LETTERS

Setting standards

David Jewell's editorial¹ raises important issues and makes many valuable points, but contained within it are the seeds of potentially worrying advice. Two sentences serve to illustrate this. "Clinicians attempting to improve their own practice by using standards set by others must do so with caution." "Those who assess clinicians' performance ... need to accept that local standards are the only way to improve care, however far removed they are from the grandiose statement of more august bodies."

While being aware of the dangers of extrapolating from one arena to another we should not use this as an excuse to justify possible shortcomings: "They may be able to do that in their practice/hospital/district, but of course things are quite different here and it would be impossible for us to achieve those figures/set up that system/give that degree of care." This may be a very reasonable statement or a poor excuse for an uncritical or unambitious approach. We should certainly strive to insure that standards set by national bodies are practical and relevant to real life, but we should also be encouraging development of more national guidelines as the proper basis of much that goes on in audit. Some local policies may be trend setters and eventually may be incorporated into general practice, but others may be used as a cover for less than optimal ways. The challenge is to get the blend right to ensure good general standards while not discouraging local initiatives, and not allowing local variations to disguise poor practice.

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1 Jewell D. Setting standards: from passing fashion to essential clinical activity? *Quality in Health Care* 1992;1:217-8.

AUTHOR'S REPLY

I agree with Dr Griffith that we should not use excuses to justify shortcomings. However, the implication – that clinicians are happy to accept poor practice, provided that they can find a reasonable justification, and that they therefore need some national guidelines to bring them into line – is very much at variance with my own experience. The principle of Kaizen, as I understand it, and which is closer to my own view of most doctors in the United Kingdom is to start from the assumption that everyone is trying to do their best. Equally, my own experience of standard setting is not that doctors are prepared to accept low standards but that, on the whole, they always set unrealistically high standards. If the

purpose of the exercise is to improve the quality of care then it has to be up to those doing the work to decide what is a realistic target, given the point they are starting from. It doesn't help to say, in the words of the old joke: "Ah, but you shouldn't be starting from here." If those setting local standards set them at a point which is wildly adrift of all current practice and do not amend them when they have been attained, then questions should be asked. Can Dr Griffith quote a single example of such behaviour? And does he think much will be achieved by practitioners obliged to aim at nationally set standards far remote from their own current clinical practice? The evidence is against him.

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Improving quality of health care

Dr Richard Thomson and Professor Raj Bhopal¹ have provided a most useful exposition on the role of public health physicians in the new world of purchasing and providing health services. I would add a personal comment pertaining to two of the subjects they cover.

As regards actual outcomes and potential outcomes they encourage public health doctors in the field to consider "effectiveness rather than efficacy." In reality, these considerations revolve around targeting scarce public health physicians' management effort. My own view is that such effort would be better deployed in ensuring the high quality implementation of a service change whose value has been established in experimental conditions rather than designing information systems toward re-examining a hypothesis, albeit under practical (as opposed to experimental) situations. As regards outcomes of care public health medicine has indeed a distinct contribution to make in the formulation and analysis of outcomes of care which are useful in assessing service quality improvements. However, the management effort involved, which has been well described in at least two recent publications,^{2,3} is often considerable.

Those working in the specialty, who are keen to further demonstrate its contribution, may do well to concede this from the outset. Perhaps the development of useful outcome measures may then be taken forward as a shared activity within the specialty, with a focus on areas where their development is likely to be of greatest practical value.

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- 1 Thomson R, Bhopal R. Improving quality of health care: the role of public health medicine. *Quality in Health Care* 1993;2: 35-9.
- 2 Garratt AM, MacDonald LM, Ruta AD, Russell IT, Buckingham JK, Krukowski ZH. Towards measurement of outcome for patients with varicose veins. *Quality in Health Care* 1993;2:5-10.
- 3 O'Brien J, Bowie C. A methodology for collecting outcome measures for common hospital conditions. *Public Health Med* 1992;14:380-4.

BOOK REVIEWS

Hospital Referrals. Roland M, Coulter A, eds (221 pp; £18.50). Oxford: Oxford University Press, 1992. (Oxford General Practice Series 22.) ISBN 0-19-262174-2.

So far as hospital medical treatment is concerned, hospital referral is the jobbing general practitioner's "needs assessment." Referral follows from a decision that a patient has a need for investigation, treatment, or reassurance which we lack the knowledge, facilities, time, or inclination to meet. It is hardly surprising, therefore, that large variations exist in the rate at which general practitioners refer patients to hospital.

The British system by which general practitioners largely control patients' access to medical specialists has been central to the cost effectiveness of the NHS. It is associated with lower usage of expensive specialist facilities than prevails in other industrialised countries. It is likely that under-referral is at least as great a problem as over-referral. Consumerism, the government's substitute for local democracy, will increase pressure for readier access to specialists. None of this has prevented cost conscious commentators from seeing, in the variability of hospital referral rates, the potential for even greater economies in public spending. This explains the political spotlight on the subject – and the consequent importance of this excellent book. *Hospital Referrals* should be required reading for any manager thinking of acting on referral rates and for any general practitioners who find themselves on the receiving end of such action – or, more importantly, who wish to embark on a critical analysis of their own referral practices.

The book describes the British referral system, sets it in the context of the history of the health service and the medical profession, and compares it with the interface between primary and secondary care in continental Europe and North America. There is a chapter on the impact of the recent NHS reforms – more than half of which, appropriately enough, is devoted to a section entitled, "Problematic areas." The literature on measuring referral rates, appropriateness of referrals, and explaining their variability is critically reviewed. The implications of incorporating the patient's perspective more explicitly into the assessment of the referral process are considered, and the problems encountered in developing referral guidelines are discussed, as are the even greater problems of attempting scientific evaluation of whether or not such guidelines achieve anything useful. It is noteworthy that the long and detailed chapter on the general principles of evaluating guidelines could cite only one study in which the effectiveness of a

referral guideline had actually been measured.

A key theme of the book is how little wisdom has so far been yielded by our knowledge. Problems of allowing for differences in age structure and case mix and for the effects of random variation make referral rates difficult to interpret. Existing systems for collecting the data are often unreliable. But having obtained reliable data, we move on to a greater problem; to quote David Wilkin, "Because we know nothing about the appropriateness of referrals or their outcomes for patients, we do not know whether wide variations in patterns of referral are a sign of inefficiency, or whether reducing variation will increase efficiency."

There is a paradox here, in that almost any district general hospital consultant knows, for his or her specialty and his or her own patch, the answer that is eluding the collective efforts of the data collectors – namely, which general practitioners tend to refer too soon and which tend to refer too late. Conversely, general practitioners, particularly if they organise the sharing of information on referral outcome, know more about the quality of hospital services than is likely to emerge from any provider's prospectus. Improving the functioning of the referral system is much more likely to be achieved by constructive and sensitive use of this sort of local knowledge than by the collection and publication of uninterpretable statistics by family health services authorities. It remains to be seen whether the adversarial environment engendered by the reforms will prove conducive to initiatives of this kind, but anyone seeking to make the referral system work better should read this book first.

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Clinical guidelines. Report of a local initiative. Haines A, Hurwitz B, eds (pp 91; £11.50). London: Royal College of General Practitioners, 1992. (Occasional paper 58.) ISBN 0-85084-179-8.

Protocols are a growth industry. In the United Kingdom they have been produced by general practitioners for contractual reasons, particularly in order to obtain approval and thereby payment for health promotion activities and surveillance of chronic disease. Clear statements of performance are also seen as an essential part of the audit process, encouraged by medical audit advisory groups. This emphasis on each practice producing its own protocols and guidelines is in contrast to the approach of other countries, notably the Netherlands, where national guidelines have been published for a wide range of conditions.

This occasional paper presents an alternative approach: the development of guidelines in one locality, initiated by an academic department and resourced by local hospital specialists and general practitioners. The family health services authority supported the initiative by

printing and distributing the guidelines locally. The fact that these local guidelines have been published as an occasional paper for a national and international readership suggests that the Royal College of General Practitioners wants to stimulate a debate about the use of protocols. In his preface Professor Pereira Gray suggests that it may soon be necessary (sic) for the college council to endorse protocols formally.

The occasional paper starts with a review of the principles underpinning guidelines, the evidence of guidelines' effectiveness, and the methods used in Islington. The bulk of the paper is the guidelines themselves, of which there are fifteen, ranging from chronic diseases such as diabetes and asthma and health promotion topics such as cardiovascular disease, child health surveillance, and management of chronic drinkers to clinical areas of general practice such as ophthalmology and skin diseases. The authors state that conditions were selected on the basis of accounting for 10 or more consultations per 1000 in general practice.

In their introduction the authors describe how guidelines can be designed by four methods: subjective judgment, evidence based, outcomes based and preference based (that is, including the public's opinions). All the chapters, most of which are co-authored by a general practitioner and hospital specialist, are in the first two categories. The extent to which research evidence is cited varies, with over twenty references at the end of the chapter on cardiovascular disease, and none for the chapter on skin diseases and ophthalmology. This diversity reflects the different approaches used; for some conditions, such as asthma, simple algorithms are used whereas other chapters are descriptive in the undergraduate textbook mode, sometimes with unnecessarily detailed appendices on such issues as specific screening procedures in children. All chapters end with suggestions for audit, which, not surprisingly, are most useful in those chapters which contain explicit standards of care.

Practitioners differ in the amount they read, the type of material they read, and when they read it and particularly in their use of reference materials during consultations. The guidelines in this publication could be used in three ways: during consultations, in formulating a practice policy, and in developing similar initiatives in other health districts. There is a paradox at the heart of the trend towards guidelines; the evidence suggests that they influence only those actively engaged in their formulation whereas it is obvious that one person has not the time nor energy to address more than a small area of practice. By providing a template on which practices or districts can build this publication fulfils an important function. It is also a refreshingly concise account of current approaches to important aspects of primary care.

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Audit and Development in Primary Care. Humphrey C, Hughes J (pp 82; £9.50). London: King's Fund, 1992 (Medical Audit Series 5.) ISBN 1-85717-030-X.

When audit in primary care became a government objective the strategy was to encourage and facilitate it in whatever way seemed appropriate for the setting. The result has been, as described in *Audit and Development in Primary Care*, confetti audit.

One of the problems of this model is the difficulty in getting a feel of what is really happening and of seeing the whole picture. The major achievement of this book is that it is an anthology with comment of primary care audit as it is now. There is a lot of good reading for all facilitators and advisors in audit. There seems to be no unnecessary repetition of examples, and from my personal experience of the examples quoted, the reporting is accurate.

However, this book is more than an anthology. It is a reasoned argument for the development of audit along particular lines – the lines of a managed service. There is no exploration of the debate that this method has been so successful because it corresponds so well with general practice as it is, and that this should be the underlying philosophy to be developed. This would not in itself be a problem except that the first major part of the book is the executive summary, and that is where health care planners and strategists often begin and end their reading. If we, the profession, wish to see audit develop along different lines we have to start saying so now.

I would have liked to see a glossary of the terms, such as broker and stakeholder. They are explained but not defined in the text, and there is scope for the reader to take them beyond their original meaning. The idea of an audit broker is new and could have been developed to help those unfamiliar with these management terms to grasp the concept. For instance, broker is listed with facilitator and champions of change, but the role as described in the text is as one who promotes collaboration between local practitioners and establishes vertical links between primary care and the interested service agencies. Many facilitators who have fostered their practices with assurances of confidentiality and separation from the family health services authorities will be anxious to see their job develop in this way. Much time and effort have been invested in neutralising the paranoia in the grass roots. The investment should be seen as planting trees not as a cash crop. Patient development based on an educational foundation is likely to lead to fruitful outcome. The policy makers and planners would do well to listen to the enthusiasts in primary care who have championed the changes and causes, before making hasty moves towards synthesising the educational with what might be construed as regulatory audit.

However, the profession does have a wider responsibility to the public and,