MEETINGS REPORTS

European working party on quality assurance in family practice, Utrecht, December 1991

In the United Kingdom we are nearing the end of the first year of medical audit run by the medical audit advisory groups. The enormous tasks of gaining the participation of all family doctors, even the most reluctant, and negotiating funds and safety from interference from family health services authorities have absorbed all the energies of these groups. Because of their preoccupations members of these groups may be surprised to learn that their experiences are not unique. Family doctors in other countries are facing similar challenges, and the alternative approaches they have chosen are worth careful study.

In December 1991 a group of family doctors from fifteen European countries met for three days in Utrecht at the first meeting of the European working party on quality assurance in family practice, otherwise known as Equip. The Dutch college of general practitioners acted as host, and the meeting was convened by Richard Grol, who has a long record of innovation in quality assurance for family practice. Representatives came from as far afield as Israel and Iceland, and the differences between them were illuminating: the richest country was Germany and poorest Hungary; in one country there was one family doctor for every 1000 people, in another the ratio was up to one for 4000; some doctors had many facilities and equipment others almost none; and the standing of family practice varied from being the central feature of the health service to an almost peripheral activity ignored by government and the rest of the profession.

Despite their different origins the participants all shared various common concerns. They all believed that if family practice is to flourish and best serve its patients and the public it must improve its quality. Every country was facing the related issues of costs, quality assurance, and health service reform. Progress towards quality assurance varied. The most advanced systems had three features: a legal framework that committed family doctors and government to quality assurance; an organisational structure responsible for supervising activities; and adequate funding. Effective quality assurance was more likely if these three features were used to encourage family doctors to take charge of quality and lead developments rather than simply to compel participation, an approach that created resentment and poor compliance. Medical audit advisory groups could learn much from some of the specific projects in these countries. The Netherlands has special expertise in peer review and standard setting. In Spain a regional framework has encouraged the development of a rigorous scheme to monitor preventive care. From Finland came advice to relate local quality assurance to the needs of the population as revealed in a “community diagnosis.” In Norway there is a novel accreditation system that allows doctors who fail the assessment to continue in practice but lose 15–20% of their income. One aim of Equip is to undertake a formal study of quality assurance in each member country, and this will provide more information about successful quality assurance systems. The group also intends to establish a network to exchange information about quality assurance and publish reports to help those seeking to develop quality assurance in different health care systems.

What can we learn from other countries about quality assurance in family practice in the United Kingdom? We seem to be the only country without a “medical audit.” Everyone else talks about quality assurance. Until we start talking about quality the introduction of continuous improvement or total quality management will be difficult. Though we have a structure to promote quality assurance, many family doctors remain to be convinced of its value. The projects undertaken are usually at a relatively simple level and we can expect a rapid increase in their sophistication as long doctors take the lead and have the confidence to accept innovations. The different patterns of work of family doctors in Europe gave rise to reflections on what should be provided — for example, how many patients should a doctor care for or how many consultations can be undertaken in a day without reducing quality. It is curious that there is no consensus about these basic features of practice. No doubt many clinical standards will be devised in the next few years, but perhaps there will also emerge a set of standards on the structure of family practice. This could prove a powerful stimulus to encourage some governments in Europe to improve quality by investment in family practice.

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Continuous quality improvement headed the Department of Health’s agenda for 1992 as the year began with a one day conference on clinical audit that uses the term presentations from representatives of various therapy professions and a national overview by Richard O’Connor of studies on continuous quality improvement issues supported by the Department of Health. The studies, such as that concerned with evaluation of standard setting (the Odyssey project) at the Royal College of Nursing; a study at King’s College, London, assessing the reliability and validity of predetermined quality assessment tools; and a study at Newcastle Polytechnic, considering outcomes reflect the issues and concerns about clinical audit raised by conference delegates.

What was clear from the presentations and the subsequent debate at the afternoon workshops was that the nursing and therapy professions consider that there is great potential for collaborative audit but that several issues need clarification before it will be adopted as the norm. Of pressing concern is what is actually meant by clinical audit. Does it refer only to the audit of clinical practice? Is it multiprofessional or uniprofessional, or both? What is its relation with medical audit and organisational audit? What are the resource implications of these questions? How do the nursing and therapy professions access money made available for audit by the Department of Health?

For clarification the department is considering producing a glossary of the terms used to define and describe clinical audit and its process. There was a strong feeling among the delegates that development of a glossary should be informed by further debate of the issues and by adopting the bottom up approach advocated by many experienced in continuous quality improvement. It is important that it promotes an understanding of the concepts of audit and a shared language.

The improvement of tools of measurement and the continued consideration of outcome in relation to intervention and to the process were raised by delegates as key elements in the development of clinical audit. The commonalities of experience with audit among the professions represented in the oral and poster presentations highlighted the need for a forum to share information and exchange ideas. The Royal College of Nursing currently runs a network for all health care professionals to facilitate such exchange of ideas, and it was suggested that the Department of Health become involved in the networking process.

The reassessment of the patient’s experience during the course of the day showed the value of clinical audit and the need for collaboration between all health care professionals, as well as patients and other carers, if audit is to achieve the objective of continuous quality improvement of health care.

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