Why standards?*

H. W. K. ACHESON, OBE, FRCGP
Senior Lecturer, Department of General Practice, University of Manchester.

SUMMARY. My experiences of growing up in a general practitioner's home and practice led me to want to be a general practitioner myself.

The early 1950s were critical years for general practice. Three developments—the foundation and work of the College, the introduction of vocational training, and the development of postgraduate medical centres—have led to its revival.

The next main change may well be the interest in, and development of, clinical standards. In my opinion this ought to be done by general practitioners themselves rather than by society via the Ombudsman.

Introduction

WHEN I became a general practitioner in the early 1950s, my knowledge of general practice, and all that it meant, was based upon observations of my father's work. Living in a house where the drawing room had become the waiting room, the breakfast room had become the surgery, and the old cloakroom off the hall had been converted into a dispensary, it was difficult to avoid being involved. It was a family affair. My mother did the accounts, our housemaid was the receptionist, and my sister and I were frequently pressed into service as messengers.

I remember one occasion when my father emerged from his consulting room with the instruction to go at once and get two ounces of Smith's Mixture. I set off on my bicycle to the nearest chemist, who said that he had none in stock. The next chemist said he would order some which I could collect next day—an offer I declined being mindful of the urgency of my father's request. The third chemist searched all his books and wholesaler's lists but could find no mention of it. "My father is a doctor," I said, "and knows what he wants. It must exist." My errand so far being fruitless I returned home to admit defeat, only to be told it was tobacco he wanted!

In this and other ways my vocational training for general practice had begun almost before I left school. I came into contact with many of the problems of general practice by living with them. I met many of the general practitioners in the neighbourhood and listened avidly to their conversation, nearly always about medicine and medical politics, and was involved frequently in the social occasions when a consultant was 'called out' on a domiciliary visit, being enjoined to be on my best behaviour and to wear my best suit. What I saw and heard never altered my resolve to become a general practitioner.

At medical school I was fortunate to have good teachers with a high sense of clinical responsibility who indoctrinated me with the view that, whatever the specialty, it was clinical acumen that mattered, or as one of them put it, "clinical gumption", and that this could not be achieved without a wide knowledge of medicine and a wide knowledge of people: what is now called human behaviour.

When I became a general practitioner my knowledge and skill were limited by my experience, but my attitudes had already been influenced by the teachers with whom I had had the good fortune to come into contact. It was therefore with something of a shock that I discovered that the standards of general practitioners varied so widely.

Difficulties in general practice

The 1950s were a difficult time for general practice. The newly formed NHS had unleashed demands for 'free' medical care, 'free' medicines, and 'free' corsets, which general practitioners found difficult to meet. The division of the profession into hospital doctors, the élite, and the rest was having a stultifying and demoralizing effect.

*This article is based upon an address given at the symposium on Standards and Settings in General Practice, held at the time of the Annual General Meeting of the Royal College of General Practitioners, November 1977.

© *Journal of the Royal College of General Practitioners,* 1978, **28**, 692-695.

Fortunately the dangers were recognized. In 1951 John Hunt and Fraser Rose wrote their now famous letter to the *British Medical Journal* and the *Lancet* and 25 years ago the College of General Practitioners was founded.

The influence of the College, often despite opposition, has been largely instrumental in the development of general practice, a branch of the profession to which we are proud to belong. The renaissance of general practice had begun.

Isolation

The nature and structure of general practice present difficulties which are not shared by other branches of medicine. Most specialists are hospital based and work in institutions to which patients go or are taken. They daily rub shoulders with colleagues from many disciplines which gives them the chance to learn of advances in these disciplines and to discuss their relevance to their own specialty.

General practitioners are found where people are, distributed among them singly or in small groups in relative isolation. They have few opportunities for discussion with colleagues from other specialties.

The loose structure of general practice, compared with the more compact cohesive structure of the hospital-based specialties, presented a problem to the founders of the College. They recognized that general practice needed an organization that was based locally and with which general practitioners could identify. They therefore proposed a structure of regional faculties with central representation and the faculties began to be involved locally in many educational and research activities.

In those early days it was evident that if the standards of primary medical care were to be improved a great deal of educational activity would be needed and the faculties set about this task. Many successful symposia were held on topics of current medical interest, some of them attended by hundreds of enthusiastic general practitioners. However, even this valuable contribution was not enough. Opportunities for continuing education were few. Courses, when they were held at all, were often at remote centres and attendance usually meant a few days' absence from the practice which was often difficult to arrange. Even the regional faculty organization was too remote for most general practitioners and because of the problems of time and distance, frequent meetings were impracticable. A sense of personal identity with educational facilities did not develop.

Postgraduate medical centres

In the 1950s I was practising in Stoke-on-Trent where there was an active and thriving medical society and it became apparent to me and a few colleagues that something different was needed, something that was both local and tangible with which all members of the medical profession could have a sense of personal identity. A building was needed where all members of the medical and paramedical professions could meet for study and social discourse and to discuss medical problems. We envisaged an educational and research centre which would have the proper equipment for educational activity, a library, and facilities for private study. This would operate an active educational programme for all branches of the greater medical profession where formal and informal interdisciplinary contact would be encouraged. In this way the first of the modern generation of postgraduate medical centres, the North Staffordshire Medical Institute, was conceived and founded.

Funding

How it was to be paid for was another matter. When we first contacted the Department of Health and Social Security (DHSS) they were not able to provide finance although they encouraged the idea; and medical charities and foundations felt that the project would not be an appropriate use of their funds. So the money was raised locally, from the profession, industry, and the people of North Staffordshire. A registered charity was formed and an appeal committee set up. Later we received a generous interest-free loan from the Nuffield Provincial Hospitals Trust for £50,000 which was repaid as donations were received and which enabled building to commence earlier than expected. About £110,000 was collected. The centre opened in 1963, the official opening being performed a few months later by Sir George Godber, then Chief Medical Officer of the DHSS.

That the need for a truly local interdisciplinary educational centre had been correctly identified was demonstrated by its subsequent success and the rapidity with which the idea spread. We received visits and enquiries from far afield and postgraduate medical centres are now a normal part of the medical scene. Although they have developed largely independently of the College, I can affirm that it was the influence of the College that helped to generate the idea.

The provision of local educational facilities was not enough on its own. What standards should they aim at? What type of educational activity was needed? In short, what level of knowledge should general practitioners strive to attain? The Royal College of General Practitioners, through its support of vocational training, the establishment of the MRCGP, and countless other activities, has been influential in this respect.

I believe the three innovations of the last 25 years likely to have the greatest permanent influence upon general practice are first and greatest the founding of the College of General Practitioners; the other two might be the acceptance of vocational training for general practice and the establishment of postgraduate medical centres. These three have provided a structure

within which postgraduate and continuing education, and much else, can flourish. What will be the fourth great influence?

Clinical standards

The goal towards which we continually strive is the improvement of the standards of general practice. The last 25 years have shown an effective change. The framework has been provided. We must now examine closely the standard of clinical work within that framework to see whether the educational structure that has been created is producing effective results and whether it can be improved. Clinical standards must be examined, which is an exercise that could well become the fourth great influence upon general practice.

The term 'clinical standards' is often associated with the spectre of audit. Audit is regarded as a threatening procedure to be resisted and, by circumlocution, the examination of clinical standards is regarded also as threatening. The threat is that of having actions exposed to scrutiny and, by implication, to judgement.

Why should discomfort be felt when clinical standards are mentioned? Many hypotheses could be suggested. Perhaps the primary one is a desire not to be found out: an attitude of mind more applicable to childhood, when to be found out was often physically unpleasant, than to professional maturity.

Another reason may be a tendency for general practitioners to regard themselves as free to act as their judgement dictates and to deny to anyone else the right to question that judgement. Strictly, this has never been quite true. Our actions and judgements have always been under some degree of scrutiny: by the processes of common law, by the General Medical Council, and through its disciplinary procedure by the NHS. 'Big brother' has been around for a long time—not always motivated by brotherly love.

A profession, by definition, governs its own standards by controlling the level of knowledge required to join it and by supervising the standards, albeit at present mainly ethical, of those who are members of it. A profession which fails in this duty runs a risk of ceasing to be a profession. Surely general preactitioners as a body should be as much concerned about standards of clinical care as standards of ethics and the qualifying examination.

Secure in the belief that the medical profession will act only in the best interests of patients, society has regarded it with trust and confidence and given to medicine a special position. This position and our right to independence will continue only so long as society regards the standard of medical care and ethics, and all that they imply, to be worthy of trust. There are signs that society may be beginning to question whether this is so and whether it is getting value from the £6,000 million it is costing to run the Health Service each year. If society believes that its trust and confidence is misplaced it may attempt to impose additional outside controls. Perhaps we can already discern a trend in this direction.

Ombudsman

In 1976 Barbara Castle, then Secretary of State for Social Services, announced that the Government was to investigate ways of extending the powers of the Health Service Ombudsman to cover clinical work. Recently we have learnt that a Select Committee of Parliament has recommended that this should be so. No doubt 'case law' and built-in safeguards will determine how the Ombudsman will operate. However, the message is plain: there will be another body empowered to investigate clinical judgement.

From which point of view will the Ombudsman make judgement? That of the patient or that of the doctor? We all wish to have satisfied patients but there are times when the patient's interest is best served by not satisfying him or her. Such a decision must be reached only on medical grounds. It is a matter of professional judgement. There are dangers in taking too literally the modern tendency towards patient satisfaction, and the danger is principally to the patient.

Professional responsibility

Unless our work is of such a standard that our patients and society feel confident to place their trust in us, some degree of scrutiny from outside will be inevitable. If *we* do not examine our own standards; if we are not constantly self-critical, both individually and as a profession, society will attempt to impose greater control and in doing so will believe that it is acting in its own best interests.

I have always maintained that good general practice is the most difficult and demanding job in medicine. It requires a broad knowledge of medicine and human behaviour, and the greater his knowledge and skills the better a general practitioner can serve his patients. The converse is also true: if knowledge and skills are deficient the service given to a patient may prove to be a disservice. We must continually be examining and re-examining the standards of knowledge, skills, and attitudes that a competent general practitioner should possess. We must be prepared to discuss our actions and judgements with our peers and learn to give and receive constructive criticism. Education brings about learning. Learning ensures that we know what to do. If we do what we know we should do, we should be willing to allow our colleagues to judge our actions.

Defining standards

I do not hold the view that medical audit is an end in itself. I am not even sure that a comprehensive system of medical audit can ever be devised. Some things can be examined to see how they may be improved or to find out whether there is a better way of doing them; and if

there is a better way, why not use it? In making this type of judgement the action is being compared with a criterion which represents the better way. The criterion, if widely accepted and based on the conventional wisdom of medicine (Irvine, 1976), may be regarded as the standard to be achieved.

Standards, so created, cannot be absolute nor immutable. They will change as medical knowledge advances and their application may have to be varied according to the circumstances and needs of the patient. If, however, a standard is not reached it should be possible to give acceptable reasons for failing to do so. Equally, a standard must fail which favours a treatment in the face of a newer better one.

Good clinical standards may be defined as follows: "Good clinical standards are the standards of professional knowledge, skills, and attitudes expected of a physician in the light of current medical practice and his status in the profession." The two essential ingredients of this definition are that standards cannot be static and that they will vary with the degree of specialism professed, a concept recognized in courts of law.

Standards can be created only in relation to what is known and the resources available. Change must not only be possible; it must be made easy whenever advances in knowledge dictate, or when resources increase or change. Many believe, for example, that geriatric care should not be provided in separate hospitals. It is now known that amphetamines have only a limited place in therapeutics (I wonder whether tranquillizers will go the same way?). Perhaps standards can state more easily what should *not* be done than what should be done.

The process of care

I have referred elsewhere (Acheson, 1975) to the problems of creating criteria for standards in general practice and the principles underlying their description. Donabedian (1966) has indicated that audit and the examination of medical care should proceed in relation to structure, process, and outcome. It is to the examination of the process of care that we must now turn. What information do we require, what alternative plans are available for the management of a patient's problem, and what factors should govern their selection? As a result of this exercise we can set criteria for standards.

The next step is to test standards in practice, to find out whether compliance is feasible and whether it has any effect upon other aspects of care, such as preventive medicine or the presymptomatic detection of disease. Does the situation and geography of the practice make any difference to the application of a standard? The answers to these questions depend upon examining the process of care and other factors which influence it. Education and the assimilation of new knowledge is relevant. The most effective way to raise standards would be to ensure that all physicians were well educated in modern medical practice and able to put their knowledge to effective use.

It would be impracticable, and in a profession worthy of the name unnecessary, to arrange periodic re-examination or re-certification on a national basis. What is needed more is an organization geared to disseminating new knowledge, to provide the means for self-assessment and remedial learning material. The new MSD Foundation has the resources and the opportunity to meet this need for the first time.

Many issues are involved, some of them complex. For the moment we must continue the debate, discuss our ideas with our peers, and examine our differences, striving always to improve the quality of care in general practice. It is upon this that our standing and integrity as a profession will depend. Not all of us can be chiefs but we can all try to be good Indians.

References

Acheson, H. W. K. (1975). *Lancet,* **1**, 511.
Donabedian, A. (1966). *Milbank memorial Fund Quarterly,* **44**, 166.
Irvine, D. (1976). In *A Question of Quality?* Ed. McLachlan, G. London: Oxford University Press for Nuffield Provincial Hospitals Trust.

Depression and loss

Recent losses occurring in the two years before the onset of depression in women are distinguished from past losses occurring at any time before this. Of past losses only the loss of a mother before the age of 11 is associated with a greater risk of depression, both among women treated by psychiatrists and among women found to be suffering from depression in a random sample of 458 women living in London. The past loss of a father or sibling before the age of 17 (or a mother between 11 and 17), or a child or husband, is not associated with a greater chance of developing depression. However, among these patients all types of past loss by death are associated with psychotic-like depressive symptoms (and their severity) and other types of past loss with neurotic-type depressive symptoms (and their severity). It is argued that these associations probably reflect direct causal links, and a sociopsychological theory to explain them is discussed.

Reference

Brown, G. W., Harris, T. & Copeland, J. R. (1977). *British Journal of Psychiatry,* **130**, 1-18.