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The quest for higher standards in primary care is as old as the practice of medicine, and it's a fair bet that it will continue as long as there are professionals practising. The difficulty has always been in tying down to a simple formula something so varied and personal. The difficulties of assessing basic competence are reflected in Stuart Murray's account of developing summative assessment (page 894). Interesting that direct observation of consulting turned out to be the most discriminatory element in the assessment. Since 2004 in the UK we have had the QOF, but even with later revisions it describes a tiny part of the medicine that we practise, and leaves out so much. One group working in the Midlands has reported on their attempts to widen the scope of the QOF, using additional data routinely collected by PCTs (page 856). They found little correlation between QOF score and indices of deprivation. Some other indicators were associated with the overall score, so that benzodiazepine and antibiotic prescribing both diminished with higher QOF scores.

The article on page 839 suggests that we may not be that good at looking after patients with osteoarthritis, one of the many conditions not currently included in QOF. Using nine well-validated performance indicators the authors assessed the overall quality of care and found it patchy. One difficulty was in using the information recorded in notes, when some tasks might have been completed without being recorded. David Memel admits that 'there are persuasive arguments against adding even more conditions to the QOF' (page 835). Even so, he deplores the exclusion of osteoarthritis, on the grounds that it is 'the most common cause of physical disability, particularly in older people.' The effect may be to shift our attention away from assessing function. The importance of doctors asking very directly about functional impairment is underlined by the study on page 844 on patients with end-stage COPD. The participants revealed themselves to be reticent about discussing their disabilities with doctors. Sometimes this was because they didn't recognise their limitations to be abnormal, perhaps a result of the humbling ability of humans to adapt to considerable handicap, but also some had already concluded that they were beyond help.

Norwegian doctors took part in a study to explore how they assessed function (page 850). They found assessing the physical consequences of illness to be, perhaps predictably, the easiest part;

assessing mental and social consequences much more difficult; and sorting out the effects on work often required skills beyond their usual expertise. Taken together, these all point back to core primary care, emphasising the importance of focusing more on how illness affects individual patients and their ability to enjoy fulfilling lives.

On page 880 there is a very serious attempt to quantify the probabilities of certain symptoms and symptom clusters indicating a brain tumour, and using the risks for guidance with the decision whether to investigate further. One aspect of this paper is to encourage us all to think about an acceptable level of risk before we investigate. Red flags are set at a probability of 1% of a brain tumour. Is that too low? It suggests that we might do up to 99 normal MRI or CAT scans for every brain tumour detected. At that level we should worry about the cost, but also about adverse outcomes, such as identifying incidental pathology where the natural history is imperfectly understood. But increasing the probability at which a scan is ordered to, say, 5% would presumably mean missing more.

The editorial on page 837 examines cost in greater detail, with a lot of troubling conclusions. For instance, the poor prognosis of brain tumours means the cost per quality-adjusted life year is much higher. It's a surprise that it is partly offset by the patients who have had a scan using much less in terms of resources in the year following. In the end, Hamilton points out that painkillers and triptans matter much more than brain scans, rather echoing the importance of paying attention to the problems as patients experience them.

We've had monthly reports from Norman Gland for the last 2 years. Sadly this month's is the last with the trainee doctor making a valiant attempt to learn something useful from her experiences (page 898). The perfect formula would also include standards for the care of such patients and all their illness and misery that we find impossible to diagnose. The key is to remember that every measure can only ever see a tiny part of the whole picture, and that the quest for high quality practice is an endless journey.

David Jewell*Editor*

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