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Quality assessment or quality control?

IN the midst of the confrontation between the government and the medical profession over the future of the National Health Service, medical audit stands out as the one area where there is agreement. However, this agreement may be more apparent than real. It is easy in the abstract to approve of audit but conflicts may emerge when detailed proposals are considered. The different perspectives of doctors and their employers in their approaches to audit can be summed up by the difference between the terms quality assessment and quality control.

Quality control

For the government and for the health authorities, the aim of audit must be to try to contain costs and to ensure consistency and equity in the provision of health services. This is the quality control approach to medical audit — analogous to the quality control departments in manufacturing industry. This is an important aspect of audit but should not dominate the picture. It is legitimate and desirable for family practitioner committees and health boards to try to measure the pattern of services provided by general practitioners, for without reliable information it is not possible for health authorities to plan for the future of the service or to allocate resources in a sensible way. Under the present contract, general practitioners provide information about their work and it is these quantitative data which are likely to be the starting points for the quality control form of external audit. Prescribing costs, referral rates, immunization rates and other items of service claims could already be used in this way. With the cooperation of general practitioners this data could readily be supplemented by information gathered specifically for audit purposes, for example consultation rates and other information on workload.

One danger of the quality control approach to medical audit is the distorting effect this could have on clinical practice. The most easily measurable is not necessarily the most important aspect of general practice. Time spent in achieving the targets set by the government in preventive care may only be achieved by restricting time spent on other clinical work. The crucial point to make about external audit of this kind is that the data are really descriptive and do not immediately relate to the quality of care provided by a practice. For example, patterns in the use of laboratory investigations by different practices may provoke discussion and point to the need for further enquiry by the doctors concerned but do not in themselves indicate good or bad practice. There is a danger that deviation from the mean in any area of medical practice may be regarded as a bad thing.

Quality assessment

Quality assessment, however, describes the approach to medical audit in which general practitioners themselves actively participate. Quality assessment is not an end in itself but a means of improving the quality of health care with the aim of improving the health of the population. The scope of the activities is extremely wide: it encompasses health promotion, the prevention of disease and the treatment of ill people.

Quality assessment begins when doctors, individually or a group, no longer assume that they are working in the best possible way. Thus in starting to carry out quality

assessment in general practice, the most fundamental requirement is positive motivation. External audit can be one means of creating such motivation but may instead provoke defensive reactions among general practitioners. For an operational specialty such as general practice, quality assessment should be at the core of continuing medical education. Small discussion groups of colleagues are powerful ways of stimulating interest in quality assessment.

A number of publications in a range of countries have looked at the theoretical basis of quality assessment activities and at the strategies within health care systems which may facilitate or promote this work.¹⁻⁵ However, few publications have described the practical methods of quality assessment.^{6,7} There are several reasons for this gap in the literature. The scope of general practice is both wide and variable. Not only are the characteristics of primary health care culturally defined, but the position of general practice within primary health care varies from place to place and country to country. Because of these problems, reports of quality assessment activities may be relevant in only a single location and thus papers describing quality assessment are not attractive to journals that publish information from which general inferences can be drawn.

In its first statement on this subject the New Leeuwenhorst Group, a European working party concerned with teaching and learning in general practice, identified three essential requirements for quality assessment activities: the motivation of general practitioners to become involved; the resources needed to carry out projects; and the skills to ask the right questions and collect and interpret the appropriate data.¹ Motivation has already been referred to. Internal motivation should be fostered by undergraduate and vocational training aimed at stimulating a spirit of inquiry and questioning. However, without some form of external support, stimulation and challenge, these internal factors are likely to atrophy. The Royal College of General Practitioners' initiative to introduce fellowship by assessment can be seen as one form of encouraging quality assessment in general practice.

The resources needed to carry out quality assessment have been insufficiently acknowledged. They concern time, money and access to the appropriate information. In most general practices information is held in individual patient records which are themselves poorly organized and structured and hence record linkage for the pooling of information is at a rudimentary level. Consequently evaluating services is a time consuming process. Although computerization of general practice will make quality assessment activities easier to carry out, protected time for doctors to carry out this aspect of their work is essential. Financial help is most important when setting up information systems. The skills which doctors need to carry out quality assessment projects are not difficult to acquire. Simple methods of data collection and analysis are already available.⁸ More demanding are the skills necessary to effect changes in response to the evidence from the data analysis.⁹

Selecting a project

The first step in any quality assessment project is selecting a suitable subject for study and this should be done carefully and in consultation with colleagues. There are a number of points to consider. Is it an aspect of practice which is measurable? This does not apply only to the numerical approach to the evaluation of care. Standards and criteria of care need to be agreed but they are not immutable. Similarly quality is not an absolute concept but comprises subjective selections and priorities. Secondly, are the necessary resources available? The first discovery in a quality assessment project may be that the clinical record does not contain enough information upon which to base

an opinion. Further progress will depend upon the development, agreement and implementation of policies within a practice about items which are to be recorded in the clinical notes. Although quality assessment may support or legitimize existing practice, in essence it aims to create change.

A further difficulty in selecting a subject for study is the uncertainty about whether performance in any one area can be assumed to represent quality across the broad range of general practice. Tracer conditions have been used to assess the global quality of care provided in general practice. This approach has some validity in single retrospective studies;¹⁰ it is less valid in repeated studies because doctors learn to concentrate their time and effort in the areas of care which they know will be monitored and this could lead to a deterioration in the quality of other aspects of their work. Otitis media, epilepsy, childhood immunizations, antenatal care, and an aspect of practice organization such as availability have been suggested as tracer conditions because they are common enough to ensure a sufficient number of patients in each study group and they are conditions which have reasonably well established standards of good care. These examples encompass as much of general practice as possible by including a common acute condition, a common chronic disease, preventive work and practice organization. This is a pragmatic framework which has appeal for practitioners, but arguing from a theoretical basis, Donabedian⁵ has advocated a framework for quality assessment under the headings of structure, process and outcome. Baker⁷ has applied this framework to general practice and he gives practical methods of undertaking quality assessment activities.

For most general practitioners their highest priority is the immediate care of patients and their quality assessment activities therefore tend to concern the process of care. For some conditions criteria of good care can be based on research findings but many criteria are simply based on consensus and the number of conditions for which explicit criteria of good care exist are limited. Even in conditions such as diabetes and epilepsy, judgements about quality of care may depend on the frame of reference employed. A doctor who is technically competent in monitoring drug levels of a patient with epilepsy may succeed in keeping him free of fits but may have neglected important psychosocial aspects of the disorder. An excellent illustration of this point is provided in a study by Taylor.¹¹ This was unusual in the literature for following through the full cycle of quality assessment from initial evaluation to re-evaluation. The motivation for the study was one doctor's concern about the apparently poor control of seizures and the poly-pharmacy among his patients with epilepsy. The study began in 1978 at which time research evidence had shown that effective monotherapy could be achieved in most people with epilepsy. The cohort of patients studied were identified from a practice disease register and from the patients requesting repeat prescriptions. Interviewing the patients and reviewing their medical records confirmed the doctor's impression about poor seizure control and poly-pharmacy. Stimulated by this evidence of current practice the general practitioner and his colleagues established specific aims for their care for people with epilepsy. These were: accurate diagnosis and seizure classification in order to determine the choice of treatment; patient education; reducing the number of drugs prescribed; and maintaining regular supervision of patients. Specific criteria relating to these aims were set down. Re-evaluation of the performance of the doctors two years and six years later show that poly-pharmacy had been reduced and that improvements in seizure control were achieved and maintained. However, in his description of this quality assessment project the author remarked that qualitative improvements were at least as important as the measured changes.

Some people with epilepsy chose to remain on multiple drugs rather than risk a further seizure and others preferred to have occasional seizures rather than take tablets. This study indicates that protocols of care have a place in general practice but should not be imposed in a rigid way. Personal circumstances should and will always influence the type of care offered and the treatment decisions made by patients.

This example brings us back to the important difference between quality assessment and quality control. Quality control is external audit which will encourage doctors to achieve high standards of care as they are currently defined. Quality assessment implies an active participation approach to audit which will generate new ideas and concepts of health care. To be effective this participation includes patients as well as the primary care team.

E.G. BUCKLEY

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Is there a future for general practice postgraduate education?

THE Department of Health's proposed new contract for general practitioners' will mean major changes for general practice postgraduate education. Both the vocational training allowance and the postgraduate training allowance will be abolished, and a new postgraduate education allowance will take their place. This will be worth £1700 and will include an element to pay course fees, travel and subsistence. It also appears the funds previously available under section 63 will be abolished apart from use by trainees.

The new contract proposes a rigid set of criteria for the new allowance. These include a minimum of five days training per year in the previous five years. The courses that will qualify under the new regulations include those on health promotion and prevention of illness, disease management, and service management; the general practitioner will have to attend two courses under each of these three headings in each five-year period. The regional adviser will still have a role in deciding whether the course is educationally valuable and should be recommended for general practitioners. The family practitioner committee will decide, with advice from the regional adviser, into which category each course falls.

With vocational training for general practice now up and running successfully, the next major educational task in general practice is the establishment of continuing medical education for all general practitioners. However, the new contract does not appear to help towards this goal. It does not mention general practitioner tutors, course organizers or associate advisers nor the great strides made in the last 10 years in general practice education, young principals' groups, general practice research workshops, audit groups, Balint groups or symposia run by general practice tutors. There is no mention of assessing the value of courses, an activity which should be an integral part of education. There is no mention of study leave, or of the master's degree courses in general practice currently being set up in several universities.

Presumably vocational training will continue as before, with

course organizers paid by the family practitioner committee under the fees and allowances system. A major concern is the serious effects the new contract will have on continuing education. All that has been learned in general practice education in the past 20 years seems to have been disregarded with the likely return of the 'expert' lecture. We all remember lunchtime lectures when the expert came to talk on some esoteric subject, of no relevance to general practitioners or their patients. The lights went out, slides appeared on the screen, and quite soon most of the audience were asleep. Some doctors merely ate the lunch, signed the attendance book and went home while others felt they could do better, and set about organizing more meaningful general practice educational activities.

Most regions now have some sort of general practitioner tutor scheme. In the West Midlands region there is a general practitioner tutor in every postgraduate centre.³ In most centres there is a single tutor, but in some the general practitioners prefer to have a small group to run the general practice side of the postgraduate centre. General practitioner tutors are paid a small honorarium for their efforts and they may also claim a 'chairman's fee' for each meeting that they organize and chair. With the abolition of section 63, this funding will be lost, and it may lead to the end of the general practitioner tutor network. When the new proposals for hours of direct consultation in the surgery come into force will general practitioners who have been extensively involved in organizing educational activities still have the time to do this work? There appear to be no provisions made for general practitioners who already carry out educational work. Presumably, those who spend one day a week organizing postgraduate education will need to work every weekend in the practice in order to fulfil the new basic criteria for surgery consulting sessions. The latest proposals² suggest that the surgery commitment could be reduced to four days to take account of general practitioners' work on 'health related activities elsewhere in the public service — for example the hospital sector'. There is still no confirmation that educational activities carried out