

*Towards quality in general practice and the launch of 'What sort of doctor?'*³ and the 'quality initiative'.⁴ Indeed the practical application of 'What sort of doctor?' has been attempted quite enthusiastically by some faculties⁵ and can be seen as a major step towards assessing the quality provided for patients by everyday general practice.

All the documents and discussions about quality reaffirm the importance of general practice, while looking for some consistency in the quality of service to patients. Unfortunately many of us still feel that quality of care has not been defined — indeed we are unsure how to measure it. This problem is not peculiar or unique to general practice.⁶ We can measure quality in terms of structure (practice profile, members of staff attached and employed, building and surgery hours), process (what we do in consultation and prescribing) and outcome (changes in health of the individual or population).

Any attempt to raise the standard of patient care must be welcomed. The underlying principles of objective inquiry into structure, process and outcome, followed by standard setting with consensus and local peer assessment merits serious consideration.⁷ However, we find ourselves caught in the trap of measuring those things which can be easily measured, and transferring this measurement to all aspects of care. A variable that is measurable may make it sensitive but it does not make it valid.⁸

Can we really measure 'good care', and indeed can we even agree on a definition of 'good care'. The biggest criticism of all the various documents discussing quality is that they have more to do with the doctor and his quality, than with the care of patients. For many of us patient care is of paramount importance: 'Personal satisfaction is derived from doing the job of general practice well-fostered by the doctor/patient relationship'.⁴ We can aim for high standards and the College is appropriately involved with this.

I can look objectively at my infant immunization rates and note that nearly 100% has been achieved. I can look at my prescribing figures and note a low prescribing rate — but is low prescribing necessarily good medicine? I can look at my referral rate and be surprised at the low referral pattern — but is low referral necessarily good medicine? However, being confident about these figures does not help me with the care of individual patients.

How do I feel about the young lady with the breast lump that I felt sure was benign; after my initial reassurance, referral resulted in a mastectomy for breast cancer. How do I feel about the medicines I prescribe that I do not really believe in?

The penicillin I sometimes prescribe for sore throats seems more likely to produce allergy than to stop any associated streptococcal problem.⁹

Even more important are the reluctant patients — those who do not come to see me because I do not understand them, or because they find me difficult, insensitive or too sensitive. How do I feel about the young girl who is still depressed five years after her mother's death, but who would not come to see me? Fortunately she discovered that one of my trainees was rather easier to talk to about her feelings. But how many more of these patients are there?

Evidently we still have not decided what we mean by quality in general practice. If we concentrate on measuring the measurable items in general practice, we will improve something. But surely there is far more than that to good everyday general practice.

PETER ELLIS

Medical Centre
Simpson House
255 Eastcote Lane
South Harrow
Middlesex HA2 8RS

References

1. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Primary health care — an agenda for discussion (Cmd 9771)*. London: HMSO, 1986.
2. Royal College of General Practitioners. *Quality in general practice. Policy statement 2*. London: RCGP, 1985.
3. Royal College of General Practitioners. *What sort of doctor? Report from general practice 23*. London: RCGP, 1985.
4. Irvine D. Quality of care in general practice: our outstanding problem. *J R Coll Gen Pract* 1983; 33: 521-523.
5. Ellis P. North and West London Faculty. *J R Coll Gen Pract* 1984; 34: 173.
6. Brinkley D. Quality of life in cancer trials. *Br Med J* 1985; 291: 685-686.
7. Campion PD. Setting standards in general practice. *Br Med J* 1985; 291: 499.
8. Donabedian A. Advantages and limitations of explicit criteria for assessing the quality of health care. *Health and Society* 1981; 59: 99-106.
9. Taylor JL, Howie JGR. Antibiotics, sore throats and acute nephritis. *J R Coll Gen Pract* 1983; 33: 783-786.

Do women bother about their cervical smear results?

Sir,
The women most in need of cervical screening are the least likely to attend of their own accord. It was the death of a

single woman that provoked a public debate over the responsibility for notifying an abnormal result.¹ Fifteen per cent of invasive carcinomas of the cervix have been attributed to failure of follow-up of abnormal cytological results;² failure to implement treatment being one problem of the cervical cytology screening programme in Britain.³ In Scotland recommendations have now been made that every woman should be notified of her cervical smear result.^{4,5}

In our inner city practice, which has a strong bias to social class 5 patients, we hold two well-woman sessions per week. We also do opportunistic case-finding cervical smears during surgery consultations.

Whenever a patient has a smear taken she is told to collect the result, either in person or by telephone, from the receptionist after four weeks. The reports are taken on average four weeks to be returned by the laboratory. The date the smear was taken and the message to be given to the patient, for example 'clear' or 'see doctor', are entered in the practice results book when we receive the report; the 'message' is ticked off in the results book when the patient has collected her result. No laboratory or X-ray report can be filed until signed by both partners and the 'patient message' entered in the book. The results book is kept with the receptionist at all times.

When the smear is taken, we stress to the patient that it is her responsibility to collect the result as a fail-safe in view of previously publicized problems in other areas. She is also told that if the result is not available when she telephones, she must ask weekly until she has it. Whenever further action is required the woman is routinely sent an appointment for surgery attendance.

Between 1 April 1985 and 1 April 1986 a total of 205 smears were taken, of which 81 were eligible for item-of-service payment: 71 women requested and were given their result; four of them had abnormal smears requiring further action. However, 134 women did not request their cervical smear result and seven of these required follow up.

Despite a results information procedure which is simple and easy to operate, two-thirds of the screened women, who have been sufficiently motivated to have a smear taken, do not bother to ensure their own follow up. We consider this to be an important consideration in patient management.

ILORA G. FINLAY
MARGARET C. HARRIS

Maryhill Health Centre
41 Shawpark Street
Glasgow G20 9DR

References

1. Anonymous. Cancer of the cervix: death by incompetence. *Lancet* 1985; **2**: 363-364.
2. Chisholm DK, Haran D. Cases of invasive cervical cancer in the north west in spite of screening. *Br J Fam Plann* 1984; **10**: 3-8.
3. Chamberlain J. Failures of the cervical cytology screening programme. *Br Med J* 1984; **289**: 853-854.
4. Hughes HE. The appropriate use of diagnostic services. The effective use of cytology services. *Health Trends* 1985; **17**: 3.
5. McIlwaine GM. The cervical cytology service in Greater Glasgow Health Board. *Primary care circular*, Feb 1986.

Acute febrile mucocutaneous lymph node syndrome (Kawasaki disease)

Sir,

We would like to report the following case. A two-year-old girl was referred to the dermatology clinic after presenting with a seven-day history of sore throat, fever and a skin rash. A five-day course of cloxacillin had had no effect on the pyrexia. Examination showed an irritable, ill child with a pyrexia of 39°C and there was a blotchy erythematous rash on her trunk and legs, with areas of desquamation. Her fingertips were red with peeling back of the skin towards the base of the fingers. There was left cervical lymphadenopathy and conjunctival injection. Examination revealed no other abnormalities. The diagnosis was not clear at this stage and she was admitted to hospital for further evaluation.

Over the next few days she remained highly pyrexial despite penicillin V therapy. Extensive crusting and ulceration of the tongue and lips developed which necessitated feeding via a naso-gastric tube. Significant haematological findings included neutrophil leucocytosis, thrombocytosis and raised erythrocyte sedimentation rate (ESR). Both electrocardiogram and chest radiograph were within normal limits. Cultures from multiple sites revealed no pathogens; blood and urine cultures were sterile and serological tests were negative. At this stage a diagnosis of Kawasaki disease was made. Detailed questioning of the mother about events prior to the onset of symptoms revealed that the house had been extensively 'spring-cleaned' during the preceding week.

Soluble aspirin was commenced and there was a dramatic clinical response. The pyrexia resolved within 24 hours and the

mouth ulceration healed within four days. The skin rash and desquamation had cleared within a fortnight. The soluble aspirin was stopped after four weeks, the platelet count and ESR having settled to within normal limits. At this time also, a distinct transverse furrow was noticed on all the fingernails (Beau's lines). At follow-up over a two-year period she has remained well apart from developing allergic rhinitis, eczema and mild asthma.

Our patient presented with a perplexing clinical picture which did not really correspond with any of the common febrile illnesses. However, it did fit with all of the established principal features of Kawasaki disease^{1,2} which are fever, conjunctivitis, mouth ulceration, inflammation of palms and soles, exanthemata and cervical lymphadenopathy. Kawasaki disease is most common in children between six months and four years of age. It occurs most commonly in the late winter and spring. Cardiac involvement occurs in 20% of patients with Kawasaki disease, with ensuing fatality in 1-2%. Fortunately there was no evidence of cardiac involvement in this patient. Another feature is thrombocytosis which may increase the risk of thrombosis. The most useful treatment is aspirin which has several beneficial effects. Corticosteroids appear to be contraindicated.

The cause of Kawasaki disease remains unknown. Clustering of cases has suggested a common infectious agent though none has been consistently isolated. Immunological tests during the acute phase of the illness have indicated exposure to the house dust mite which suggests that the disease may be due to a hypersensitivity to the mite itself or to some organism carried by the mite.³ Our patient would probably have been exposed to high concentrations of house dust mite during the 'spring-cleaning' of her house just before the onset of her illness and so this could have been the precipitating event.

We present this case to make this disease more widely known among general practitioners since they spend a significant amount of their time in dealing with febrile illness in young children. The differential diagnosis includes scarlet fever, staphylococcal scalded skin syndrome (toxic epidermal necrolysis), Stevens-Johnson syndrome and Reiter's syndrome. Because of the potentially fatal outcome of Kawasaki disease, early recognition and prompt treatment are essential.

GERARD J.J. MURPHY
RAYMOND A. FULTON

Altnagelvin Hospital
Londonderry BT47 1JB

References

1. Kawasaki T, Kosaki F, Okawa S, *et al.* A new infantile acute febrile mucocutaneous lymph node syndrome (MLNS) prevailing in Japan. *Pediatrics* 1974; **54**: 271-276.
2. Price J. Kawasaki syndrome. *Br Med J* 1984; **288**: 262-263.
3. Fujimoto T, Kato H, Ichiose E, *et al.* Immune complex and mite antigen in Kawasaki disease. *Lancet* 1982; **2**: 980-981.

The treatable canary

Sir,

The efficacy of doctors' management and treatment of patients depends on another part of their job — the reaching of a diagnosis. The importance of making a correct diagnosis is never more obvious than when an incorrect one has been made or an important one has been missed. The least that a patient expects of their doctor is that he or she will know what, if anything is wrong with them. Doctors are not omniscient, yet along with their other tasks they are required to find a cause for a multitude of complaints and queries. How best can they do this, correctly, consistently and promptly?

Underpinning the teaching and practice of making the diagnosis are the almost absurd-sounding maxims that 'common things occur most commonly'; and that 'the bird on the wire is more likely to be a sparrow than a canary'. But there is no absurdity here. These maxims, though imperfect, are valuable devices bringing a logical sequence out of the multiplicity and even chaos of symptomatology. For each symptom and sign, a huge list of possible causative diseases may be compiled. It is impossible to try and exclude by thorough investigations each and every disease until the correct one is alighted upon. Over-investigation is costly, meddlesome and does a disservice to the patient. The matching of symptoms and signs to the frequency of occurrence of each disease — its commonness — usually leads speedily to a correct diagnosis.

Thus, most patients with headaches do not need computerized tomography scans. Their headaches are understandable using simple means and have a common, benign cause. Most children with a fever and red pharynx need neither a blood test nor a bone marrow examination. Their upper respiratory infection is common, benign and self-limiting. The problem is that brain tumours and leukaemia do occur, and provided they are diagnosed at a sufficiently early stage they can be treatable and curable. Yet they are often missed until it is too late. Review of the history in these cases may reveal their con-