AUDIT 2

Maintaining standards of primary care in America

K. A. SNIDER, MRCGP, DCH, DRCOG, DTM&H

Clinical Instructor, Department of Family Practice, University of Iowa, USA; Associate Director, Siouxland Medical Education Foundation, Sioux City, Iowa, USA

SUMMARY. The evolution of present day attitudes toward maintaining standards of medical care in the United States is described, and the main methods identified. Their influence on current practice is discussed, and application made to the promotion of high standards of care in British general practice.

Introduction

I die by the help of too many physicians

Alexander the Great

CONCERN over the quality of medical care, like most things, is not new. That patients throughout the ages should have expressed concern about the quality of care provided by physicians is understandable, and it is to the credit of the profession that this aspect of its function has long been considered worthy of scrutiny and protection. In Britain acceptable standards of care were defined and regulations to support them introduced in the middle of the last century with the formation of the General Medical Council. While these standards were mainly ethical in character, they did influence clinical standards indirectly through regulations governing approval of medical schools.

A similar concern about quality existed in the United States at the turn of the century. One of the most forceful characteristics which has shaped that nation is an aggressive self-sufficiency, which is probably responsible for the pride in independence and determination to succeed which are seen in many sections of American society. One of the results of this attitude was an excessive number of 'doctors' who were practising with few qualifications other than their own wits, and over whose standards there was little control. In 1910 Abraham Flexner published his study of medical education for the Carnegie Foundation. As a result of this report, many medical schools of questionable repute closed, and a new emphasis was placed on adequate scientific instruction based on a strong academic foundation. While this had the desired effect of lowering the physician/population ratio while at the same time increasing the standard of available care, it also had the effect of producing a redistribution of physicians within the community and an increase in the amount of specialization, as more physicians trained at centres of academic excellence and then entered specialties within range of needed diagnostic and therapeutic facilities.

In association with this movement within the profession there grew an emphasis on maintaining the improved standards by means of procedures for monitoring levels of care, a feature of practice which is accepted as integral and necessary amongst those who practise in the USA today, but which is still looked upon with suspicion and discomfort by many physicians in Britain.

Aim

I wish to describe and examine some of the methods used in the United States to maintain and encourage high standards of care, and to relate these where applicable to British general practice to try and identify those aspects in which similar methods might apply.

American practice

In the United States the term 'primary care' is taken to include paediatrics and general medicine as well as family practice. Physicians see patients in their offices and also admit patients to hospitals where they continue to have responsibility for their care. Domiciliary care comprises a very small part of practice and is now almost absent from most physicians' work. Mainly because of the structure of medical practice in the United States, and also for administrative reasons, methods of monitoring standards of care focus largely on hospital practice, although increasing attention is being given to the ambulatory care setting.

Esselstein (1958) has suggested that "Standards of quality of care should be based on the degree to which this care is available, acceptable, comprehensive, continuous and documented, as well as on the extent to

© *Journal of the Royal College of General Practitioners*, 1979, 29, 712-718.

which adequate therapy is based on accurate diagnosis and not on symptomatology". Whether American or British practice might be said to be of the higher quality by these criteria is open to debate; in terms of availability and continuity of health care (and some would say also in terms of acceptability) British practice might be considered more favourably than American. Marsh and colleagues (1976), in their study of the clinical content of general practice in Iowa and in North East England, showed that there was little difference in the age structure of patients or in the amounts of acute or chronic illness which they presented. The differences lay in the relative frequency of diagnoses made and methods used. By and large, American doctors were more clinical in their approach than their English colleagues. Nevertheless, there can be no doubt about where the greater emphasis on standards of care lies. The main methods used in the United States to maintain or improve standards may be listed as follows:

1. Vocational training.
2. Continuing medical education.
3. State licensure requirements.
4. Board certification requirements.
5. Problem-orientated medical records.
6. Professional standards review organizations.

1. Influence of vocational training

In the United States, vocational training for family practice is relatively new. The first department of family practice was formed in 1969 and there are now (March 1979) 92 departments (out of a total of 116 medical schools in the nation), training a total of 6,033 vocational trainees (residents) in 348 programmes. The rapid growth in the number of departments of family practice is an attempt to correct the relative shortage of general practitioners which followed the swing to specialization already mentioned, and the consequent shortage of family doctors in the nation as a whole, especially in rural areas. This vocational training covers a period of three years, and while each programme has its individual style, the general outline tends to reflect the usual form of practice, involving:

1. Office-based practice with each resident responsible for the care of a specified number of families.
2. Simultaneous hospital-based practice on the staff of a specialist.
3. Precepting by family physicians.
4. Frequent lectures and demonstrations.
5. Continuous review of residents' case records.

Many of the training programmes are community, rather than university, based, the emphasis being on the need to supply doctors in rural areas. At present family practice is the only specialty receiving increasing funding from the Department of Health, Education, and Welfare for the development of its training programmes (funding for paediatrics and general medicine is being held at its present level). Both the United States and Britain have thus recognized the need for vocational training in order to establish a solid basis for good quality care, although the approach of each is different and appropriate to its own setting.

2. Continuing education

It is true to say that continuing education is a way of life for most family physicians in the United States today. Since its foundation in 1947 the American Academy of General Practice (which changed its name in 1971 to the American Academy of Family Physicians) has required a minimum amount of continuing education for membership, the first specialty organization to do so. Together with requirements for State licensure, board certification, or membership in medical societies, this requirement has emphasized the degree to which family practitioners are expected to participate in educational activities as an intrinsic part of their professional careers. The American Medical Association has developed a system for accrediting the content and quality of continuing medical education, educational programmes being offered by sources as diverse as drug companies, medical schools, voluntary health organizations, and professional organizations.

3. State licensure requirements

In each state it is necessary to have a valid licence to practise medicine. Licences are issued for a period of one year, and requirements are generally similar to those of the United Kingdom involving a 'provisional' licence for a period of one year after graduation and a 'full' licence thereafter, the latter being granted on completion of an approved period of training. An increasing number of licensing authorities require some continuing medical education for renewal of the licence. In Iowa this amounts to 20 hours per year.

4. Board certification

The American Board of Family Practice was formed in 1969 and was the first board to require re-certification of its members (every six years) to ensure their continued competence. Membership depends in part on completion of a family practice residency, and re-certification on accumulation of 50 hours per year of acceptable continuing education credits. Such credits are gained mainly by attendance at formal refresher courses and seminars, but may also include audio or video tapes or self-assessment questionnaires up to 20 per cent of the total. Other elements of the re-certification procedure consist of assessment of licensure status, a cognitive examination consisting of a combination of multiple choice and patient management problem questions, and a patient record review, consisting of a review of 20 patient records by questionnaire and also by photocopies of some of the records.

5. Problem-orientated medical records

The problem-orientated medical record was developed by Weed (1969) as an aid to hospital inpatient management, and its usefulness in general practice was demonstrated by Bjorn and Cross (1970). The general structure of the problem-orientated record is sufficiently well known not to need description. Rakel (1977) has found that this type of record is being used by 97 per cent of all family practice residencies, with the inference that its use is likely to become more widespread as graduates of vocational training programmes include it in their practice. The American Board of Family Practice has incorporated record review in its re-certification procedure in an attempt to evaluate standards in this aspect of care, and the problem-oriented record lends itself well to this procedure. Froom (1974) has emphasized the importance of study to evaluate the problem-orientated record in terms of improved quality of patient care and cost in physician time, but its continued use in family practice seems to be assured.

6. Professional Standards Review Organization

About 80 per cent of the population in the United States is protected by private medical insurance, such as that provided by Blue Cross and Blue Shield. Medicare is a federal insurance programme providing protection for those over 65, while Medicaid is a federal/state scheme providing assistance to the medically indigent. Such 'third-party payers' insist that hospitals with which they are involved meet standards set by the Joint Committee on Accreditation of Hospitals, and be reviewed triennially.

In 1972 the Professional Standards Review Organization was formed by act of Congress. Its function is twofold: to ensure quality and to ensure appropriate use of services. The method includes peer review in use of services (utilization review), quality assurance activities (including medical auditing, tissue review, death review, and activities concerned with credentials), and other involvement in hospital operational activities. At present most attention is focused on functions within the hospital setting, but standards within long-term care facilities and in ambulatory care are receiving increasing attention. Physicians wishing to work in a hospital are granted privileges by a credentials committee and are asked at some time to serve on one of the Professional Standards Review Organization committees, the idea being that each physician will become involved in the standards-monitoring process.

Many hospitals also operate an intensive internal auditing procedure to monitor the quality of medical care provided (often using criteria defined by the major professional organizations). Each specialty is represented as a 'department' and the members of each department are thus involved in monitoring and improving their own work. Deficiencies are reported to the departments concerned, which may then take steps to make the necessary corrections.

Discussion

The incentive to maintain high standards in American family practice therefore lies in two main areas:

1. An educational motivation exemplified by vocational training programmes and the emphasis on continuing education.

2. Legislative requirements which influence family practitioners through their involvement in hospital practice by means of audit and review of patient care.

Members of the American public are well aware of their right to choose their physician, as are the physicians themselves. The resulting spirit of free enterprise within medical communities produces an element of competition which requires that practitioners keep their medical knowledge and methods right up to date and encourages the pursuit of high standards. Patients expect swift diagnosis and cure, and physicians are anxious to meet their expectations, both from a sense of professional pride and also from fear of losing the patient should they fail. Clinical and educational meetings are held frequently in many medical communities and are well attended. (In the community in which I worked, physicians willingly gathered at 07.00 hours on a Saturday morning to hear clinical presentations.) The public's expectations, and the profession's willingness to meet them, have been influential in the extensive use of medical technology and the tendency to use multiple screening methods of diagnosis ('blunderbuss investigation') rather than the system of branching logic which is practised in the United Kingdom. (Such screening methods also tend to reduce the threat of malpractice litigation which is prominent in some specialties.) Although these methods are likely to lead to rapid diagnosis (and possibly reveal unsuspected pathology), they are expensive and undoubtedly contribute to the high cost of health care in the United States. Such costs, as well as the length of hospital stay, are kept to a minimum in the case of federally funded health programmes by the use of utilization review and audit. There is at present a great deal of discussion on the subject of the Administration's declared intention to introduce a national health insurance scheme, the government contending that cost control measures will permit the development of new health programmes from the resultant savings, while the profession believes that the introduction of such legislation would inevitably lead to a reduction in standards of health care and rationing of provision (the British National Health Service is often cited in support of this latter view). Despite this, it does seem likely that some form of national health insurance will shortly be introduced.

In terms of accessibility of health care, the United States is faced with problems common to any country

with large areas of sparse population. It is becoming commonly accepted that there are enough physicians in the United States to meet the needs of its population in terms of absolute numbers, but that there does exist a maldistribution in terms of geography and also of specialty. The government has gone some way to meet the need by encouraging the development of family practice training programmes, especially those which are community based, and as a result the discipline of family practice has experienced a growth in numbers and stature similar to that which has occurred in the United Kingdom.

The American Academy of Family Physicians and the American Board of Family Practice have been influential in the development of the new specialty. Their concern for continued growth through research, education at both undergraduate and graduate levels, and continuing discussion amongst those who look for excellence in the workings of the specialty, represents a strong force behind the provision of high quality family medicine. The American Board of Family Practice is the only specialty board in the world which requires periodic re-certification of its members by examination (*Journal of the Royal College of General Practitioners,* 1977.) It remains to be seen whether this lead will be followed by other specialty boards, although several are observing with close interest.

Whilst the different form of practice in the United Kingdom precludes many of the influences mentioned above, nevertheless several analogous areas remain. The last quarter century has seen an unprecedented growth in the status of general practice, thanks mainly to the influence of the Royal College of General Practitioners on the organization of, and training for, general practice. Now that the distinguishing content of general practice and its role in medicine have been clearly defined, increasing attention is being given to standards of medical care and ways of monitoring quality. This is a natural development, and it is admirable that the incentive behind this effort should come from within the specialty rather than be imposed from without by either the government or the public, although it is certainly true that these two bodies have made their influence felt. From observation of American attempts to ensure high standards in health care, some lessons can be learned and some pitfalls avoided. I suggest that efforts to promote high quality general practice should be concentrated on four aspects:

1. Education

The introduction of vocational training has done much to improve standards of care through the injection of well trained family doctors into the medical community. Nevertheless, the establishment of mandatory training for general practice in the early 1980s will not be enough to ensure the *continued* provision of high quality care. This is especially the case when the motivation of those who now enter voluntarily on a course of vocational training is diluted by those who are constrained to do so. The postgraduate centres are a valuable asset and go some way towards meeting the needs of general practitioners for continuing education, but accessibility, frequency of meetings, and programme content are often less than is needed to meet their particular requirements.

It is incumbent upon every practitioner seeking to provide the best quality care for his patients to attempt to keep himself fully informed and well educated in his discipline, and it behoves the College to help him in this attempt. Irvine (1978) has pointed out that the faculties are well placed to involve themselves in meeting the educational needs of practitioners on a local level, and several independent organizations are also able to offer relevant educational material to general practitioners. What is needed is a strong emphasis by the College, through its faculty groups, on continuing education.

2. Outcome studies

Donabedian (1966) suggested that studies of the quality of medical care should be directed at structure, process, and outcome. One of the earliest American studies (Codman, 1916) of standards of care was directed at outcome. However, the poor results which were observed quickly led to the promotion of structural standards for the hospitals involved, and from this emerged a concern with the process of care. Today most attention is directed to the process of care, with attempts to define proper procedures for the management of a host of diseases. Whilst applicable to some organic diseases in hospital, this approach is much less appropriate in family practice where the spectrum of dis-ease is more diffuse and management often reflects the particular qualities of the practitioner, patient, and family. If physicians are sufficiently well educated and knowledgeable, it seems likely that the process of care which they employ will be appropriate. General practice, with its emphasis on early diagnosis, familiarity with environmental and familial influences, and individuality of style, is a fertile field for the pursuit of outcome studies. By using such studies we may be able to discover just how much effect the physician's intervention actually has in the course of a disease and to define those variables which also influence outcome, without replacing the practitioner's individual approach with a checklist of approved procedures. The faculty groups of the College are ideally placed to co-ordinate and evaluate the necessary studies which would include audit of individual practices, and to disseminate information gained amongst the practitioners in the region.

3. Improved practice records

Much has been written about the suitability or otherwise of the existing NHS record for adequate record keeping

in general practice. Good record keeping is a discipline which requires precision and thoughtfulness and the problem-orientated record certainly encourages the development of such qualities. The family-orientated record is also a useful tool for producing a comprehensive and cohesive family health profile. Equally important is the clear display of information in a form which is readily available to anyone needing access to it, especially when research is being considered. The College has much information to offer on medical record keeping and should continue to encourage the use of well developed records as an aid to better management of illness and as a research tool.

4. Periodic re-examination

Until such time as specialist registration in general practice is introduced, the public is likely to assume that completion of vocational training implies competency. It has been suggested that some form of accreditation should be introduced for those completing training but not wishing to become College members, and this seems sensible. However, continued competence can be objectively assessed only by periodic re-examination, including audit of actual disease episodes. The College is in a position to set an example, since one of its objectives, laid down in its Royal Charter (RCGP, 1979), is to "maintain" the highest possible standards in general practice. Re-examination would, I submit, be of value in that:

1. It would assure the public of continued competence on the part of members of the College.

2. It would provide an incentive to members to pursue high standards of care and ensure their familiarity with recent developments in medical practice.

3. It would assure the general public and the government of the College's concern over standards of care and its willingness to maintain these.

Conclusion

The incentives to maintain high standards of care which are seen in the United States have developed over many years and are now integral to medical practice. While they do illustrate a real concern and pride in maintaining standards, they are often complicated and show an excessive concern with the process of care. This reflects the system of medical provision which includes third-party payers and agencies which approve medical facilities.

In the United Kingdom it is now possible to examine the work of general practice in terms of outcome and thereby identify standards of good quality care. The College faculties are in a good position to develop this work and to involve themselves in encouraging practitioners to pursue high standards by educational effort and peer review.

References

Bjorn, J. C. & Cross, H. D. (1970). *Problem-Oriented Practice.* Chicago: Modern Hospital Press.

Codman, E. A. (1916). *A Study of Hospital Efficiency: the First Five Years.* Boston: Thomas Todd Co.

Donabedian, A. (1966). Evaluating the quality of medical care. *Milbank Memorial Fund Quarterly,* **44**, No. 3, Part 2, 166-204.

Esselstein, C. B. (1958). *Principles of Physician Remuneration.* National Conference on Labour Health Services.

Flexner, A. (1910). *Medical Education in the United States and Canada. Bulletin No. 4.* New York: Carnegie Foundation for the Advancement of Teaching.

Froom, J. (1974). The problem-oriented medical record. *Journal of Family Practice,* **1**, No. 3/4, 48-51.

Irvine, D. (1978). The future of the College. *Journal of the Royal College of General Practitioners,* **28**, 146-153.

Journal of the Royal College of General Practitioners (1977). Compulsory re-examination in general practice. Editorial, **27**, 67-68.

Marsh, G. N., Wallace, R. B. & Whewell, J. (1976). Anglo-American contrasts in general practice. *British Medical Journal,* **1**, 1321-1325.

Rakel, R. (1977). *Principles of Family Medicine.* Philadelphia: W. B. Saunders Co.

Royal College of General Practitioners (1979). *Annual Report.* London: RCGP.

Weed, L. L. (1969). *Medical Records, Medical Education and Patient Care.* Cleveland, Ohio: The Press of Case Western Reserve University.

Breast self-examination practices and breast cancer stage

To determine the relation between breast self-examination performance and the clinical and pathological stage of breast cancer at first diagnosis, we studied 335 patients with breast cancer. Approximately one fourth of the patients reported that they had been practising monthly breast self-examination and half that they had never practised breast self-examination. More frequent performance of breast self-examination was associated with more favourable clinical stage and fewer axillary lymph node metastases on histologic examination. On pathological examination, the age-adjusted maximum tumour diameter of patients practising monthly self-examination was 1·97 ± 0·22 cm (mean ± S.E.M.) as compared with 2·47 ± 0·20 for those performing self-examination less often than monthly and 3·59 ± 0·15 for patients never performing breast self-examination.

These data associating more favourable clinical and pathological stages of breast cancer with more frequent breast self-examination need to be extended by determination of the survival rates of the various self-examination groups.

Reference

Foster, R. S., Lang, S. P., Costanza, M. C. *et al.* (1978). *New England Journal of Medicine,* **299**, 265-270.