QUALITY OF CARE

Quality of care in general practice

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Improving the quality of care must always be a major aim but where do we start? Each member of Council is to choose two aspects of the services provided to his patients, to define specific objectives for the care of his patients in these two areas and to monitor the extent to which these objectives are met (August *Journal,* p. 521). However it does seem that this process is being started halfway between the horse of objective standards of quality and the cart of appropriate processes for achieving them.

ONE of the problems that concerns everybody who handles material from general practice is the enormous variation that exists between doctors doing the same job. A simple illustration of this is presented in Table 1 in which we present a variety of measures of performance as recorded by 21 to 25 singlehanded practitioners in the first two years of the Second National Morbidity Study.[1,2]

The table includes the value of the correlation coefficient *(r)* which in general exceeds 0.90, indicating a remarkable consistency of performance by individual doctors from one year to the next. With the exception of that for the consultation rate, the values of the standard deviation are approximately one half those for the mean. This relativity indicates wide variation and implies caution in the use of data based simply on means as appears to have been the case in the Council debate.

The variations encountered in these national morbity data cannot be explained by differences in age and sex composition of the practices nor by variations in social class; the explanation almost certainly lies in the way doctors perceive their own role and the way in which patients respond to that. High quality may be provided at both ends of the spectrum. Quantity and quality are not related. In the absence of measured data, the problem is compounded because of the gap between what a person thinks he does and what he actually does, an observation confirmed by Hull.[3] Let us therefore confine ourselves to observed measures of performance. At the same time, let us beware of misusing statistics—77 people receiving treatment for raised blood pressure is meaningless unless there is reason to believe that they all need treatment.

Desirable areas of performance

How therefore are we to move forward? Let us welcome the suggested initiative that two aspects of performance are assessed, but at the moment let us go for areas of performance that are unequivocally desirable. For example:

—the blood pressure of every man aged 40 years should have been recorded in the notes in the last five years.
—every woman aged 50 who still has a cervix should have a cytology smear report available in the notes from the last 10 years.
—every two year old child should have completed a primary immunization course.
—every woman aged between 15 and 40 years should be known to be immune to rubella.

In assessing the achievement of these goals, it is essential that the objective is assessed and not the practice system for achieving it.

The search for quality

What about other activities and services to patients about which there are not, as yet, satisfactory and agreed definitions of quality? How does one make progress here?

Standards set by 'wise men' engaging in discussions in the Socratic tradition has been the conventional approach, but it is the failure of this approach that has precipitated the present crisis in the search for quality. We have already considered the range of variation that applies to practically every general practice activity and for very few of these are there any unequivocal indications that some specific rate within that range represents better or worse care.

Any worthwhile approach to this problem starts with knowledge of individual performance. That performance must be seen in relation to the behaviour of colleagues doing the same job and hence we applaud the regular report of the Prescription Pricing Authority providing prescribing costs information for doctors, which is concerned not only with absolute costs but provides an indication of performance relative to that of colleagues.

Watkins has referred to the concept of adequate care.[4] Whilst norms do not indicate quality, they are useful in identifying adequacy, a position from which we may move on to look at quality. We are convinced of the value of the consensus of trained minds in steering us forward but only in the context of prior information about each participant's actual performance. There is little doubt that the scientific training that we have all shared will be a constant stimulus to us individually to challenge the 'norm' wherever that is appropriate. Furthermore, standards however derived are not fixed for good and all and require validation from continuous monitoring.

A framework for assessment

If the first step towards quality is defining what we actually do, the second is the provision of a framework for assessing it. This involves appropriate feedback of information to doctors and a favourable environment for consideration of the results.

Our concept of a favourable environment is locally organized self-evaluation discussion groups and here the

College has an organizational role. It is from these groups that standards will emerge, not overnight, but gradually. The list mentioned in this paper, though quite obvious in retrospect, emerged as a realizable objective from a consideration of practice performance in preventive care.[5]

Quite apart from establishing standards, there is an additional value in the discussion of measured performance. At an individual level an important part of progress is the identification and discarding of redundant and inappropriate procedures or treatments. Learning is so often associated with the acquisition of new gems of information that it is easy to miss the importance of discarding the waste. Eccentric behaviour is quickly identified where we measure performance and compare it with our colleagues'.

References

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4. Watkins CJ. The management of the quality of general practitioner care. *Occasional Paper 15.* Royal College of General Practitioners, 1981.
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Table 1. Comparison and correlation of individual practice activity rates—Second National Morbidity Study; year 1 and year 2.

	Number of Practices	Year 1 70–71 Mean	SD	Year 2 71–72 Mean	SD	*r*
Consultations per patient at risk	23	3.30	.80	3.46	.75	.93
Specialist referral per 1,000 patients at risk	22	119	56	119	47	.88
Patients investigated per 1,000 patients at risk	21	153	88	149	94	.89
Home visits per 1,000 patients at risk	25	562	305	522	320	.97
Home visits per 1,000 consultations	25	158	65	150	69	.95

Quality of Care in General Practice

Sir,

A warm welcome for Dr Irvine's paper (August *Journal,* p. 521) and for the Council debate. There could however have been more effort devoted to finding the cause of the trouble; why do too many general practitioners have low standards?

From 1920 to 1948 I was in general practice in Wandsworth and Battersea ('Up the Junction') where the quality of care was not always of the highest. There were several reasons for this. A doctor entering general practice had:

—no test to pass. Anyone (with some cash) could take on a large practice the day after he qualified. Hence new entrants always included the dregs.
—no proper training. He had been prepared for hospital work but knew nothing of general practice.
—no time. In the poorer districts low payments for panel patients and even lower fees for their dependants meant few doctors, large lists and long hours.
—a solution provided by the patients. They wanted symptomatic relief—above all a bottle of medicine (tablets alone they would have scorned). So 'Here's the prescription. Next please.'

How far have things changed today? There is now one hurdle before entry—vocational training for three years; and unless this sinks below the level of other entry tests the first danger is overcome.

Other perils are lessened but not eliminated. There is some training in general practice; but is one year enough to counteract the influence of the seven or eight spent in undergraduate and postgraduate hospital training, with its implication that only consultant practice is really worthwhile? Above all, can training ever be satisfactory while the great majority of teachers—and the leading medical journals—persist in trying to find a material cause for everything, and (unscientifically) disregard the influence of the mind?

As for time, there is more but not enough. There cannot be without more general practitioners—and we shall not get them unless we can overcome the resistance of the consultant establishment and the civil servants at the DHSS, who have jointly secured the preponderance of the acute hospital services.

Some patients are not now satisfied with a physical examination and a prescription—but are they more than an intelligent and well-publicized minority? The great majority appears still to demand only immediate relief for its present condition. In any case is it not better for doctors to lead patients than patients doctors?

Council has adopted two aims. Both are entirely reasonable, but both are marred by one word. 'Should' implies a claim to superiority in knowledge, intelligence and morality which does much to explain the antagonism which our College excites amongst certain members of the profession.

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Sir,

I am surprised that Council's debate on Dr Donald Irvine's briefing paper (August *Journal,* p. 521) survived beyond Dr John Fry's searching question 'What is quality and how do we measure it?' and Dr Paul Freeling's answer 'We can't'. But it did; and now Council has decided to send the paper, in its present form, to the faculties for further consideration.

In my view the basic flaw in the paper is that, unwittingly, Dr Irvine has used the words 'quality' and 'standard' throughout as if they were synonyms. Quality implies a grade of goodness. Like excellence, beauty, health or pain, quality is a perception that cannot be corporately defined and measured. Standard, on the other hand, is a level of adequacy. Standards can be set and can therefore be measured. Surely this is what Dr Irvine meant. If his paper were retitled 'Standards of care in general practice: our outstanding problem', and the word 'standard' substituted for 'quality' throughout the text, then it would prevent faculties from becoming embroiled in yet further futile discussions about what is good quality in medical care.