

## Comparisons with colleagues

ONE of the main themes in the development of general practice in Britain is the growing interest which general practitioners are showing in analyzing both their clinical and organizational work. General practitioners have long been isolated, and the trend towards partnerships and groups, which occurred so suddenly in the middle of the twentieth century, inevitably led to increasing interest in comparing different ways of organizing work.

Another important influence accelerating analysis and audit in general practice has been the explosive development of teaching, both undergraduate and vocational. In order to help the next generation learn more quickly it is first necessary to analyze the aspects of care.

This *Journal* has a long history of reporting such analyses and we still believe that encouraging our readers to compare their work with colleagues is particularly valuable. Certainly for many it has been the stimulus to rethinking, redefining, and then improving standards of care.

### Peer review

For those who welcome audit such comparisons may be a useful beginning. For others, they may be, as

described today, the start of useful discussions within the practice. Whatever their application, only by comparing with colleagues can we begin to identify the boundaries of our performance, to know whether we are behaving like most of our peers or whether we differ in some way. If we differ, are we better or are we worse, and if so why?

However, the scope for comparisons with colleagues is limited, especially for those in rural practices or geographically far from the main centres. We therefore begin today a new series in the *Journal*, in which, with the help of the Birmingham Research Unit of the College, we offer general practitioners the opportunity of obtaining simple information about their practices and sending it for analysis to the Birmingham Unit. We shall publish the collective results later.

This series is presented in as simple a way as possible, and is, we hope, not threatening. We invite our readers to complete the enclosed forms anonymously so that no-one will know the individual performances of anyone else, but everyone will know the range and average performance of those who participate.

We hope that these returns will help to provide data about what is going on in general practice and make it easier for all of us to carry out comparisons with colleagues.

## Practice activity analysis

ENCLOSED today, with this issue of the *Journal*, is the first of a series of self-measurements of different aspects of work in general practice. There will be six of these altogether and they will cover several different aspects of day-to-day work in general practice.

The forms have been designed to ensure that the methods of recording are as simple as possible, and the instructions have been reduced to a minimum compatible with the need to retain comparability of results between all those answering. The total number of consultations (defined as face-to-face consultations between patient and doctor) provides the key to standardizing results and thus aiding comparisons.

It is therefore necessary to establish a record within each practice of the number of consultations, including home visits, undertaken by each participating doctor.

We believe that this work, which is already done routinely in many practices, is most suitably undertaken by receptionists or secretaries, although some of the recording in the series will have to be undertaken by doctors.

This month's activity analysis is about the punctuality of appointment systems and the recording can be undertaken by receptionists. The subsequent analyses simply involve counting and we have chosen the method used in cricket score books (Table 1).

Double marking is illustrated in the digits in the five to 14-year age group.

The instructions for each analysis will be printed on the appropriate sheet. Some discussion will be necessary between doctors and receptionists when, for example, blood tests are requested by another team member.

**Table 1.** An example of an activity analysis showing method of counting.

Age	0-4 years					5-14 years					15-64 years					65 + years				
Erythromycins	<del>1</del> 6	<del>2</del> 7	<del>3</del> 8	<del>4</del> 9	<del>5</del> 10	<del>1</del> 6	<del>2</del> 7	<del>3</del> 8	<del>4</del> 9	<del>5</del> 10	<del>1</del> 6	<del>2</del> 7	<del>3</del> 8	4 9	5 10	1 6	2 7	3 8	4 9	5 10

5, 12, 3 and 0 prescriptions for erythromycins in appropriate age-group boxes.

It is not, of course, necessary for all readers to undertake each individual analysis in this series, but we hope that the readers of this *Journal* will join in as many of the different analyses as possible.

Additional copies of the pro formas can be obtained from the Birmingham Research Unit of the Royal College of General Practitioners, at 54 Lordwood Road, Birmingham B17 9DB. These can be used for colleagues, partners, or trainees who do not at present receive the *Journal*, and for other follow-up analyses in the practice. Once the Birmingham Research Unit has received the results they will be analyzed and the collective scores published in later issues of the *Journal*.

This series is intended to be an educational project rather than a research project. We believe that the greatest value will come if those doctors who have

participated, after comparing their results with colleagues, discuss them in peer groups inside the practices or in postgraduate centres.

The other titles in this series will be: the Choice of Antibiotics, Investigation Procedures, the Use of Psychotropic Drugs, Referrals to Specialists, and a Visiting Profile.

We hope that a great many practitioners from general practices of all sizes will respond. The bigger the response, the better the results will be.

**Acknowledgement**

The Birmingham Research Unit and the *Journal of the Royal College of General Practitioners* acknowledge support by Messrs Reckitt and Colman and their help in preparing this series.

## Trends in national morbidity

MUCH of the information about the kinds of sickness experienced by people is based on analyses of patients admitted to hospital. For some conditions and procedures hospital-based information is ideal, and reports such as the *Hospital Inpatient Activity Analysis* are important sources of data for those interested in the organization of health services.

However, of equal importance are the conditions which take people to the point of entry to the health services, in Britain, to general practice. In 1955-56 the Records and Statistics Unit of the Royal College of General Practitioners and the General Register Office pioneered in the First National Morbidity Survey one of the most important pieces of collective research in general practice ever carried out in the world. Exploiting the unique advantage in Britain of precisely defined practice population, the Morbidity Survey organized a team of general practitioners and recorded every episode of illness presented to these general practitioners during a year.

Inevitably, such a study had to face tremendous problems of definition, classification and recording, and considerable advances were made in the whole science of collective investigations in general practice through the experience and skill developed by the

Birmingham Research Unit in that study.

Having completed it, however, not only were the results of considerable interest, but they formed a natural baseline against which future changes in the use of general practice and in the patterns of illness as perceived by patients and by doctors could be judged.

The Second National Morbidity Survey was organized by the Birmingham Research Unit, in conjunction with the Office of Population Censuses and Surveys and the Department of Health and Social Security. Whereas the first study took place in the years 1955 to 1956, the Second National Morbidity Survey covered the years 1970 to 1971, and the results have been published (Royal College of General Practitioners, Office of Population Censuses and Surveys, and the Department of Health and Social Security, 1974).

What is now of special interest are the differences which have emerged in those 20 years, and especially the trends which are emerging, which may be guidelines to future patterns in general practice.

We are therefore pleased to publish *Trends in National Morbidity* as *Occasional Paper Number 3* in our new *Journal* publication series. This 41-page booklet analyzes in detail the trends that have emerged from a comparison of these two morbidity surveys, and