Playing by the rules ...

It is indeed a laudable objective of this journal to promote a truly integrated multidisciplinary approach to quality health care evaluation. As previous issues of the journal have illustrated, the job of the editorial team has been to ensure that a balance between medical, nursing, managerial, and paramedical views of a quality service is achieved. Yet already there are several issues emerging. For example, it is often reported to me that while nursing colleagues are really doing a lot on quality at grass roots level they are not prepared to write up their work for journals such as this. The consequence is an overrepresentation of quality issues in medicine rather than in nursing or an integrated view. Similarly, managers are allegedly too busy to put pen to paper, thus facing the same potential disenfranchisement when it comes to defining quality.

One conclusion drawn from this is that medical practitioners, given the volume of audit articles being generated, are the only members of the team with sufficient time and resources to document their work! The rest of us are too busy doing the job! Though this view may quickly be dismissed as a false conclusion, the question of why there continues to be a disparity in the volume of information generated by different members of the health care team does need to be addressed.

My own view is that this situation reflects a profound and complex problem. Fundamentally, if there is no description and interpretation of a discipline in the language and terminology it chooses then there is little possibility of that discipline developing its expertise. So if nurses and others do not document their efforts in quality improvement they are making it impossible for others to see their particular perspective on quality. And if the particular contribution of one discipline is not clearly recognised it is virtually impossible to have a collective approach to quality – all that results is a monopoly in which one group dominates the whole proceedings.

Definitions of quality are context related and are influenced by the values and beliefs of those individuals involved in the activity. The definition of quality agreed on also affects the methods used to audit the aspect of quality under investigation. That medical views of what constitutes a quality issue may often be diametrically opposed to a nursing perspective is illustrated in the following example.

A group of nurses were concerned about the dignity of elderly men who had undergone transurethral resection of prostate operations. Often several of these patients when mobile were found to be exposing their genitals because of bulky catheter bags, inappropriate drainage systems, and ill fitting pyjamas. The nurses decided to set a standard to improve the situation, part of which related to evaluating the range of catheter equipment used routinely in the ward. When invited to attend a lunch time seminar on the quality problem, one surgeon asked whether there was a problem with infection. When told that there was not he asked why there needed to be a meeting at all and departed.

The example is clear enough: a medical interpretation of what constituted a quality problem in this case related to incidence of infection rates; a nursing perspective defined the problem in terms of patient dignity. The questions to be answered are: is patient dignity a legitimate topic for audit? If so how would one go about auditing it in a way that was accessible to all members of the health care team? Why, in this case, was there little or no appreciation of the quality issue that the nurses wished to explore? Was it the way they presented the problem or the language they used?

This example reflects the different ideological perspectives that doctors and nurses tend to hold regarding definitions of quality – with medicine being located in the technical-rational domain and nursing moving into areas of interpersonal relationships. It also raises the question of how either group would choose to audit their quality improvement. Infection rates lend themselves more easily to the routine quantitative audit process whereas the measurement of a concept such as dignity may require a more qualitative audit approach.

The issue then becomes one of questioning whether the whole audit process is more oriented to solving what could be called technical problems, which more traditionally locate themselves within a medical context. Perceived nursing problems tend to be more interpersonal in nature, areas notoriously difficult to measure precisely using conventional approaches. (This is not uniquely a nursing problem – specialties within medicine such as general practice, psychiatry, or palliative care face similar issues.) The challenge then changes. Should nurses identify quality problems that are more technical in order to fit in more comfortably with the dominant approach to audit? Or should the audit process itself begin to accommodate a much more eclectic approach to quality evaluation?

The experience of nurses involved in continuous quality improvement using standard setting shows that when the objective is improvement in the service the methods required for evaluating practice must be broad ranging. Chart audits are of value, but they certainly are not the only means of evaluating practice. Because nursing has not emerged from a traditional, technical-rational approach to problem solving the skills associated with it are often underdeveloped, and opportunities to
acquire those skills are rarely offered. Consequently a
nursing perspective on audit methods tends to select
techniques such as continuous observation, peer review,
and case study approaches rather than a quantitative
approach.

The picture emerging then is one in which different
health care groups working ostensibly together will
perceive different topics as areas for quality
improvement, will describe the problem in their own
particular language, and will go on to select a
methodology with which they feel comfortable. The fact
that medical audit this year has been resourced up to
eight times more than the corresponding nursing and
therapy audit (£48.0m as opposed to £6.2m) leads to
the suspicion that the technical-rational, traditional audit
approach is favoured more than some other approaches
(or, more controversially, that medical audit is more
highly valued than other professions’ attempts to audit
their practice).

We can now begin to sense the problems posed for a
journal such as this. Do we continue the conspiracy and
play by the (medical audit) rules? Or do we begin to
bring in a new set of methodologies, with different rules
and different techniques? Is there sufficient respect
among members of the health care team for the varied
contributions we all make in order to expand the perspective and methodologies of audit. Only if this is
possible will the objective of this journal be realised and,
more importantly, will assessment and improvement of the quality of care become a truly patient focused
experience.

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Uncertainty in medicine: can it be reduced?

“Nous sommes dans un nuage d’inconnaissance et
d’incertitude, et la connaissance a produit ce nuage.”

E MORIN

The development of medicine as a science began in the
second half of the nineteenth century. The “paradigm of
certainty,” inherited from the mechanistic model of
scientific knowledge, was applied to medical science by
Claude Bernard in the 1860s. Conclusions from
observation and research admitted as “true” facts were
believed to reflect, in medicine as in physical sciences,
the true organisation of matter and determination of
disease. Modern doctors and the general public have
been brought up to believe that knowledge of the
mechanisms of disease was sufficient to establish correct
diagnoses; provide accurate prognoses; and, through
application of medical research, produce cures.

**Diminishing confidence**

But confidence in medicine has faltered. Influential
writers have expressed doubts about the effectiveness of
medicine. Some medical interventions which were
assumed to be effective have proved to be ineffective,
and some untreated patients have fared better than
treated patients. Diagnoses and opportunities for
treatment are missed despite the emphasis on the
technical possibilities of early detection and prevention
of diseases. Slower progress than anticipated in the
development of effective treatments for solid tumours
and chronic diseases; the unwanted secondary effects of
chemotherapy, radiotherapy, and other treatments; and,
more recently, the impotence of therapeutic agents
against viral diseases and AIDS have all contributed to
a wave of scepticism. Doctors are criticised for failing to
inform patients about treatment options and the likely
consequences of available treatments.

Moreover, many unexplained variations in the use and
appropriateness of medical interventions and variability
in medical judgements have been described. Such
variations seem to be counter to a discipline which has
a scientific basis, and they suggest either important gaps
between the results of research and medical practice or
a profound uncertainty in the practice of medicine.

All this has occurred despite an expansion in medical
information. The volume of medical literature increases
by 6% every year and in the course of a medical career
will increase tenfold. About 250 000 new articles or
books, or both, are registered by the National Library of
Medicine in Washington every year. So a general
physician wanting to keep up with only the 10 leading
journals in internal medicine would need to read 200
articles and 70 editorials a month. And a reader setting
out to read one article a day from every subsequently
published medical journal would be 55 centuries behind
in their reading one year later.

Not only is the quantity of medical information
overwhelming but much of it describes work of poor
scientific quality. Williamson et al analysed 28 articles
that each assessed the scientific adequacy of methods
(study design, data, statistical inferences, etc.) used in
a total of more than 4200 medical research reports. The
significance of their conclusion that “serious and
widespread problems exist in the clinical literature” is
further amplified by the knowledge that many
practitioners are not adequately trained to evaluate the
quality of the research results with which they are
presented.

Further causes for concern are that the use of many
current medical interventions is unsupported by
adequate evaluation and that there is no clear consensus
for their use. Wennberg writes that there is “double
standard for truth in medicine,” for, in contrast to the
careful evaluation mandated for drugs, no system of
careful evaluation for safety, efficacy, and appropriate
use of other interventions exists. Information is
fragmented, inaccessible, and variable in quality.
Perhaps it is not surprising that there is uncertainty and
variation in medical practice. So, although medicine has
developed a considerable theoretical scientific basis, the
determinants of its application remain to be better
understood. In other words, what may be lacking today
is a science of medical practice.

**Focusing on practice**

One response to the need to reduce variation in practice
and the need to synthesise the valid information from
Playing by the rules ...

A Kitson

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