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General practice: continuous quality improvement since 1948

If we aspire to provide top quality care the whole time, we are destined to be disappointed. The complexities of health care, the vagaries of human nature, the generation of new ideas about the aims and outcomes of care, and limitations on resources, all mean that there are always opportunities to improve. Yet this has not caused general practitioners (GPs) to give up their efforts to improve quality. Beginning two years after the creation of the NHS in 1948, Collings[1] and then Taylor[2] reported detailed investigations of general practice that disclosed major deficiencies in quality. Ever since, GPs have fretted about quality, and done much to improve it. This supplement to the journal makes it clear that general practice continues to give much attention to providing better care.

A pessimistic view of the continued interest in quality improvement is that little or no progress has been made, and that quality remains an obstinate problem. Indeed, recent high profile failures of medical care would sometimes lead one to think that serious problems of quality are widely prevalent. This would be the wrong conclusion. A great deal has changed, and quality has been transformed since the time of Collings. For example, the advent of audit in the 1990s has been associated with fundamental changes in our attitude to the work we do, and is evidence of steady, if slow, improvement in quality.[3] More recently, clinical governance has stimulated a wide range of quality improvement activities which should in due course feed through to better patient care,[4] and a new contract for GPs may introduce financial incentives for providing high quality care. In 1991, the General Medical Services Committee (GMSC) of the British Medical Association wrote: 'Over many years the GMSC has, understandably, taken a somewhat ambivalent view of audit. While lip service has been paid to the concept of audit (particularly 'self-audit'), little has been done to formalise its development or to make it part of a GP's contractual obligations'.[5] Ten years later, the findings of a national survey of over 23 000 GPs undertaken by the BMA, found that only 18.5% disagreed with the concept of clinical governance (a much more demanding concept than clinical audit), and only 29.2% disagreed with revalidation.[6]

The Royal College of General Practitioners has also taken a leading role in improving the quality of general practice during its 50-year history; for example, through the promotion of vocational training for general practice and the development of a range of quality improvement programmes. The Quality Initiative of 1983 led to a major policy statement in 1985, which foreshadowed both fellowship by assessment and regular assessment of all practices for financial performance incentives, such as health promotion targets and the measures in the contract currently under negotiation.[7]

However, despite the progress some aspects of care remain stubbornly difficult to improve. Although the inverse care law was first described more than 30 years ago,[8] inequity can still be found. Variations in performance between practices or GPs are well documented and persist despite decades of effort. To some extent, variations can be justified, since different doctors care for patients with different preferences and in different social and healthcare contexts, but the range of performance is usually wider than can be justified by these factors.[9] Variation can therefore contribute to inequity in the delivery of care[10] and, potentially, also to outcomes.

Policy developments also serve to focus attention on quality improvement. This occurs not simply because governments introduce systems for activities, such as clinical audit, guideline development, quality circles patient safety, but also because policy developments may challenge our pre-existing views about 'good' general practice. In the UK, the creation of walk-in centres, and the telephone advice and triage service NHS Direct, are obvious examples. Although these improve access to care for some patients, they may impair continuity and coordination of care for others. Access and continuity are both core values for GPs, and alteration in the relative importance of either has major implications for our discipline. These examples show how important it is for the discipline to be very clear about its values, and to argue for the care that we believe will benefit patients most.

Some GPs have also had new ideas about the nature of high quality health care, and these ideas can directly challenge the values of the profession. For John Berger, in his portrait of the archetypal personal GP, the question was how to take the measure of the contribution of an ordinary working doctor.[11] Berger said that the doctor eases, and occasionally saves, people's lives, but how do we assess how successful a doctor has been in the easing of people's lives? More recently, the idea of quality has been expressed as the doctor who delivers the advice from best available scientific evidence, although the arguments for evidence-based medicine continue to be challenged.[12] The most recent ideas of quality are more consumerist in orientation. Although doctors may prefer to think about quality in terms of shared decision making or patient participation, the consumerist approach concentrates on quick and convenient access to healthcare advice.

Since values determine how we define quality, the provision of high quality health care rests on the values of individual health professionals. In addition to values, the commitment and performance of health professionals, and the availability of resources, all influence quality. Our duty as professionals is to recognise and maintain the best of our values, and to nurture commitment to providing care in accordance with these values. Some of these values can be found expressed in *Good Medical Practice for General Practitioners*[13] or *The European Definition of General Practice/Family Medicine*.[14] The duty of healthcare organisations is to respect the importance of values, to maintain the motivation of professionals, and to provide the resources needed. These issues come at a critical time for general practice, when there are high hopes — but no certainty — that funding changes in the UK will lead to more resources, better motivation among GPs, and the opportunity to meet the public's expectations of the doctor. From the time of Collings and Taylor, it has been clear that the quality of general practice is heavily dependent on the administrative policies in place and the resources made available. GPs have

shown themselves willing to implement new policies; now they need the resources to turn policies into high quality care.

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References

1. Collings J. General practice in England today: a reconnaissance. *Lancet* 1950; **1:** 555-585.
2. Taylor S. *Good General Practice*. Oxford: Oxford University Press, 1954.
3. Hearnshaw H, Baker R, Cooper A. A survey of audit activity in general practice. *Br J Gen Pract* 1998; **48:** 979-981.
4. Campbell S, Wilkin D, Roland M. Primary Care Groups and Trusts in the new NHS: improving quality of care through clinical governance. *BMJ* 2001; **322:** 1580-1582.
5. General Medical Services Committee. *Building your own future. An agenda for general practice*. London: BMA, 1991.
6. General Practitioners Committee. *National Survey of GP Opinion. Overall results top-line report.* London: BMA, 2001.
7. Royal College of General Practitioners. *Quality in General Practice. Policy statement 2*. London: RCGP, 1985.
8. Hart JT. The inverse care law. *Lancet* 1971; **1:** 405-412.
9. Seddon ME, Marshall MN, Campbell SM, Roland MO. Systematic review of quality of clinical care in general practice in the UK, Australia and New Zealand. *Qual Health Care* 2001; **10:** 152-158.
10. Khunti K, Ganguli S, Baker R, Lowy A. Features of primary care associated with variations in process and outcome of care of people with diabetes. *Br J Gen Pract* 2001; **51:** 356-360.
11. Berger J. *A Fortunate Man*. London: Allen Lane, 1967.
12. Malterud K. Reflexivity and metapositions: strategies for appraisal of clinical evidence. *J Eval Clin Pract* 2002; **8:** 121-126.
13. Royal College of General Practitioners and General Practitioners Committee. *Good Medical Practice for General Practitioners*. London: RCGP, 2002.
14. Allen J, Gay B, Crebolder H, *et al.* The European definition of key features of the discipline of general practice. *Br J Gen Pract* 2002; **52:** 526-527.

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