Towards quality in general practice

Sir,

I have recently read the RCGP Council discussion document *Towards quality in general practice.* I think it is an extremely important initiative for several reasons.

First, the standards of general practice in the United Kingdom are so varied. It is to their great credit that many general practitioners offer standards of care which are exemplary. Many of those I have had the pleasure to work with in the College are in this category. The care they provide is second to none, yet we all know that there are other general practitioners whose standards of care are deplorable.

Secondly, the College has always stood for, and promoted, the highest standards in practice. The College's educational initiatives such as vocational training and the examination for membership have played a role in producing changes which are now well known. But hitherto the College has been reluctant to stand up and be counted on the subject of quality of care *per se.* Specifically, the College has so valued all general practitioners that it has undervalued the best by overvaluing the worst.

Thirdly, as Government is bent on limiting the amount of cash available to the National Health Service, there is now much less slack in the NHS to make up for those doctors who are simply not up to it.

In order for this document and the ideas it contains to gain acceptance the College will have to weather a storm of accusations of elitism. My voice is on the side of quality. If that makes me an elitist, then so be it.

The College must, however, ensure both that the standards whereby quality is to be judged are known, and that it provides a means whereby those whose performance is thought to be lacking are helped to improve.

I would strongly urge the College to hold fast to the drive to improve quality whatever the immediate reaction. In the long term, this move will be seen as a major departure; a rite of passage.

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Sir,

I am writing to record my amazement at the latest College initiative. It appears that it is seriously proposing that after years of examinations during school, university and vocational training my partners and I should submit ourselves to further assessments on pain of loss of income.

It is proposed that we should allow our 'peers' free run of our practice records and procedures even to the extent of placing video cameras in our consulting rooms. Then if their (debatable) suggestions are not acted upon, we could lose money. After 10 years as a full partner in general practice I do not take kindly to this threatened loss of independence and do not see why I should contribute £100 a year to the proponents of it.

I understand that the career-minded Minister for Health is to have consultations with the College. No doubt he will ignore the suggestions which will cost money, for example, extra training and study leave, but will accumulate ammunition to use against general practitioners in future negotiations. It is noted that he took not the least notice of the Colleges' views on the limited drug list. The College has a reputation for naivety in its negotiations with government and should leave this work to the British Medical Association.

It seems to me that the College is giving itself a poor image by its preoccupation with 'standards' and 'audit' which give College utterances a carping tone and are not the sort of thing to attract new members. Personally I would like to see a retreat from politics and compulsion and more trust placed in the individual general practitioner, together with practical suggestions for the benefit of patients and doctors.

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Sir,

In the discussion document *Towards quality in general practice* I read 'a high standard of primary health care is the right of every man'. The public has no right but may enter into a financial agreement with the profession to provide a preventive medical service, but any steps to agree this as an extension of the National Health Service should be taken with great caution. Past and present experience of the Government's willingness to abide by financial agreements should lead the profession to be most suspicious.

Hitherto, the Royal Colleges have restricted their attentions to proclaiming standards while leaving financial bargaining to the British Medical Association. It seems now that the Royal College of General Practitioners is prepared to soil its white kid gloves with filthy lucre. Such behaviour will diminish its popularity with the Ministry and Government, but may well result in its being on better speaking terms with more doctors.

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Membership examination

Sir,

I had understood that our College originally developed its membership examination as a means of tempting aspiring members to try to raise their academic standards. In recent times, most doctors completing vocational training in general practice take the exam and many seem to believe that the cachet of College membership may help them in the difficult search for employment. Although there is no good evidence that this is the case, the College exploits this popular myth by allowing doctors who have not quite finished their training to take the exam, presumably to allow them to append an exam success to their job applications. I believe that this slightly dishonest practice should stop as it neither reflects credit on the College nor helps the young doctors to get jobs. Furthermore, the focus on swotting up on exam technique during the final months of vocational training certainly seems to be an interference with the more appropriate activity of learning about general practice. This hardly seems to be a behaviour defined in any academic catalogue of worthwhile educational objectives. Perhaps it would be better if the exam could only be taken after a period of time as a principal in a practice.

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Generic prescribing

Sir,

I felt the June issue of the *Journal* was particularly interesting, and I would like to comment on two articles and a letter, which had the common thread of discussion on prescribing.

In relation to the article 'Prescribing — a case for prolonged treatment' (June *Journal,* pp.284-287), I believe that only if the participants in group discussions on prescribing draw up their own formulary will they make any long-term change in their prescribing habits. Otherwise good intentions are quickly overtaken by individual idiosyncracies. Such formularies

should not be totally restrictive, but rather a guide to the majority of prescribing to be done by the participants and it is important that all the participants feel that they have contributed to the contents of the formulary. I believe that all drugs in the formulary should be in their generic form, and this should include combination preparations if the names are not too cumbersome. Where a formulary drawn up by others is used I believe that the participants should make such modifications as to make them feel it is to some extent their own work.

This leads me on to the discussion of the use of generic prescribing (June *Journal,* pp.293-295). I believe that this is in some sense scientific and helps to place drugs into their categories as well as saving costs. If more doctors prescribe in this way it will enable the pharmacist to keep the generic formulations as the main stock. My pharmacist adviser tells me that the bulk of his return comes from the fixed returns on prescriptions, and very little from the 'on cost' element. The drug companies who develop worthwhile new drugs will make good profits, so too will the efficient producers of generic drugs; only those who produce 'me too' formulations of no particular merit will suffer deserved decline in profit.

I think we should also learn from the Israeli example as set out in Dr Cohen's letter (June *Journal,* p.300). House doctors in our hospitals should be given simple generic lists from which they could prescribe on their own initiative, having to refer to senior doctors for the more complicated and expensive drugs. While undergoing vocational training in general practice, trainers and trainees together should prepare their own lists for the trainees to use. This sets a sensible pattern for self-regulation and careful generic prescribing for the future. This is the way for the profession to avoid government interference. In many cases self-regulation already happens; if it becomes universal we have nothing to fear.

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Sir,

Until recently I was a keen devotee of 'generic' prescribing. It was clearly a 'good thing', and it gave me a sense of superiority over the fusty old general practitioner who couldn't spell dextropropoxyphene. However, a friend who is a drug company representative then told me that the Government is able to regulate directly the amount of profit that a pharmaceutical company makes in this country. The fact that the pharmaceutical industry has recently cut its advertising budget drastically in response to a Government 'clawback' suggests that he is right. If the Secretary of State for Social Services should suddenly need to raise £100 million from the industry it seems that he can do so directly without the need for a limited list. Of course, if too much is taken back, the drug companies may get annoyed and close down their research and manufacturing units in this country, but this is a political problem and not the concern of the general practitioner.

'Proprietary prescribing' means that the patient will always receive a product of the same external appearance and bioavailability, from a company with reputable quality control. The placebo effect is important; what are our hypertensive patients to think when they receive a different colour and shape of tablet every month? The good general practitioner will decide whether a prescription is necessary and, if it is, he will decide what pharmaceutical agent or agents are required. If he should choose a compound preparation he will have good reasons for his choice, but once the choice has been made, there is no merit in using the generic name for its own sake.

I think that we should prescribe what is best for our patients, and let the Government haggle over the total cost with the pharmaceutical industry.

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Antibiotics in urine specimens

Sir,

Many urine specimens received from general practice patients contain antibiotics.[1-3] Does the presence of antibiotics make the diagnosis of urinary tract infection more difficult and therefore are these specimens 'nonsense urines'? We have identified the antibiotics that are present in urine specimens received from patients of general practitioners in the Leeds area using a simple microbiological method, as described in a previous publication.[2] Patients may take antibiotics that have been left over from previous prescriptions or be taking antibiotics for the treatment of unrelated conditions such as upper respiratory tract or skin infections, or have provided a specimen after antibiotic therapy has already commenced. Some antibiotics, notably trimethoprim, may be present in significant concentrations in the urine for several days after completion of therapy and reduced renal function, particularly in the elderly, may delay the clearance of an antibiotic otherwise rapidly excreted in the urine, making it difficult to collect an antibiotic-free post-treatment specimen. Antibiotics, such as erythromycin, that are not routinely prescribed for urinary infections may still inhibit the growth of *Escherichia coli* sufficiently to obscure laboratory diagnosis.

All urine specimens received in December/January 1984/85 (limited to 1000 specimens) from general practice patients were tested for the presence of antibiotics, which were then identified.[2]

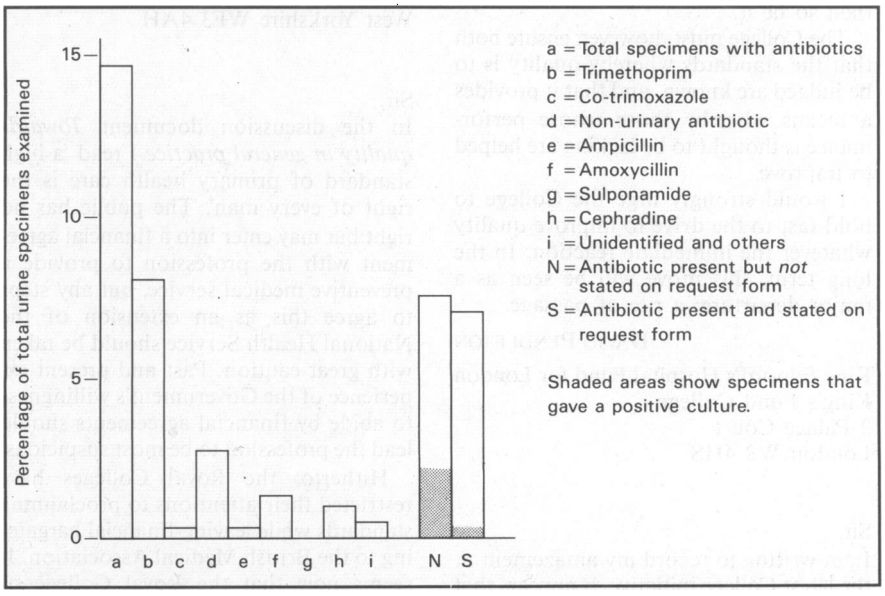

Figure 1. *Percentage of total urine specimens examined containing antibiotics. Those samples containing antibiotics where antibiotics were and were not stated on the request form are also shown as a percentage of the total urine specimens examined (n = 1000 specimens).*