

Quality of care in general practice: can it be assessed?

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DURING the early stormy years of the NHS and the creation of the College of General Practitioners, the organization and structure of general practice presented overwhelming difficulties. Auld¹ described accurately and with wit the problems involved.

Donabedian's² division of the organization of health care into its structure, the diagnostic and therapeutic process of care, and the outcome of care clarified a complex phenomenon. After the Second World War general practice was directed mainly towards what was clearly most inefficient—the actual structure within which it took place. Buildings were ill-designed and ill-equipped, secretarial assistance was lacking, lists were large, there were no appointment systems, and little or no nursing or social work support.

Structure

The foundation of the College of General Practitioners³ allowed its members to tackle the problems of structure. Taylor's *Good General Practice*⁴ became a 'bible' and Collings⁵ a gadfly to be proven wrong. Better buildings and equipment, the development of teamwork, appointment systems, and the increasing development of partnership practice produced benefits to both patients and doctors. But corresponding problems of availability and accessibility arose. The new standards of general practice have been too readily accepted without proper assessment of their effect on the quality of care.

Process

With a more comfortable structural base from which to work, it was natural that general practitioners should then begin to look at 'process'. The new College acted as a major catalyst to new studies which explored the perspectives of traditional medicine, psychology, and the behavioural sciences in order to forge better models of the consulting process in both its diagnostic and interventive aspects. For the first time, specific general-

practice ideas and teaching methods began to be developed and shared.

As structure improved and process clarified, general practitioners developed skills in conceptual thinking, writing, scholarship, and a capacity for clearer causal analysis. Inevitably this led to the questioning attitude that is true science. The new methods of teaching and learning made what once had seemed simple and certain infinitely less so. Doubts were reinforced from within and from without. Sociologists, educationalists, ethnologists, better informed and more vocal patients, social workers, nurses, and a bureaucracy at last developing claws and a network of information and research departments—all seemed determined to remove some of the gloss from Medicine's more cherished illusions. Debate sharpened. For the rest of the century, medicine was to be practised in a goldfish bowl.

Outcome

General practice had moved through the stages of 'structure' and 'process' and was finally moving towards measurement, assessment, and the audit of medical intervention. The age of 'outcome' and the questioning of the use of resources had arrived. It found medicine less well prepared than its challengers.

If we are to attempt to assess the quality of care in general practice, the only feasible way to do so is by a general systems approach with analysis of each of the components of that system.

Ackoff⁶ provides a crude definition of a system as "any entity, conceptual or physical, which consists of *interdependent* parts." We are interested in those parts which display activity, that is, behavioural systems. A behavioural system may be a conceptual construction as well as a physical entity.

I try in this essay to analyze the assessment of quality of care in general practice using a set of paradigms or models. Why paradigmatic? When used in its accurate sense, a paradigm provides a useful framework when working in an area of doubt. Paradigms are not theories but patterns of thinking about research which, when carried out, can lead to the development of theory. In

constructing them with research in view, one is making a preliminary and tentative search for variables capable of evolution into testable hypotheses.

What then are the parts of the system here examined? I postulate that there are eight major dimensions of quality.

Examined first, in a position it rightly holds, are the patients' perspectives of care. The influences of traditional medical education are criticized, and new methods of education and a problem-solving process different from that taught in hospital are described. The symbolic and non-symbolic use of drugs in the process of care are examined and the uses of audit are considered. Finally, the effect of the third party and the team approach are dissected.

In the concluding section, the tools of assessment and accountability are considered and ways are suggested by which general practice may progress from paradigm towards theory in order to raise standards. Theory has one function in general practice; it is a prelude to action.

The main dimensions and attributes of quality of care in general practice

Concept 1. The effects of structure and process on care

Kaim-Caudle and Marsh¹³ have pointed out that although doctors may be aware of patients demanding too much, they are less aware of the dangers of patients demanding too little.

There is little empirical evidence of the consumers' perception of need, but one can make deductions from that which patients find unacceptable. Cartwright and her colleagues⁷⁻¹¹, Varlaam *et al.*¹², and Kaim-Caudle and Marsh¹³ have reported consumer opinion. Stimson¹⁴ has studied children's views and has argued that drug compliance gives an implicit view of a doctor's competence¹⁵. Other reports have been published by the General Medical Services Committee¹⁶, Klein¹⁷ and the Consumers' Association¹⁸.

From the general practitioner's point of view much of the development of appropriate theory comes from Balint and his school¹⁹⁻²². His work has been widely and often uncritically acclaimed; it is curiously one-sided and slanted towards the provider's view. The patient remains largely mute.

From the 'stories' of classical sociology, there is a diminishing quality of care given to the lower social classes^{7 9 10 11 23 24}. Hart²⁵ describes social class variation, but it has been suggested that doctors and their relatives are at the nadir²⁶.

Hodgson²⁷ is an assiduous critic of general practice: the "Mary Whitehouse" of nasty things in the perineum of primary care. Her criticisms are mainly of structure and she sees health centres as a serious threat to personal doctoring; she is in no doubt that general practitioners want power, dominance, and a large income.

Hodgson²⁷ and Hodgkin²⁸ point to hurried consultations, the unknown doctor provided by deputizing services, the barrier and delay created by appointment systems and the high resentment towards receptionists. Arthur²⁹ refers to the "great protection racket" afforded by deputizing services, delegation, and receptionists. Logan and his colleagues³⁰ suggest that a true consumer should have choice, based on information and the possibility of alternatives. Hodgson and Logan and their colleagues are clearly saying that the role of the patient is too passive. Fox³¹ has emphasized how lack of effective communication may underline this aspect of patient behaviour.

In the Consumer Association Survey¹⁸ the doctor's ability to create confidence was regarded as most important. Stimson¹⁵ points to the patient's anxiety as an almost constant factor. Snow³² wants his doctor to be a radical with an active speculative imagination. Platt³³ refers to the need to have a general practitioner to whom a patient can talk and in whom he can have faith. The experience of Boulnois³⁴, himself a doctor, is salutary: troubles with the receptionist, the deputizing service doctor, the specialist, and eventually the severe depersonalization of his whole family. The whole topic of discontent of patients is summarized by Klein¹⁷.

If we are to attempt to assess quality in general practice we must learn to listen and understand what our patients feel and think of the structure, process, and outcome of our work.

Concept 2. Traditional medical education: the making of blind and deaf men

However valuable a professional and socializing experience it may be, traditional medical education is related mainly to certain closed-system medical functions. Too often it is inappropriate to the open system of problem-solving in general medical practice. Too often it makes doctors blind and deaf to patients' pleas to be treated as people.

Wootton³⁵ stated that the education of the future general practitioner was a classic example of training for one job those who were destined for another. Horder³⁶ has described the defects in his own medical education. That a thorough grounding in traditional scientific diagnosis and treatment is necessary is not in dispute; there are good reasons, instinctively understood by general practitioners, for a common socializing experience for all doctors.

In 1815 the apothecaries in England were the first semi-profession to professionalize themselves in the Johnsonian sense³⁷ and it is clear that they did so for covert political, status, and fiscal reasons. The Medical Act of 1858 established a single standard for medical education and registration. In its memorandum of evidence before that Act, the British Medical Association (ever the stronghold of general practice) emphasized the need for a common education for all physicians. But science advanced, and therapeutic

intervention began to reap great rewards and great penalties for the patients subjected to its ministrations.

Control of medical education by specialists. The education of all doctors is in the hands of a relatively small group of specialists who have ensured that all medical students are subjected to a prolonged educational and social experience, designed to fit the neophyte for a life in consulting practice (despite token exposure to general practice) on horizontal captive patients within the decontaminating chamber that is the modern teaching hospital. The method of selecting medical students is increasingly done by isolating those with high mathematical skills of convergence, and by the "halo" and "Hawthorne" effect of entry-interview by specialists. Hudson's work³⁸ on the characterization of convergence and divergence, suggests that other methods are possible.

The General Medical Council³⁹ had, in 1971, only three general practitioners among its 48 members. With this minuscule minority to speak for the difficult, and different, problems of primary care the Council lays down firm guidelines for medical education.

The Dawson Committee⁴⁰ was among the first to express dismay at the disparity between the expectations nourished in students and reality. The hospital-learned virtues of affect-neutrality were doubtless excellent mechanisms for handling acute organic cases, but unhappily they are widely and inappropriately transferred to a general gestalt of distancing all sick people by labelling them as patients or cases.

The tenuousness of the illusion of equality among the branches of the profession, never very great, wore thinner. It was completely shattered by the advent of the NHS in 1948, when public policy firmly ejected the general practitioners outside the hospital walls. In the same year the Cohen Committee (BMA⁴¹) rejected the proposal that general practitioners should participate in undergraduate teaching and added (BMA⁴²) that all education for general practice should be postgraduate; thus totally ignoring the bias produced by many years of hospital experience upon all future education and practice.

Perhaps the most telling of recent attacks on medical education and its reaction to primary care are those by Hart⁴³ and Simpson⁴⁴. Hart doubts that the present imitative departments of general practice can alter the socializing process in teaching hospitals and points out the need to correct in all students a basic social ignorance. Simpson complements Hart by stressing the need for an enlightened approach as a method of tempering a self-perpetuating oligarchy and its blinkered use of the educational process in medicine. Both of them are saying that the social system of the medical school ensures a blindness to see and an inability to hear and that such defects prevent a mobilization and exchange of learning between those who come for help and those whose social function is to give it.

Concept 3. An anatomy of the problem-solving process

There is nothing that is mysterious. A mystery is only a reasonable, logical state of affairs, with the reason not yet discovered.

Bernard Shaw

Here we examine a universe of concepts from various sources, many of them empirically based, in a move to extend the current simplistic notions of the diagnostic and therapeutic process.

Theory here has but one proper function: it is a prelude to action in the assessment of the validity of process. An attempt is made to examine van der Post's *Geography and Laws* of the imagination and inner world in a move towards creating a system, or method, as a templet whereby the clinician's "subjective and within" becomes congruent with his "objective and without".

The reasoning and creative thinking in a general practitioner's mind is extensive and complex. We must try to conceptualize it to understand, teach, and assess its process. For this we need to know something of the scope and limitations of the human mind in problem-solving. If we cannot examine this function we cannot evaluate the central importance of the consultation-communication on all levels, with our patients and within ourselves.

Such an approach must be seen as an active step towards assessing the validity of diagnosis, intervention, and the prediction of outcomes. It attempts to ensure that an intellectually assessed, criterion-based diagnosis and therapy is translated into a contextual one, that is, in a single patient in his specific environment. Its objective is to humanize medicine. Kuhn⁴⁵ wrote: "The study of paradigms is what mainly prepares the student for membership of a particular scientific community in which he will later practise."

A major paradigmatic shift overtook medicine in 1940. First the introduction of 'Prontosil red', penicillin, and their successors forced us to think of the rational non-symbolic use of drugs. Secondly, the application of statistical method, especially the randomized controlled trial, influenced the assessment of outcome for the patient. Thirdly, came the causal logic of epidemiology which made us question the value of that thought-stopper—the clinical impression.

I believe that in a world of exponential change we should develop a social system that can learn how to adapt more rapidly, and we should accept the challenge of continuous assessment.

Thought process in general practice. If medicine is to continue to advance it should show a marked and very proper tendency to plagiarize and test ideas from all quarters. What debts do we owe for a heightened awareness of the function of the mind? What is the implicit or explicit logic in the reasoning process of experienced general practitioners? What search strat-

egies do we employ as we attempt to solve problems? What psychological forces are involved in the generation of hypotheses for diagnosis and treatment? Is the so-called scientific inductive method actually used by clinicians, or are more rational and honest methods of thinking employed?

There is an extensive relevant literature: on creativity^{38 46 47 48}, perception⁴⁹, memory⁵⁰, the concept of mind^{51 52}, systems thinking⁵³, mechanisms of reasoning⁵⁴ and decision theory⁵⁵. Abercrombie⁵⁶ was one of the first to assay such ideas in the assessment of medical education. Popper's⁵⁷ and Medawar's⁵⁸ defence of the hypothetico-deductive method of thinking can be seen as a ferocious criticism of inductive so-called scientific medical education, and an encouragement to medicine, general practice in particular, to have confidence in its own processes of thinking and action.

Just as the work of Pickles⁵⁹, Fry⁶⁰, and Hodgkin⁶¹ was seminal for the collection of clinical data in general practice, so was the work of Crombie^{62 63 64}, McWhinney^{65 66}, Tait⁶⁷, Medalie⁶⁸, Hull^{69 70}, Wright⁷¹, Howie⁷² and *The Future General Practitioner*⁷³ seminal in expanding and clarifying thinking on the anatomy of clinical judgement and problem-solving. Stevens⁷⁴ proposed a Kuhnian model of the use of shifting paradigms in closed and open systems in general practice.

Important aspects of the psychology of clinical judgement have been put forward by Feinstein⁷⁵, especially his application of set theory and Boolean mathematics to decision-making. One of the earliest attempts to use computer technology in the assessment of medical diagnosis and treatment was reported by Jacquez⁷⁶. Other studies have since been reported^{77 78 79 80 81 82}. Although much criticized, Weed's⁸³ work on the rational recording of data was a necessary reminder of the discipline required. His insistence on recording an explicit 'assessment' and 'plan' of diagnosis at an honest level of understanding led to the means whereby subjective and objective data might be recorded and assessed.

Concept 4. The symbolic and non-symbolic use of drugs in the therapeutic process

That a large range of drugs is rationally used in non-symbolic fashion is obvious, but, with the exception of some primitive notions about the placebo effect, medicine has largely ignored the symbolic aspects of drug intervention. This concept explores the symbolic use of drugs in conflict and control in the social system of general medical practice (Parsons⁸⁴).

Much of the medical profession's power to control³⁷ comes from its influence as a pressure group in persuading central government to legitimate professional privilege by retaining in its hands the prescription of many drugs. This control is a major source of power and conflict in the consultation.

The conflict is compounded by a wide range of variables including the control of powerful drugs, the

control of occupation in the guild sense and the uneasy truce between the apothecary-shopkeeper-pharmacist and the general practitioner, especially in rural dispensing areas. The influence of the drug industry is all pervasive. Increasingly the Department of Health and Social Security, as a much involved third party, seeks to influence and control the activities of maker, taker and giver.

The importance of symbolism looms large in the consultation. It is not surprising that every doctor commences his prescription with a sign—a defaced capital R—the incantation being “By the Eye of the Great God Horus take this substance if you are to be created whole again”⁸⁵.

There are few anthropological constants: a major one is the creation of a physician to guard both psyche and soma. He is always distanced from ordinary mortals, invested with heroic qualities, over-rewarded for social effectiveness and ferociously punished for failure.

The prescription of drugs is so integral a part of being a physician that a consultation without a prescription is a comparative rarity⁷. Jefferys⁸⁶, Dunnell and Cartwright⁹, and Cartwright¹⁰ confirm that the non-medicine taker is a deviant. Culturally there is a high expectation, and widespread mutuality and collusion, that patients will receive medicine after a consultation. The danger of this is compounded by the cost of medicaments⁸⁷ and the possibility of iatrogenic, organic, and social illness⁸⁸ lulling the patient and doctor into a passive acceptance of using drugs as a substitute for social change and the proper use of the doctor-patient relationship. Such views as these put power in the physician's hands, leaving the patient, society, the DHSS and the drug companies too docilely static.

It is difficult to believe that the attitude of the public will change. The major responsibility for change lies with the profession, who will be subject to pressure from within and from without. The outer pressure is most likely to come from university departments of behavioural science.

Balintian insights have been a major factor in influencing the understanding of the symbolic content of exchanges in the consultation and the use of the 'drug doctor'. His school has been a lone deviant voice from medicine improper, psychiatry. If the psychological aspects of prescribing have been slow in their formulation, the lack of ideas from medicine of the social aspects need hardly be surprising.

Stevens⁸⁹ has suggested young doctors should be taught to probe for the meaning behind reported symptoms. Hippocrates urged upon us three principles:

1. *Vis medicatrix naturae.*
2. *Primum non nocere.*
3. If treatment is good, treatment after thinking is likely to be better.

Investigations of drug intervention. Cartwright^{7 8 10 11}, Dunnell and Cartwright⁹ and Parish⁸⁷ have

been outstanding in the empirical investigation of drug intervention—both self-administered and physician-administered. Illich⁹⁰ has attacked the dependence of patients. Recurrent physician-burning has taken place throughout history, the consumer thus cleansing himself of dependency⁹¹⁻⁹⁸.

However, physicians prescribe a minority of the drugs patients take^{9 99 100 101}. Self-medication exists on a huge scale, and the iatrogenic morbidity produced is large. Beanland¹⁰² sees self-medication as a necessary evil and Buck⁹³ would make certain drugs more freely available. But such nostrums are too naive to effect any lasting change in the habits of medicine and pharmacy. They profoundly misunderstand the symbolism involved: that a person who is sick, or thinks himself to be sick, is sick and almost always regressive. He is not a person with normal coping mechanisms intact. When we look up and “perceive the machinery by which we have been moved” and fail to see more than the single hand of medicine on the winding spindle, we should close our political eyes and open both sociological eyes to see the flurry of multiple hands so engaged.

Cartwright¹⁰ discusses a wide range of prescribing variables which affect, and are affected by, the doctor-patient relationship; Balint and his colleagues¹⁰³ view the same phenomena from a psychological stance. It often seems that the sociologist's urge to control the physician is matched by the physician's urge to control his patient. Symptoms are so widespread and patients so different that an infinity of responses is possible, and drugs will then symbolize many interpersonal problems.

The swing of fashion and the speed with which drug companies create a ‘fit’ between new drugs and changes in human and moral behaviour further complicates drug symbolism. Parish⁸⁷ maps out the changes from bromides to barbiturates, pep pills, tranquillizers and antidepressants, as fit becomes possible with the techniques of Madison Avenue and their paid servants in the laboratory. As costs rise, so the third party, the DHSS, steps in.

Cartwright⁸ describes the mutuality and reciprocity that often goes with an exchange of gifts. Stimson¹⁵ discusses the imperatives used by physicians to describe non-compliance in patients. Balint and his colleagues¹⁰³ made a remarkable exploration in theoretical terms of the meanings to both sides in the repeat prescription situation. Deviation and default from drug-taking symbolize the negative opinions of doctors held by their patients. The seemingly innocent repeat prescription is less a form of treatment than a diagnosis of a relationship. The meaning lies surely in the patient's need to control.

Concept 5. The objective assessment of outcome: an eight-component paradigm for setting clinical standards and the basis of scholarship in general practice

In the medical world, discussion on clinical standards makes a basic assumption: that such standards refer to

“hard clinical medicine”. From a general-practice point of view, this is quite unwarranted. It is accepted here, without reservation, that clinical standards are of central importance and that, without them, we are not doctors. The discussion on other concepts in this essay is not meant to diminish in any way the central importance of clinical standards in the accepted, if somewhat narrow, sense. The integration of the other measures of care ensure the translation of the somewhat rigid algorithms of Concept 5 into a contextual form of ecological holism in an individual patient's life, which, if not the art, is certainly the artistry involved in being a personal doctor in general practice.

There is a natural history in the process of innovation which responds to a successive hierarchy of problem pressures. Previously the pressures to improve our structure were overwhelming. Quite rightly they took precedence over all other activities, but the time is now ripe to innovate by auditing our process and outcome of care for the patient.

There are a number of major problems needing solution: our records are largely unstructured—most practices have no simple technique for identifying cohorts of patients with the same problem—or in at-risk categories. We possess no skills in methods of retrieving and storing published information. Few of us have created visible explicit clinical management plans or protocols. There has been little development of specific flow sheets. We have not yet developed in ordinary non-academic practices suitable educational arrangements to ensure a vigorous and rigorous debate in our practices, amongst our peers, and with hospital-based specialists.

We have, therefore, no firm basis for the application of scholarship to our work—undoubtedly the greatest weakness of general practice today.

There are doubtless a hundred roads to Rome and a thousand ways of achieving grace. I wish to demonstrate neither. I merely wish to report for criticism a method of audit based on internally directed educational effort by a large group of Suffolk general practitioners. It is one possible framework for setting and maintaining reasonable clinical standards in the rough and tumble of ordinary, overworked general practice. I like the word ‘reasonable’ with its feeling of being sensible and rational but at the same time not asking too much. We have in our practice a large notice which we apply every day to all we do in our clinical and educational work. It says quite simply: “To Hell with Islands of Excellence; the excellent is the major enemy of the merely good!”

Our concern has not been with the vocal five per cent who inhabit the marble halls and ivory towers of centres of excellence, but rather with the great silent majority of reasonable men and women sweating out their guts in the nurture of others. How can those of us in non-academic practice help ourselves? There are, I believe, eight components of a paradigm for setting, auditing, and maintaining some simple clinical standards in general practice. We have found after many years of

difficult labour (I hesitate to call it research), that there is a reasonable, rational system of proceeding with safe internal practice audit and validating our methods of safe peer and consultant review in our postgraduate centre and in the Ipswich vocational training scheme.

What then are the eight components we need as a basis of scholarship?

1. *Records.* Clinical records are at the centre of the problem of the assessment of care¹⁰⁴. The institution of unstructured A4 records would be little short of a national disaster. A well tested modified problem orientated medical record which employs the traditional paper size exists¹⁰⁵.

A problem orientated medical record requires six sections: a problem list; screening and immunization data; demographic data; a record of drugs; SOAP continuation notes; and a questionnaire completed by the patient.

2. *A practice library information, storage and retrieval system.* De Alarcon's method¹⁰⁶ of keywords is admirable and needs to be supplemented only by a well-stocked library in the practice.

3. *A modified disease index.* This is a simple method of recording only patients with problems which the practice intends to audit over a prolonged period.

4. *Clinical management plans (CMP).* Created at an honest level of understanding, such protocols should tolerate an analysis by Jefferys's criteria, i.e. that they should contain "explicit, measurable consensus objectives or desired outcomes" which individual practices wish to assess. These may be in narrative, table, or algorithmic flow-chart form which depict the pathways of clinical or organizational decision-making. Only internally generated management plans which are checked by peer review are likely to prove valid and reliable instruments. General practice should approach such standard-setting mechanisms with as much vigour as those who conduct external audit.

5. *Flow sheets.* A flow sheet is a system of tabular or graphic recording of data which enables a rapid monitoring of a particular parameter or cluster of related parameters or relationships.

6. *Specific practice educational meetings.* An hour a week is enough. The ground rule should be that practice management is never discussed at the meetings. It has the strongest tendency to creep in at all times.

7. *Re-arrangement of educational activities in district postgraduate centres.* There is certainly an important place for experts giving formal lectures, but our postgraduate centres in the districts should be, in the main, places for rigorous debate about real clinical problems. They should be the place where clinical management plans evolved in practice audit are

presented in semi-external audit before one's peers, trainees, and involved and interested hospital staff. This is an essential check and balance to good practice.

So far in Ipswich ten different practices have audited, and presented audits for criticism to audiences averaging 40 to 50 doctors on hypertension, diabetes, thyroid disease, lower limb ulceration, pyrexia of unknown origin, delay patterns in the diagnosis and treatment of malignant disease, postgastrectomy problems, surveillance of the elderly at home, and problems of backache. It is our hope in the new academic year to establish a district management plan for the care of our 2,500 diabetics. If this proves feasible I believe it will be the most exciting educational experiment of the decade.

8. *Overriding importance of individual care.* That there should be a clear recognition that all of the above do not absolve one from the "criterion versus contextual problem"; that is, that however explicit the criteria for management of a certain problem may be, it is provisional only, and will always have to be adapted to the practice of a particular doctor endeavouring to help a particular patient in the context of his own life and problems other than that under review. This is the practice of personal medicine which is at the very centre of the problem of quality.

These, then, are the eight essential tools for creating, monitoring, and assessing clinical standards and patients in particular at-risk categories. By using similar paradigms of assessment, successive generations will be able continuously to update the natural history of disease in the community following in the wake of Fry's⁶⁰ pioneering studies. McWhinney¹⁰⁷ puts it thus: "As an educational experience a good system of medical audit is worth any number of postgraduate courses".

Crombie¹⁰⁸ and Stevens¹⁰⁹ previously suggested similar mechanisms for the construction of clinical standards and their audit, and Irvine¹¹⁰ and Taylor¹¹¹ are working on similar lines.

Concept 6. Politics and pressure groups

The methods by which the medical profession seeks to influence government reflect the methods employed by society, through its political structure, to control medicine. To effect change, those outside a structure have no other option than to institutionalize themselves as a pressure group. Eckstein¹¹² has said that if pressure groups did not exist they would have to be invented.

To put the question into context, I intend first to examine briefly the social structure from which pressure groups spring; then to examine the British Medical Association as typifying the social system of a single pressure group; and lastly, to examine the role of the Royal Colleges as an example of an important sub-pressure group and the political utility of pluralism.

In our society social democracy is a product of the main political forces; the common ground of theory between Left and Right. Party government is the major

theme and functional representation the minor theme.

In an increasingly technological society the government must have access to pressure groups in order to function. Depending upon the type of crisis, the government can call upon groups of producers or groups of consumers for support—the former via direct contact with the executive, the latter via parliamentary representation.

In the UK, there are four structural elements in the political system. Each represents the four main phases of policy-making at which group influence may be felt: the electorate, the legislature, the party, and the executive. To be effective, a pressure group must represent those it claims to represent; factions will diminish its power. The greater the degree of central control, the greater, paradoxically, must be the degree of consent and participation by interest groups.

Eckstein¹¹³ points out that the BMA is an indispensable provider of political services to the profession. That this function only followed structure is illustrated by the formation of the BMA's first medico-political committee in 1903, 70 years after its formation, as a result of increasing government concern with medical matters. The attempt to change structure after the Chambers Report¹¹⁴ was intended to present a united front to the government by abolishing the General Medical Services Committee and the Central Committee for Hospital Medical Services, but was unsuccessful.

Although the BMA holds the premier position as a medical pressure group, there are other influences. Medical groups exist in Parliament and small groups exist to present a particular point of view, for example, the Socialist Medical Association, the Medical Practitioners' Union and the General-Practitioner Hospitals Association. Other influences emanate from the DHSS and the Central Health Services Council. The latter often exude the odour of the contract research and have a curious habit of buttressing current ministry ideology¹¹⁵⁻¹¹⁸.

Sources of professional advice and pressure. In the post-war period, professional advice and pressure has come from three principal directions: the 'executive' committees throughout the service, hospital management committees and 'cogwheels' (DHSS¹¹⁹), and from local medical committees. While the latter are in reality an extension of the BMA, the former carry out the ideological consensus of the Royal Colleges. The influence of the consultants in regional hospital authorities and medical executive committees has been enormous, seldom innovatory, but maintaining the *status quo* of dominance, the 'sacred' bed, and the powerful satrap capacity to drain whole ransoms to realms against the public interest^{120 121}. The major intention of NHS reorganization is to curtail such influence; no doctor will in future influence strategic DHSS policy^{122 123}, but will be limited to tactical dog fights for limited resources in the district management team.

The BMA has all the stigmata of a successful pressure

group: political skill, representational density, prestige, a large income, and effective articulation with the DHSS. It produces its trade union shadow—the British Medical Guild—to rattle the sabre of resignation at intervals¹²⁴. In exchange for the massive triumph of the socialization of a whole profession society has agreed, in the name of détente, to titbits of professional freedom on the conditions and terms of service, the independent contractor status, and freedom from local authority rule.

To follow the lines of communication within the NHS is to be led to the loci of power. They have been carefully traced by Stevens¹²⁴. The BMA structure reflects its 'artisan' origins: the apothecaries¹²⁵ versus the gentlemen—the physicians¹²⁶. Predominantly, it represents the general practitioner through the GMSC. The CCHMS is a marriage of convenience to maintain the myth of solidarity and for the élite to keep an eye on the peasants. With a separate junior hospital doctors' committee within the BMA, the Junior Hospital Doctors' Association will increase latent conflict and tension. General practitioners have fired their warning shots—lower differentials, abolish merit awards. Irvine¹²⁷, in arguing the need for the Royal College of General Practitioners to have a Royal Charter, has stated that such provision would mean that the College would have to be consulted on all relevant problems. This accords with the central policy of articulating with a major pressure group¹²⁸.

Finally, we come to the influence of the Royal Colleges. Their absolute co-operation was politically vital to the implementation of the NHS and was obtained at the price of a regional structure with disproportionate consultant bias, a well-paid career structure, and the right to private practice. The Royal Colleges augment their many influences via the General Medical Council^{129 130}, comprised of five general practitioners and 36 specialists!

Although the many ways in which the medical profession seeks to influence government seem to be concerned primarily with status, education, and professional freedom, they all affect NHS policy. In the words of Abel-Smith, "No subject is more perilous for politicians than the organization of health services." One might add for consumers as well!

For general practice to assess the quality of care, it must have a thorough knowledge of the machinery of administration, and the freedom to negotiate a political system likely to foster happy doctors of high morale. They will always practise higher standards than those who are sad and demoralized. To assume that medicine can be apolitical is unrealistic. There are many who would abolish our independent contractor status. Its abolition would inevitably erode the quality of care we give.

Concept 7. The assessment and evolution of education for an open learning system

When general practice institutionalized itself in col-

legiate form in 1950⁹ it wisely chose education as its central function. Its stated aim was by educational means to encourage, set, and maintain high standards of care in general practice. The progress towards achieving these aims must astonish the founders of the Royal College of General Practitioners and their successors.

There are now more than 170 vocational training schemes in the UK. Each has had the problem of creating educational objectives and new teaching methods, exemplified in the experiences of one such scheme with which I have been involved.

Each trainee entering the final year of the Ipswich Vocational Training Scheme has completed a minimum of three years in hospital. The aims and objectives of the scheme have been described elsewhere¹³¹, and during a period of eight years the scheme has evolved several distinct learning/teaching structures. These are: random case analysis; the construction of clinical management plans and algorithms; project teaching; and a modified Balint sensitivity group.

Throughout the scheme there is a basic assumption that an active, prolonged and disciplined examination of all the eight concepts described in this essay will enable the trainees to give high quality care and have the capacity for self-assessment. At no time is the central importance of clinical practice forgotten, and great weight is placed on postgraduate work in medical wards, as the best single predictor of ability to giving better care¹³².

Concept 8. The assessment of team work

The literature on the health team is now large, but its assessment is largely anecdotal and uncritical. It has been extensively reviewed by Marsh and Kaim-Caudle¹³³ and by Brooks¹³⁴.

This section considers briefly contributions from various team members, the relationship of group dynamics and architecture to team care, and the major theoretical facts likely to affect quality of care.

Marsh and Kaim-Caudle describe the effects of maximum delegation of care. It was predictable that non-doctor members would be pleased to accept more clinical responsibility, that patients would be happy, and that on cost-effectiveness grounds the State would be pleased. It is doubtful if the ice of its findings will bear the weight of its conclusions.

David¹³⁵, Sowerby¹³⁶, Stevens¹³¹, Batten¹³⁷ and Bashford¹³⁸ have stressed the dangers of diluting the personal doctor/patient relationship. Brooks¹³⁴ suggests measures for the assessment of the health team, and two excellent summaries of nurse and health visitor views have been published¹³⁹. Not all general practitioners are as thoroughly enthusiastic as the nursing profession in believing that preventive and curative/caring aspects should be separated. The DHSS¹⁴⁰ and the BMA¹⁴¹ make pleas for a generic nurse to limit dilution and improve communication. Goldberg and Neil¹⁴² put well the case of social work. Forman and Fairbairn's

classic¹⁴³ gives a balanced account of the problems of teamwork and their solution. Jefferys¹⁴⁴ ¹⁴⁵ takes the viewpoint of sociology and dissects the relationship of doctor prestige and status and the effect of the team on these important elements.

Need for objective assessment of teamwork. Any attempt to assess the effect of 'other' professional intervention on quality of care in general practice needs to be empirically tested by a theoretical construct. A considerable amount of work exists on group dynamics. Many are of relevance to our theme¹⁴⁶⁻¹⁵⁰, and Grene¹⁵¹ has made a plea for such application. Crombie's¹⁵² work is outstanding. The works of Balint, and Browne and Freeling²¹ have sensitized general practice to the ubiquity of collusion and symbolism in what may at first appear to be a simple transaction.

It is not suggested that professional team members should work in isolation, but we must bear in mind that there is almost no good evidence on studies of 'outcome' that assess the value of team intervention. Nor do we know what the size, task, or composition of the team should be.

In general, major decisions are more often made subjectively, rather than as the result of measured empirical judgement (empirical evidence is tentative, no matter how strong)—choosing a spouse for example. The value of subjective assessment and imagination have equally valid claims. When considering the effect of behavioural variables on the quality of care, a typology embodying these factors needs to be constructed.

We should consider the effect of behaviour on the team as Crombie has suggested. We should consider the different behaviour of 'convergers' and 'divergers'. Fox's¹⁵³ cogently argued case for the centrality of personal care will find few echoes among team members whose interests lie in population or administrative medicine.

The use of nurses to undertake general practitioners' tasks has reached an advanced stage in the USA¹⁵⁴ ¹⁵⁵. The *Lancet*¹⁵⁶ finds this country apathetic and the BMA report on the primary health care team curiously inappropriate. It seems unfortunate that the writer of this editorial had not seen the following description of the pinnacle of American nursing¹⁵⁷:

"The modern professional nurse is so highly trained that all she wants to do is sit looking at an oscilloscope in a coronary care unit. Her reluctance to carry out what most persons regard as her duties has exasperated the medical profession . . . the [nurses'] obsession with status . . . has brought into existence a rival group of health workers . . . Meanwhile the standard of nursing care has deteriorated."

Current discussions of instrumental and expressive needs in regulating patient autonomy need to be considered¹³⁹ ¹⁵⁸. We should pause before seeking simplistic measures of care when the care of a distressed person or family is shared among many. We should listen to the voice of the consumer placed as Concept 1 to emphasize its core position.

The tools of assessment and accountability

Current instruments of assessment and accountability are blunt for work in a forest of intervening variables; their measures must be balanced by the need to explore and assess with imaginative understanding the inner meanings and motivations which impel the generality of doctors opting for primary medical care. The unique understanding possessed by experienced general practitioners of the phenomena of general practice needs to be shared with behavioural scientists using the language, skills and methodology of social research to help to develop paradigms in the field of quality of primary care.

Hunt³, the *Lancet*¹⁵⁹ and Marson and his colleagues¹⁶⁰ have shown the remarkable effects on a profession of outside critical provocation, causing it to renew its capacity for self-criticism. There can be little doubt of the beneficial effect of the classic voyeurs: Collings⁵, Honigsbaum¹⁶¹, Jungfer¹⁶², Taylor⁴, Clute¹⁶³, Peterson¹³² and Hadfield¹⁶⁴. The effects of Cartwright, Jefferys, Freidson¹⁶⁵, Tuckett¹⁶⁶, Zabarenko *et al.*¹⁶⁷, Somers^{168 169} and Klein^{17 170 171} have been more subtle and pervasive.

The patients' representatives are becoming more accurate, disciplined, and effective in their assessment of quality from their perspective^{27 172 173}. A few courageous general practitioners have taken steps towards encouraging participation by patients¹⁷⁴.

From the point of view of general practice, the contributions of Fry, Crombie, Watson, and Pinsent have been outstanding. Many research projects from general practice are catalogued¹⁷⁵ and audit is mentioned increasingly in the UK^{109 176-181} and in the USA^{83 182-188}.

Lateral thinkers of the medical scene have presented their views on the fallacy of traditional perspectives^{25 43 90 189-193}.

The RCGP has not been unmindful of the difference between words and deeds, and the assumption that formal examinations reflect standards of care has not been shared by all its members¹³¹. Considerable effort has been devoted to ensuring that the membership examination is a valid and reliable instrument¹⁸⁰. Objectives for good care have been promulgated^{73 194}; the learning of trainees has been measured^{195 196}; and external audit and periodic recertification has been reviewed^{197 198}.

The DHSS has increasingly seen its task as one of tighter control of the behaviour of doctors and expenditure and has set up an intelligence service of research units to assess quality of care which are staffed by specialists in social medicine and health economics. *Health Trends* and the many publications of the Nuffield Provincial Hospital Trust are evidence of their industry and direction.

Paradigms are models, patterns, and ways of thinking about research that can lead to the development of theory. They derive their usefulness from their very generality. In constructing them one is making a

preliminary and tentative search for variables which are capable of evolution towards testable hypotheses. These hypotheses should be contained within any general framework that attempts to assess the quality of care.

This essay attempts to move towards a holistic view of a complex dialectical set of relationships. The main objective has been to provide a primitive first analysis that makes some sense and can be communicated to others.

Observation by participants should be an essential tool in the study of doctors and patients. We need further longitudinal studies of the effect of the extended consultation¹⁹⁹⁻²⁰¹.

The light that sociology can shed is too often refracted by a curious lack of historical and anthropological insight^{202 203}.

Characteristics of the medical generalist

There are three inescapable imperatives which dominate the medical generalist. His attempt to integrate them make failure a pervasive, threatening, painful, and ubiquitous element in his daily life. If he wishes to give a good standard of care, he has no alternative but to understand organic disease and the traditional process of care, but, in addition, he needs understanding of the patient's illness and his ecosystem, understanding of himself and of the symbolic use of drugs.

A monumental omission in the literature of sociology is the almost total lack of studies of the real person—not the faceless enigma—of the family physician. From the doctor's viewpoint the silence on the inner meanings is deafening. The assessment of care is, less than half complete if we fail to assay a principal actor. If this seems too sensitive and paranoid an impression, a brief reading of Honigsbaum¹⁶¹, Freidson¹⁶⁵ and Tuckett¹⁶⁶ should provide a corrective.

This essay was constructed on paradigmatic lines; within such confines a writer is entitled, indeed expected, to speculate imaginatively towards a theory. A major missing link is the norm of the primary physician.

Perhaps the oddest characteristic of the male doctor (and 90 per cent of generalists are male) is his voluntary assumption of the caring nurturative female role. *Cum scientia caritas* (science with tender loving care) is the proud motto of the Royal College of General Practitioners. This role is emphasized by many^{36 67 137 204-209}. At every annual general meeting the beloved physician, Sir James MacKenzie, is recalled and revered in the lecture of that name. Not to stress the central caring role of the family doctor at this tribal gathering would be unthinkable and unforgivable!

A paradigm to explain the social behaviour of a general practitioner would seem to be constructed best on the assumption of introjected nurturative female meanings to the actor. When fantasy and reality coincide we are either mad or in a fortunate paradise. In putting these paradigms to the test of theory I suggest that the flexible methodological instrument devised by

Brown and Rutter²¹⁰ would be useful, but agonizingly difficult.

The skills of the behavioural scientist will be needed, but we do not need to wait. The concepts described in this essay can be explored now by all of us. We can improve the quality of care in our own practices by sensitizing ourselves to their existence. As Max Rosenheim said: "If medical research were to stop now, we could still make great progress through the next 20 years by merely securing full application of present knowledge"²¹¹.

General practice has taken enormous strides, but we must learn to do more. We must listen to our patients, develop a more rational and logical clinical judgement and become more aware of the symbolic use of drugs. We must become unafraid of internal audit. If we are to preserve the freedom to innovate we must don the horsehair shirt of politics and continually re-evaluate both undergraduate and postgraduate education and the organizational and architectural structure of general practice. All these activities should do nothing to shrink, but rather accentuate the dignity of the patient and all who work in general practice.

It has been the immense labour of post-war generations of general practitioners to improve the quality of care by improving structure and process. From this platform the trainees of today will shape the measures of quality of outcome for the patient of his, and his team's, intervention. They are more fortunate than we are, for their work will thus bring them closer than we can ever be to the very centre and purpose of the practice of medicine.

I hope that this essay may add, in the smallest measure, to the current ferment of ideas in the assessment of quality of care in general practice. It can be assessed; with increasing energy we must refine and develop better instruments for the purpose. To do these things will be difficult; not to do them should be unthinkable.

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