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.”2 “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 grandiloquent 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.”3 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 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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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 clearly enshrined in the 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: “A patient 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.

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 improvement. 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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