Reflections on quality issues: quality becomes ever more complex

When I became Chairman of the Royal College of General Practitioners in 1998, the medical audit bandwagon, largely based on College values, had run out of steam. A new more sinister one — the identification and weeding out of poor performance was running strongly. This was partly fuelled by the Bristol paediatric cardiothoracic surgery case, and the subsequent Kennedy report,[1] partly by the Shipman case[2] and partly by other cases. The public and political perception of a significant and unacceptable 'quality tail' created pressure for action.

The RCGP, by supporting and growing the educational model of quality assurance, had also, largely unwittingly, given the ammunition to a new lobby. From Sir Donald Irvine's quality challenge,[3] the College developed its MRCGP examination and Fellowship by Assessment.[4] While comfortable defining quality, writing standards and assessing those standards at the 'average' and 'highest' levels, the College historically regarded minimum standards and their enforcement as the business of others.

However, the emerging political and media consensus in the 1990s was that the numbers of underperforming doctors and their impact on patient care were unacceptable. The new pressure was towards a beguiling vision — most clearly expressed in revalidation — in which all aspects of general practice would be defined and assessed. There would be total assurances of competency at all times and a risk-free environment in which any mishap required blame. Politicians saw any reluctance to agree to this agenda as professional hegemony.

Much of my three years as chairman was, therefore, preoccupied with defending the profession from slurs while helping to design safety nets that would be both effective and minimally intrusive for good GPs. We have yet to see the final shape of appraisal, revalidation, and the work of the National Patient Safety Authority. While I recognise that the definition and enforcement of minimal acceptable standards is inevitable and that we, the profession, rather than civil servants, need to be principle players in delivering them, I also want that to be a subtext to the main message of quality improvement through 'education', rather than 'regulation'. By this I mean the encouragement and recognition of good general practice, rather than the monitoring and blaming of health professionals.

In line with this thinking, the College has, in recent years, introduced Membership by Assessment (also a vital way to establish a broader base for the College), Quality Practice Award, Quality Team Development and Accredited Professional Development. APD is important because it not only supports good practice in continuing professional development, but it will also offer support for and ease the route through appraisal and revalidation.

Beyond the College the creation of the National Institute of Clinical Excellence, the Commission for Health Improvement, and the National Service Frameworks may help us and the public — the jury is still out — to know what is best practice and to work to ensure it is delivered to as many people as possible. They may, ironically, be our most powerful weapons to get sufficient people and money to meet expectations.

Alongside these two themes — guaranteeing minimum standards and promoting good standards — is a third important theme: patient safety.[5] In the modern blame culture in health care, it is easy to believe that for every adverse event there must be a doctor to be held responsible. However, some bad outcomes from care, such as some drug side effects, are part of the range of events that we expect. Some, such as the worse cancer outcomes in the UK compared with other western countries, are due to the low resources IN the NHS and therefore, result from societal choices.

Other adverse events are due to the design of services — generic drugs from a single manufacturer may look confusingly similar. It is these events that significant event auditing,[6] which has been actively promoted by the College, can help to identify and understand. We are increasingly encouraging reflective practice, in which observations about quality of care are treasured, not ignored.

The tide may be turning now. The emphasis is moving from 'who did something wrong?' and 'are you competent?'; towards 'how good is care?' and 'how can it be improved?' The answer to this last question may concern the competency of an individual, but is more likely to concern the organisation of care.

If we as health professionals can work with the public to develop a culture of education not regulation, of patient safety not blame, of quality assurance not performance management, we may yet achieve a health system to be proud of. By building on a necessary system to ensure minimum standards (revalidation) that does not distract us from our core task of improving care, we might yet live to work in a health service that genuinely cares about quality.

MIKE PRINGLE

Professor, and Chairman of Council, RCGP, 1998–2001

References

1. www.bristol-inquiry.org.uk
2. Pringle M. The Shipman inquiry: implications for the public's trust in doctors. *Br J Gen Pract* 2000; **50:** 355-356.
3. Irvine D. Quality of care in general practice. *J R Coll Gen Pract* 1983; **33:** 521-523.
4. Royal College of General Practitioners. *Fellowship by Assessment — Occasional Paper 50.* London: Royal College of General Practitioners, 1990.
5. Wilson T, Pringle M, Sheikh A. Promoting patient safety in primary care. *BMJ* 2001; **323:** 583-584.
6. Pringle M, Bradley C, Carmichael C, *et al. Significant Event Auditing.* [Occasional Paper 70.] London: Royal College of General Practitioners, 1995.

Address for correspondence

Professor M Pringle, Floor 13, Tower Building, University of Nottingham NG7 2RD. E-mail: mike.pringle@nottingham.ac.uk