Role of users of health care in achieving a quality service

In their paper Hopkins et al 1 continue the journal’s consistent record of distilling current thought on quality in a concise and luminous way. However, they may have perpetuated an error found in many of their sources. They are preoccupied with users (plural) rather than the individual as a user. Even their section headed “individual users” (plural again) considers mainly the aggregate differences between patients and staff, their communication and information, and general feelings and interests. Because of its statistical appeal I was seduced by the same preoccupation 2 until considering patient needs analysis as a contributor to quality.

This changed my perspective on users “determining the effectiveness of care” 3 and began a quest for evaluating patient centred, patient measured goal attainment during individual rehabilitation. This began by offering the patient some menu of possible unmet needs which the services might contemplate addressing with him or her. 4, 5 but most colleagues proved lukewarm about adopting such approaches for routine audit. When Bond and Thomas conducted their survey in 1990 of the Nursing Times 6 not one out of 160 accounts of measuring outcomes involved goal attainment by patients. Of the many possible “off the peg” (menu driven) unmet needs oriented measures, we have adopted only one in Cambridge – namely, the Canadian occupational performance measure – for use by therapists in a pilot service 7 where the needs patients would present to us were quite unknown and the treatment options somewhat limited.

An evaluation of new nursing skills and resultant outcomes in a service for patients with long term problems suggested that increasing a nurse’s flexibility in negotiating with patients who feel “in charge” of their personal (evolving) care plan might generate a good partnership and promote successful outcomes. 8 An outstanding example of flexibility in goal attainment measures is the problem/goal/target approach of Marks and Toole, 9 which seems to enhance the therapeutic alliance between user and nurse, progressively. 10 A version of this “made to measure” outcome scaling is now being introduced to patient focused rehabilitation services in the community. We have found that one advantage of coherence of this type of goal attainment with an individual user’s (singular) assets and liabilities. 11

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6 Caan W. Developing a model occupational therapy service in primary care. Br J Occu-
8 Rainsford E, Caan W. Experience of super-

Appraising clinical guidelines

Cluzeau et al argue for systematically developed and critically appraised guidelines in order to ensure quality. 1 They state that the essential prerequisite for improved quality of care is that a guideline is valid. They define validity to mean that adherence to the guideline will increase the probability of bringing about the expected health outcome at the expected cost.

While the National Health Service waits for all these rigorously validated and systematically developed guidelines, should we not consider the potential value of adherence to guidelines which increase the probability of bringing about the expected healthcare process at the expected cost? The huge gap in our knowledge of the links between health care process and outcome is more complicated than Cluzeau et al suggest. We are a long way from attributing the health outcome experienced by patients to the interventions to which they have been exposed. The national research and development strategy has helped to focus research into these areas. It will be an appreciable time before the development of valid guidelines which have all the attributes proposed by the authors. Even at this stage, the skills and aptitude of the appraisers are clearly not commonly developed, as evidenced by the poor agreement recorded in Cluzeau’s (unpublished) report of published guidelines in the United Kingdom.

I hope that many of your readers agree with the vision of Cluzeau et al. The reality, however, is that clinical practice, purchasing and education will continue in the absence of such valid guidelines. The vision is helpful. A nationally coordinated approach to achieving it must take into account where each clinician, organisation, and teacher is now, in relation to where they perceive they should be in future.

I suggest that we should start by identifying and working with those guidelines which achieve a minimum level of validity. These might be defined as guidelines which clinical professionals can work with and which result in acceptance by professionals and public (preferably in collaborative ventures) of their relevance to health care delivered to patients, regardless where they live – that is, high quality health care free at the point of access.

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Total hip replacement

The article by John Ivory and colleagues 1 provides a thoughtful and authoritative description of the procedures and processes for total hip replacement that would be advocated by joint hip surgeons. But the crucial subject of the long term outcome of total hip replacement was not adequately discussed. Despite the large and increasing number of hip and knee arthroplasties performed world wide there is an astonishing lack of knowledge of long term outcome of these operations. There is, of course, evidence that demonstrates the excellent short term and medium term benefits of joint replacement surgery but these come for the most part from specialist units; for those who have taken the trouble to follow up their operations adequately. So far no study has looked systematically on an overall scale at the outcome at 10 or even five years after total hip replacement. With the increasing number of joint replacements in a population living longer and therefore expecting a “longer service” from their replaced joints this information is important.

The early morbidity, up to six months postoperatively, when patients are usually discharged back to the care of their general practitioners, is known. Subsequently, the expectation is that if the joint fails the patient will return to the surgeon who did the procedure. Such an arrangement is vague. Not only are there many examples of “joint failures” that require further surgical intervention being treated with analgesia in the belief that the recurrent pain is from recurring “arthritis” but there is no system for routinely collecting the data needed as the basis for understanding the long term consequences of this common procedure.

The most sensitive way of detecting “joint failure” is from a radiograph. One solution would be to establish a nationally coordinated routine whereby patients are reviewed and their replaced joint radiographed at five years and again, unless there are problems, at 10 years postoperatively. In Trent a regional arthroplasty panel, funded by the regional health authority, and administered by Professor Paul Gregg and Mr J W Harper at the Department of Orthopaedic Surgery, Glenfield General Hospital, Leicester, has functioned for more than two years. Even after only two