish
P10 – M	Public Hospital	Hospital manager	February 2016	Telephone Interview	English
P19 – M	Public Hospital	Head of A& E Department	April 2016	Face-to-face	Kurdish

P20 – F	Public Sector	Training Manager/ graduate nurse	March 2016	Face-to-face	English
P27 – M	Public Sector	Head of Forensic Department	March 2016	Face-to-face	English
P24 – M	Public Sector	Training Centre: Assistant Director	March 2016	Face-to-face	Kurdish
P30 – M	Public sector	Medical Lawyer	April 2016	Face-to-face	Kurdish
P31 – M	Public sector	Policy Maker	April 2016	Face-to-face	Kurdish
P32 – M	Public sector	Policy Maker	April 2016	Face-to-face	Kurdish

Appendix 4: Participant Information Sheet & Consent Form

PhD Project: 'Developing Governance to Foster Healthcare Quality in Kurdistan Semi-autonomous Region of North-Iraq.'

Dear Participant
Healthcare quality issues have been recognised as a global issue and as the result many patients are suffering unnecessary harm on daily basis. This research project is aiming to highlight medical errors and adverse effects associated with the healthcare in Kurdistan semi-autonomous region. The idea is to propose a conceptual framework of governance to foster healthcare quality in the public hospitals of *Kurdistan semi-autonomous region in North-Iraq*.

You have been asked to participate in a semi-structured interview in order to highlight medical errors and adverse effects associated with the healthcare and to identify priorities for quality in the healthcare. Your information will be critically analysed in a report, PhD thesis and other publications. The interviews will be recorded with a voice recorder and the collected data will be destroyed after three years. The recoded tape will be stored in secured file cabinet at *Nottingham Trent University* and only my project co-ordinators and I (as a researcher) will have access to your personal information. Under this research project, your confidential information will be protected, unless information relating to serious harm is disclosed. Your participation is voluntary and you have the right to withdraw your consent to participation at any time and the data that has already been collected before the withdrawal of the consent will be used in the project unless you specifically object. If you are happy to participate please sign and date the attached consent form.

Please do not hesitate to contact me if there are any questions.

Kind regards

Azhin Omer Doctoral Researcher on Healthcare quality, azhin.omer@ntu.ac.uk
Dr. Austen Garwood-Gowers Project Director - Health Law Reader, austen.garwoodgowers@ntu.ac.uk
John Tingle Project Supervisor - Health Law Reader, john.tingle@ntu.ac.uk
Dr. Linda Gibson Project Supervisor - Senior Lecturer, linda.gibson@ntu.ac.uk

Consent Form

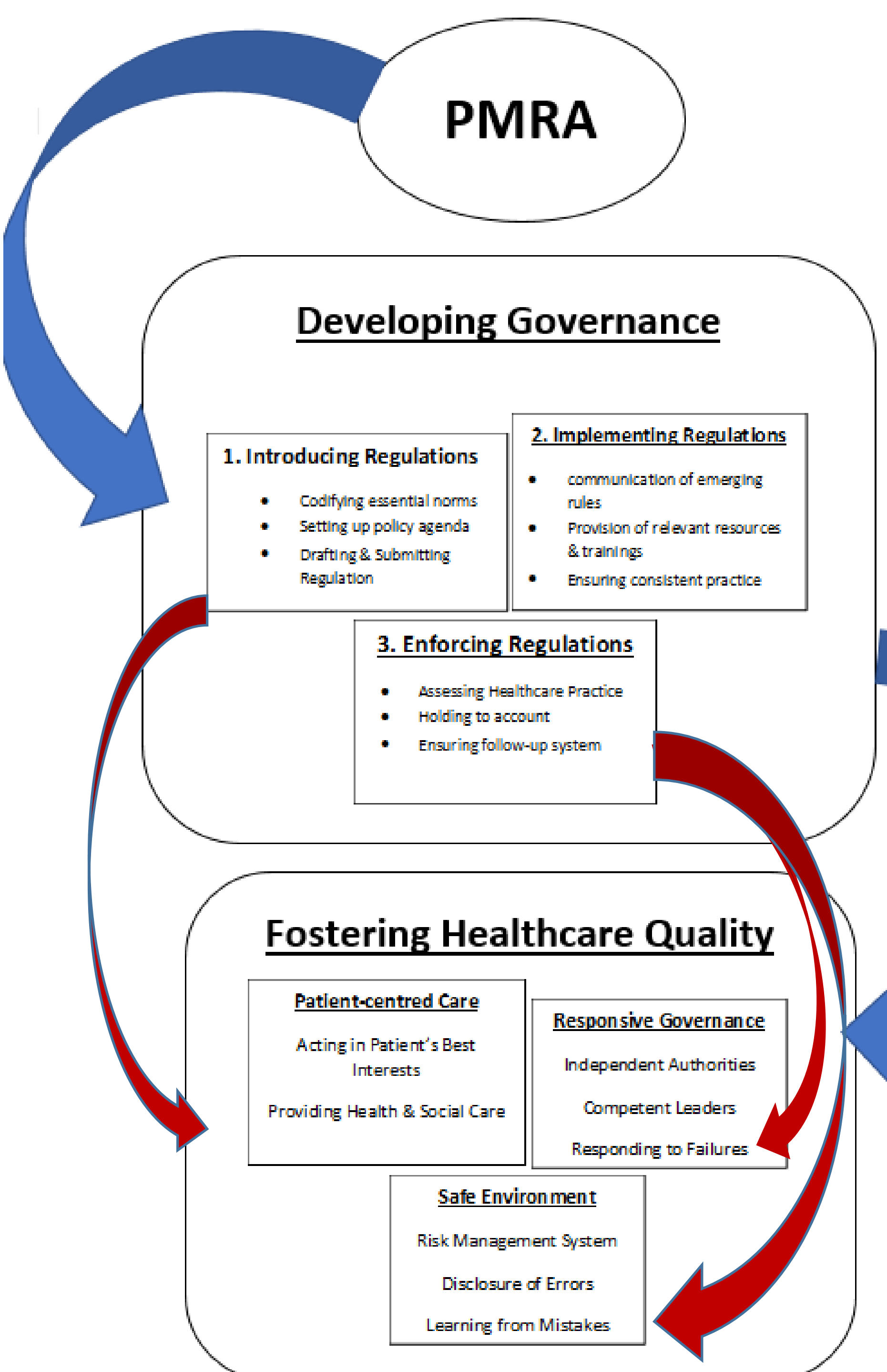
- ✓ I understand the purpose of the project
- ✓ I understand that only the researcher and the project supervisors will have access to my personal information.
- ✓ I understand that the interviews will be recorded with a voice recorder and the recoded tape will be stored in secured file cabinet at Nottingham Trent University.
- ✓ I understand that my personal details will not be identified and my employer does not know who participates, unless information relating to serious harm is disclosed.
- ✓ I understand that I have the discretion to decide whether to disclose sensitive matters that could have an impact on my reputation or the healthcare provider's reputation. I understand that I will be given the option to keep any or all responses off the written records.
- ✓ I understand that the information will be used in project report, thesis and other publications.
- ✓ I understand that I have the right to withdraw my consent at any time and the data that has already been collected before the withdrawal of the consent will be used in the project unless I object.
- ✓ I voluntarily agree to participate in this research project.

Name ……………………………………………..

Signature ……………………………………………..

Date ……………………………………………..

Appendix 5: The Impact of PMRA on Healthcare Quality



Appendix 6: Publications

Chapter in Edited Book:

Omer, A. (2018). *'A critical analysis of patient safety Strategies in Kurdistan Region in Iraq'* in Global Patient Safety: Law, Policy and Practice. Routledge: New York, pp223-234. ISBN: 978-1-13805278-9

Professional Conference Papers:

- Keynote speaker: Omer A., (2018, November) *"Kurdistan Genocide should not be ignored"* Erbil, Kurdistan Region in Iraq
- Omer A., Wheat K., Fattah A., (2018, November) *"Uncovering PTSD Symptoms: What is the Psychological Impact of Genocide on the Survivors and How this been Dealt with by Healthcare Provision in Kurdistan Region of Iraq (KRI)?"* Erbil, Kurdistan Region in Iraq
- Omer, A. (2015, October). *'Cross border healthcare, medical errors and liabilities: How effective is the EU Cross Border Directive?'* Paper presented at the European Association of Health Law Conference, Czech Republic.
- Omer, A. (2014, September). *Developing an ideal model of patient safety for Kurdistan region of North Iraq'* Paper presented at East Midlands University Conference, Leister, United Kingdom.