Role of users of health care in achieving a quality service

In their paper Hopkins et al 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 until considering patient needs analysis as a contributor to quality.

This changed my perspective on users “determining the effectiveness of care” 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, 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 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 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. An outstanding example of flexibility in goal attainment measures is the problem/goal/target approach of Marks and Toole, which seems to enhance the therapeutic alliance between user and nurse, progressively. 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. 

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Appraising clinical guidelines

Cluzeau et al argue for systematically developed and critically appraised guidelines in order to ensure quality. 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 provides a thoughtful and authoritative description of the procedures and processes for total hip replacement that would be advocated by 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 or 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 nationally a 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
years the scheme affords an invaluable directory of different types of operations, enabling surgeons and others to compare results and morbidity. As yet, despite our recommendations similar schemes have not been developed in other regions. The cost is £60 per joint replacement.

As the number of joint replacements increases so the requirement for revision of joints already replaced will increase. Revision surgery is more complex and more expensive than primary joint replacement surgery. We need to plan for the future revision rate. Centres which have accepted patients for revision surgery are now becoming overwhelmed by referrals. To quantify the need for revisions of hips and knees more information is required about the outcome of joint replacement and it is imperative that new types of prosthesis are properly evaluated in appropriately designed and conducted trials. There is no place for occasional, uncoordinated trails of new prostheses. Only by comprehensive coordinated national surveys and audit will we be able to obtain accurate information. Purchasers and orthopaedic surgeons need to work together to establish systems to enable the collation of the requisite data to create a strategy for future provision of joint replacement services. The cost is small compared with the total cost of joint replacement surgery. Not to invest in this now would be a false economy.

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BOOK REVIEWS


This occasional paper has been published at an opportune time for reassessing the learning and teaching opportunities both for doctors undergoing vocational training and for established general practitioners to obtain more value from continuing medical education than merely the collection of postgraduate education allowance points.

The document focuses on the use of adult learning principles so often ignored in traditional medical education and highlights that the learning experience requires involvement, should be enjoyable, and ultimately should lead to improved patient care. The current failure generally of the postgraduate education allowance mechanism is highlighted, and the meaning of portfolio based learning is clearly described, particularly focusing on the difference from merely keeping a log of activities attended to evidence of the learning that has taken place. Recognition of portfolio based learning as a demanding exercise and the need for regional advisors and clinical tutors to provide a flexible, granting postgraduate education allowance approval for the work of portfolio based learning are points well made. The role of mentors is emphasised, and the problems of the mentor and the mentee are highlighted. Current skills in mentoring, the time required, and the likely absence of extra funding are explicitly recognised. Issues of assessment are rather ducked; they remain difficult. The role of the portfolio as a valuable formative tool is recognised, but whether submitting a portfolio will or should remain voluntary is not addressed nor are the training requirements of portfolio learning for assessors. Personally, I am concerned about the references towards supplying portfolios of learning for higher degrees as this seems to detract from the overall function of portfolio learning, which realistically will not be attractive to the vast majority of general practitioners.

Finally, there is an excellent chapter on portfolio learning in vocational training, which gives an excellent summary, relevant not only to trainees undergoing vocational training but to experienced general practitioners wishing to participate in meaningful continuing medical education. This chapter alone makes this commendable document worthwhile reading for all general practitioners who have an interest in maintaining and developing their knowledge and skill base. It is not just for the academics or tutors and throws down interesting challenges to regional advisors for postgraduate education allowance approval. It could also be a model for other specialties to develop their own continuing medical education.

BRIAN TOMS
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Liaison is probably one of the most important factors between psychiatrists and general practitioners. There is often a misunderstanding about what both groups have to offer. Psychiatry and General Practice Today provides an up to date source book. The four different sections of the book, context, clinical problems, psycho-social management, and training and research contain chapters written by a psychiatrist or general practitioner with a special interest in psychiatry.

Exploiting the relationship between general practitioners and psychiatrists, the book reflects on how GPs can offer their services and the different models of care provided by psychiatrists, such as primary care clinics and crisis intervention services, etc. There is also an interesting chapter, well illustrated with examples, on law and ethics and what is required of doctors regarding power of attorney and court of protection. The second section will find GPs on familiar ground, looking at clinical topics such as alcohol, bereavement and on cross cultural issues. The chapter enlightens the reader with something new; I found the appendix to the chapter on older people, with its abbreviated mental test scale on geriatric depression, particularly user friendly. The section on psychosocial management looks at communications and teamwork, and also includes two chapters – on counselling and on constructive and cognitive behaviour therapy. General practitioners would certainly be able to apply the chapter on cognitive behaviour therapy in practice. Within the training and research section it was interesting from a general practitioner’s viewpoint to see how psychiatrists in training view attachments to a practice. Practical guidelines were given on how to look at videos, especially for group teachings.

The book has several strengths. The different authors write with enthusiasm but self-critically and in their individual styles. The chapters are easy to follow, and the references are up to date. Psychiatry and General Practice Today is a convenient book to dip into, and I would recommend it to anyone with an interest in mental health issues.

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We live in an information-hungry age. The role of the expert is increasingly seen as that of facilitator, rather than dictator, of individual behaviour, and this applies to the relationship between patients and doctors as much as anywhere else. Questioning the doctor’s wisdom is, however, something that tends to go on outside the consulting room: “They never seem to listen to me,” grumbles the patient. If only patients would challenge the doctor at the time – in most cases a constructive discussion would ensue, and they would take some informed decisions about treatment. Of course, for that to happen patients need doctors to invite challenge and discussion. Many doctors would probably be very amenable – after all, why waste precious time on repeated consultation if there is nothing of money wasted on drug treatments actually used, if talking for 15 minutes about the condition and the pros and cons of treatment could remove all that? But the time just isn’t available in a GP’s appointment book and the grumbles go on.

But Will It Work, Doctor? is a report of a conference on awareness and outcomes research at the King’s Fund Centre in November 1993, which explored ways of creating communication between patients and their carers, and, on the whole, it is written as a practical guide to decision support systems which allow precious consultation time to be used for decision making rather than information sharing are certainly an interesting idea,