

Quality of care in general practice *

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Air services and medical services

I OFTEN have to travel to London by air, and use the small local service to Glasgow from Dundee. 'Smallness' includes the size of the aircraft, which provides only one crew member by the pilot, for its 14 seats. Sitting in close proximity to the man in whose hands my life depends has given me occasion to reflect on the importance of educational standards and the responsibilities of those who train and attest those on whom, like pilots, we are obliged to put our trust.

It is clearly important to decide what it is that a pilot should learn, and that he should be able to demonstrate satisfactorily his acquired skill. Grading seems almost irrelevant—to an outsider, it would seem that there can be so little room for error that examiners can only differentiate those that succeed in their demonstration of competence from those who fail. And yet, technical ability apart, I am conscious, as a client of air transport services, of different qualities among air crew. I have a particular admiration for the pilot of the small craft who is also navigator, wireless and radar operator, flight mechanic, counsellor, and friend. The thorough and businesslike way he goes through the complex procedures of checking and manipulating the innumerable controls, although a mystifying ritual to the uninformed, inspires confidence; even when he shares his irritation about misted windows or faulty instruments with his clients, or his anxiety or frustration about adverse weather conditions, trust in him is rarely disturbed.

It is less easy to develop a similar rapport with the crew of a larger aircraft; the reassuring message from the faceless pilot tends to be stylised and impersonal, and without doubting the technical skills of each member of the team, it is easy to speculate on how well they work together, and how adversely an 'off day' for one might affect the performance of the group. The discomfort of an air pocket or a bumpy landing becomes a cause of complaint rather than of sympathetic understanding, and the attitudes of the air crew that one does meet can significantly determine the client's attitude to delays and diversions.

A traveller contracts with an airline to be transported to a specified place in a prescribed period of time; factors entirely outside the control of the airline or passenger may cause an entirely different outcome—even the demise of the client. Fulfilment of the contract depends only in part upon the technical and organisational abilities of the airline and its staff; the acceptability of the outcome, however modified, depends significantly on the relationship between client and the airline staff with whom he has contact.

There are, I think, some useful analogies with medical practice. There is not much a patient can do about the technical competence of a doctor—this he has to leave to those who are sufficiently informed themselves about medical practice to judge; but there is much that he can and should say about the acceptability of the medical services he receives, and how they fulfil his expectations.

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When a patient seeks medical help, his expectations relate to his general knowledge of medicine and what it can provide, but this can be profoundly modified by his previous experience of medical care, his personal reactions to illness and by his relationship to the doctor that he consults.

This in turn can be significantly affected by the way in which a medical service is organised, its comprehensiveness, its adaptability to changing circumstances, and the access it offers to its clients.

Three factors in quality

Any assessment of the quality of medical care must take into account the effectiveness of the professional services given, the efficiency with which they are provided, and their acceptability to both patients and staff. They must involve: firstly the professions—for only they can determine appropriate levels of demonstrable competence and define the limits of acceptable practice within which innovation and experiment can take place; secondly, the administrative body responsible for financing the services, whether public or private, since the provision and organisation of resources determines the extent to which demands are met, how services are used, and how needs are related to what is provided; and thirdly, the public, whose accessibility to services and possible abuse of them can significantly affect the quality of what is provided.

These three factors in quality—effectiveness, efficiency and acceptability—are discrete but interdependent; each must be taken into account in the assessment of medical care.

Measuring medical work

Assessment presupposes standards, comparisons and consensus; in turn, some means have to be found for recording the activity under review in measurable terms. It is simpler to use quantitative than qualitative measures, and it is surprising how variable these are within the National Health Service. After over 25 years of centrally financed health services, there are still considerable differences throughout the country in—for instance—the numbers of beds available for hospital care, the numbers of patients cared for by both general practitioners and specialists, and the level of many other medical and allied services (Morris, 1964).

The reasons are varied; the NHS inherited hospitals from a number of sources and their size and distribution reflected the response of many local health authorities and voluntary bodies to public need. The numbers of beds available per thousand of the population varied by a factor of two in different areas of the country (Ministry of Health, 1962); the position has not changed significantly in over two decades, and yet curiously the well-provided areas seem to keep their beds filled as well as the areas with fewer beds, and there is little difference in the lengths of waiting lists. Each area appears to adapt to what is provided (Airth and Newell, 1962). Predictably, the number of patients admitted for conditions such as an acute appendicitis where there is no alternative to hospital treatment is similar throughout the country; but the difference is apparent where there is a degree of choice between hospital and home care. Another odd situation is that the length of stay in hospital is not necessarily shortest where beds are relatively scarce; it seems irrational that patients being treated for uncomplicated inguinal hernia or varicose veins stayed longer—sometimes twice as long—in such areas where there is a relative shortage of beds than in others where beds are more plentiful.

The most significant factor in the use of hospital beds is the standard practice of the consultant in charge (Feldstein, 1967). We know remarkably little about how the practice of one consultant compares with that of others apart from simple quantitative variation in their use of resources. Crude comparisons of death rates between one area

and another, comparing for instance deaths from some diagnoses in areas with high and low bed provision, are not helpful, since so many factors, social, environmental as well as medical, are involved (Logan, *et al.*, 1972). We do know that there is a greater risk of dying from some conditions if you are cared for in some regional hospitals than some teaching hospitals (Ashley, Howlett, and Morris, 1971); we do know that there is a significantly greater burden upon families with elderly mentally ill relatives in areas with fewer beds for such patients than in others (Grad and Sainsbury, 1966). But such studies are few; it is only in very recent years that their importance has been realised and a major investment made in such operational research, and adaptation of the National Health Service administrative organisation to respond (McLachlan, 1973).

Functions of the hospital

Medical model

I imagine that if asked to define the function of the hospital and specialist services, many consultants would say that it was to diagnose and treat disease in man; and no doubt a significant section of the public would share this view. Theoretically, efficiency can be measured in terms of the numbers of patients treated related to such resources as the numbers of beds, outpatient services, doctors, and nurses. Comparison between one area and another can—and indeed does—lead to better use of limited resources. Qualitative as well as quantitative factors can be added, e.g. complication rates, recurrences, and re-admissions.

A fruitful partnership can arise between doctors and administrators, who with the objective of making best use of available resources, establish by consensus an agreed standard by comparing the work that they do with that of others within the constraints of the system in which they operate. Ideally the process is one of continuing re-evaluation in the light of the growth of human knowledge fulfilling the best scientific principles.

Sociological model

There is another public view of hospitals, especially amongst those with personal experience of illness in themselves or their relatives. Although the efforts of doctors and nurses are widely applauded, and gratitude expressed for the relief of pain and sickness, the hospital symbolises for many loss of independence, of capacity to work, of the dignity of good health; it holds the fear of suffering and even of death. This is not to suggest that hospital doctors are not well aware of their patients' personal reaction to illness and the consequences it has upon their lives; they care for them with the compassion and sympathy that characterises the humane traditions of the profession.

But their business tends to be the treatment of discernible incidents of illness, and technically the measure of their success is the number of cases treated to conclusion with the minimum deployment of resources. No one should decry or underrate the remarkable progress that has been made in the treatment of human disease in recent years, but it constitutes a small part of the causes of concern which the public sees within the medical ambit, and an even smaller part of human activity which affects the health of the community. The economic status of the country, its policies of housing and public utility, conditions of work and social welfare are more closely correlated with improvements in longevity than advances in medical knowledge and skill (McLachlan, and McKeown, 1971).

Whole-person medicine

General practitioners who live and work with their patients and who see their illnesses more as a series of events in the ebb and flow of their lives rather than as discrete entities, are perhaps more conscious than other doctors of the many inter-related facets which contribute to the quality of life; it contains measurable factors, each of them with determinable standards, but it defies human ingenuity to devise a simple index to compare the lot of one man with that of another.

So too, concerned as it is with the whole man in his changing environment, the quality of general practice cannot be rated to a single scale. Interpreting a patient's needs in social and psychological as well as biological or pathological terms, being broader and less well defined than the diagnostic process in more specialised fields of practice, does not mean that its standards are lower, or within its own terms, that it is less precise. It is not an aggregate of the generality of other specialties, but a discipline in its own right.

The general practitioner can offer no panacea for all human ills, but his prime task is to detect biological variation in his patients and to contribute what he can to establish or restore them to his concept of normality, or assist them to adapt to a tolerable alternative state. His 'concept of normality' must of course include the traditional understanding of form and function which are the basic sciences of medicine, and much of his work is to do with the application of specific remedies to the wide variety of injuries, infections, and disordered functions known to afflict man. Some occur with such frequency that the general practitioner becomes expert by reinforcement of experience to treat; others, particularly those in which special techniques of diagnosis and treatment are involved, are better treated by specialists whose narrower experience allows deeper and more refined skills to develop.

Keeping up to date

Whatever his clinical role, whether as therapist or referral agent, the general practitioner has a duty to keep informed of the current state of medical knowledge and what it can offer in the relief of disease in his patients. Therein lies the first measure of a doctor's competence and contribution to the quality of medical care. It has been said that a doctor's knowledge on graduation has a half-life of about five years. It is difficult enough for a consultant, with all the opportunities he has to confer with colleagues and with doctors in training, to keep in touch with the growing edge of his subject.

Group practice offers general practitioners the opportunity to share their knowledge with colleagues, but their wide range of medical concern is such that a planned programme of continuing education is becoming increasingly necessary simply to re-equip the doctor with the armamentarium of his clinical work.

There is of course no discernible barrier between the application of specific remedies and the other aspects of a general practitioner's work; it is part and parcel of his professional role.

Doctor-patient relationship in general practice

Skill in deriving information from patients is basic to all medical practice, but as the doctor of first contact, the general practitioner bears special responsibility for understanding how recognising the patient as an individual modifies ways in which information is elicited and hypotheses made about the nature of an illness and its management.

He needs, therefore, the capacity for forming a relationship with his patients, built up over a series of successive consultations, to enable him to understand how individual patients respond to illness over a period of time, and to develop a degree of self-understanding in this relationship. His personal knowledge of the patient's home circumstances and often his working environment also, provides insight into ways in which illnesses can be caused and influenced by environmental factors, which is not so readily appreciated by other doctors. These qualities of general practice are well understood and can be taught, but are not readily measurable in specific terms.

The capacity of a general practitioner to form a satisfactory rapport with his patients may be reflected in his popularity—even the size of his list; but the patients may be no more competent to judge this professional skill than such traditional attributes as auscultation or sphygmomanometry.

The rating scale applied to the modified essay question pioneered by the Royal College of General Practitioners is an ingenious device for assessing the skill of the doctor in this respect; it should not be assumed, however, that the skill is necessarily enhanced simply by experience. I believe it has been a salutary experience for those attending the course for teachers of general practice to observe themselves and their colleagues at work with simulated patients. There is surely much to be done in this field to advance the claim that general practice is a discipline in its own right, and no less precise than that of other fields of practice.

General practice and community medicine

The third aspect of quality in general practice is in the field of community medicine, that is the practice of medicine in relation to communities or groups of patients rather than of individual patient care. The patients of every practice form a definable community, with its own characteristics, its own age and sex structure, social groupings and patterns of morbidity and mortality. Although in totality each is unique all have common features, and comparable factors. The reports of the Office of Population Studies and Royal College of General Practitioners are invaluable descriptions of reported morbidity patterns in general practice. It is a constantly changing pattern and necessarily incomplete, for it can reflect only those incidents of illness reported to general practitioners on the initiative of their patients. It is of value in comparing patterns of care in one practice with experience in many others; with complementary information from other sources, a practitioner can begin to see his practice in the context of the known prevalence of disease in similar communities, identifying at risk groups and others with varying degrees of handicap where medical aid is appropriate.

To develop such an understanding of a practice, and to build up a composite picture of many others from which comparisons can be made, entails the regular recording of medical information from the fundamental source, that is the consultation between doctor and patient. Ways and means of recording appropriate information from the work bench of the general practitioner have been extensively investigated by the College; their development will contribute notably to the improvement of standards of practice, for no assessment can take place or yardstick be defined until there is material to measure.

Conclusions

Hence, in my view, there are three aspects to the maintenance of professional competence in general practice:

(1) Application of new knowledge in general practice

To ensure that every practitioner is aware of and sensitive to the growing edge of biological knowledge. This means that the gap between the esoteric discoveries made in the upper storeys of the ivory institutions and the real world of daily practice must be bridged, and new knowledge translated into practical applicability.

This places an onus upon the planners of continuing medical education to ensure that their courses are relevant and sensitive to the needs of the average practitioner, and this can only be the product of dialogue between research worker, specialist, and general practitioner.

(2) Free discussion between general practitioners

To provide the opportunity and incentive for all practitioners to exhibit their skill and understanding of their patients to their peers, so that each may contribute to the collective understanding of all the complexities of whole-person medicine. The written word, encapsulated in the stylised framework of the bound volume or journal article, is no substitute for the free exchange of ideas, impressions and opinions of peer group discussion centred upon the real life experience of practitioners who live and work in

the front line of medical care, and whose collective conventional wisdom is the stuff of a caring profession.

(3) *Improved records in general practice*

To ensure that the record kept of the care that the doctor gives to a patient is more than simply an *aide memoire* relevant only to a transient incident of illness. Every doctor/patient contact contributes vital information, not simply about the state of health of an individual patient, but also of the community as a whole. It is the bedrock for the assessment of the morbidity of the whole population, and the basis for comparison on which the assessment of the quality of care, however rudimentary, depends.

Modern data processing methods take much of the labour out of the analysis of the multiplicity of incidents which collectively make up the identikit of the face of medicine, and every small part improves the quality of the image. To quote Professor Weir (Weir, 1971): "All that is known of medicine today has resulted from careful observation and the recording of those observations. The conscientious attention to the recording of data in the management of patients cannot be overemphasised. Without it, intelligence is wasted, reasoned judgement impossible and honesty of intent irrelevant. Even one's compassion becomes fraudulent."

It is for the profession to ensure that these aspects of medical practice are accepted as an integral part of medical work, and on this the effectiveness of professional services will depend; the doctor also has a part to play in partnership with the administrators of the Health Service, in ensuring that the services are efficiently provided, and his records will contribute a great deal to understanding how well the patients most at need have benefited.

How *acceptable* the services given are to patients, and how far they meet expectations, is little understood. Expressions of gratitude by individual patients are curiously unpredictable and diverse, and may more often express relief of anxiety than satisfaction with medical achievement as conceived by the medical fraternity. The Royal Commission on Medical Education (1968) expressed the view that since "the doctor is concerned with the most personal aspects of human health, and indeed with the fundamental matters of life and death, this will ensure a continuing high prestige for his profession, but the esteem in which the doctor is held by the community in general will be determined much more by his demonstrated competence than by the mystique of his calling. The basis of the doctor's leadership will be his superior knowledge of the central facts of the clinical situation, his ability to exercise a decisive influence on the patient's illness, and his capacity to guide and co-ordinate the work of others whose co-operation is essential."

The fact that a patient's illness includes factors far beyond the signs and symptoms of a discernible organic disease is not an excuse for ambiguity, but a call for the continued search for understanding its nature. For it is within the questing spirit of a caring profession that the true quality of medical care lies.

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