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.

DAVID GRIFFITH
Department of Health Care for Older People,
Mayday University Hospital,
Thornton Heath,
Surrey CR7 7YE

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.

DAVID JEWELL
Department of Epidemiology and
Public Health Medicine,
University of Bristol,
Bristol BS8 1TH

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.

M A EDGAR
North Western Regional Health Authority,
Manchester M60 7LP

- 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