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New contract for general practitioners

A bold initiative to improve quality of care, but implementation will be difficult

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This week a proposed new contract between the NHS and general practitioners contains an initiative to improve the quality of primary care that is the boldest such proposal on this scale ever attempted anywhere in the world.[1] The proposal spells out 76 quality indicators in 10 clinical domains of care, 56 in organisational areas, four assessing patients' experience, and a number of indicators for additional services. The proposal furthermore sets targets for performance that will be accompanied by increased payments to providers. Like any bold proposal this one offers the promise of a quantum change in performance rather than an incremental one. To get there, however, will require a great deal of work by all involved and may come at the price of other aspects of primary care being left out of this quality framework. The net effect on primary care will therefore depend on how this initiative is implemented and the follow on work of the NHS and general practitioners at building on what works and a willingness to discard or change what does not.

What led to this initiative? There is much evidence that certain aspects of primary care are not being carried out at optimal levels—for example, the adequate control of blood pressure in people with hypertension and the management of diabetes.[2] Despite continuing medical education, publication of practice guidelines, and the efforts of professional societies a sizeable gap exists between what can be achieved and what is being achieved. This continuing gap, combined with requests from general practitioners to be provided with more resources to deliver high quality care and to be rewarded for delivering it, led to this new bold proposal. With one mighty leap, the NHS vaults over anything being attempted in the United States, the previous leader in quality improvement initiatives.

Many quality indicators

I like much in this proposal. Firstly, it specifies a large number of specific quality indicators in multiple domains of care and links these to a method of implementation that is likely to achieve real change in performance. Since a sizeable financial incentive is involved there is every reason to expect that general practitioners will change their behaviour in order to try to meet these targets, just as they improved their delivery of cervical smears and childhood immunisations in response to financial incentives. The broad number of quality indicators is also a strength. Much concern exists in the United States that initiatives to improve quality containing only a few indicators promote a situation in which providers concentrate on only those indicators to the exclusion of other aspects of care. The large number of indicators in multiple domains of care in the new proposal will help minimise, but not eliminate, this likelihood.

From my American perspective, another admirable attribute of this proposal is that it was developed by the government that pays for the care working together with the providers to reach agreement on the important aspects of care to perform and be paid for. This is in contradistinction to the approach in the United States, where the providers of care are usually left out of the equation.

Implementing the proposal

Now to look at the hard part. Implementing this proposal is going to be very difficult. Collecting data on the encounters with patients is going to be a huge task that will require comprehensive computerisation of general practices. Since for now the data are to be self reported by the general practitioner, we do not know if the mechanisms proposed to monitor the data (a detailed inspection once every three years) will be enough to overcome the strong financial incentive to present the rosiest picture possible of one's own practice.

As with any programme designed to bring about a certain change, unintended consequences present a worry. Although the number of indicators is broad and the indicators include many of the most important processes known to produce substantial health benefits, even 130 indicators cannot possibly cover all of primary care. What is to become of the care in these "unmeasured" domains? Will it improve, as general practitioners implement systems of care that improve all processes of care, not just the ones measured? Will it remain the same, neither better nor worse? Or will it get worse, as time and resources once devoted to these areas are now redirected towards those areas that are measured and paid for? Such concerns have been raised in the United States associated with the public release of quality information, but empirical data are lacking.

Another and more insidious unintended consequence is the potential for change in the relationship between doctor and patient. Will patients no longer be persons to the general practitioner but rather a series of performance targets to be met? This is a very real possibility, but I do not buy into the argument that

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improvement in one area of care must come at the expense of another. Patients value both good health outcomes and continuing relationships. The new contract has the promise of a substantial increase in funding for primary care, not merely redirecting payments from one area to another. It is up to general practitioners to respond to this proposal in a way that improves the technical aspects of quality while maintaining the values that have characterised general practice in Britain for generations.

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1 NHS Confederation. *GMS contract negotiations*. www.nhsconfed.org/gmscontract/ (accessed 24 Feb 2003).
2 Seddon ME, Marshall MN, Campbell SM, Roland MO. Systematic review of studies of quality of clinical care in general practice in the UK, Australia and New Zealand. *Qual Health Care* 2001;10:152-8.

Management of people who have been raped

Needs special expertise, and more of it

Rape is common but under-reported, with an estimated lifetime risk of up to one in four for women.[1] Definitions vary between countries; in England and Wales the term refers to non-consensual vaginal or anal penetration by a penis, of a woman or a man. Serious sequelae include psychological problems, infection, and unwanted pregnancy. People who have been raped may present, immediately or later, to general practitioners or other clinicians, not all of whom may be familiar with such situations. Here we outline the care of people who present after sexual assault; we use the relatively neutral term clients, as suggested elsewhere.[2]

Optimal management depends on the client's wishes and needs, time since assault, and whether involvement of the police is requested. Meticulous medical notes are essential even if involvement of the police is declined initially, as reports may be required later for legal processes or compensation. Immediate considerations include safety, management of injuries, forensic examination, and emergency contraception. In situations of domestic violence or perpetrator's physical proximity a client might need alternative accommodation. Although genital injuries have been found in 16-58% of clients examined and non-genital injuries in 31-82%,[1 3 4] few are sufficiently serious to require hospital referral for suturing or further investigations.[3]

Forensic examination aims to collect evidence for use in criminal justice processes, including documentation of injuries and samples for DNA and toxicology. It involves a "top to toe" survey as well as genital examination and is ideally undertaken by a doctor or nurse with special training, such as a sexual offences examiner, whose sex is acceptable to the client.[5] Retrieval of DNA is maximised by conducting the examination as soon as feasible after the assault, and advising the client not to wash, drink, or eat (depending on the orifices involved) until samples have been taken. Police officers can collect urine samples and mouth swabs, thereby minimising the client's discomfort while waiting as well as increasing the chance of detecting drugs excreted in the urine. If more than seven days have elapsed since the assault sampling for DNA is unlikely to be productive,[6] but documentation of injuries may still be relevant.

In some areas the examination and other treatment can take place in dedicated sexual assault referral centres,[4 7] otherwise police can organise an examiner. Sexual assault referral centres provide supportive and forensically secure environments; clients who have not directly involved the police can also access them to receive treatment as well as possibly providing anonymous intelligence and evidence. Availability of specialist services, and hence quality of care, varies widely.[8]

Pregnancy following rape occurs in about 5% of women of reproductive age, and adolescents are most vulnerable.[2] Risk of pregnancy and views on contraception must therefore be explored. Progesterone only emergency contraception (Levonelle) can be taken up to 72 hours after the event; we believe that it should not be withheld after rape even if the woman had unprotected intercourse earlier in that cycle. An intrauterine device containing copper can be inserted up to five days after the earliest expected date of ovulation, or up to five days after assault in the absence of previous unprotected intercourse in that cycle.

The risk of sexually transmitted infections following rape is 4-56%[7]; infections found reflect those that are prevalent locally. Referral for assessment of sexually transmitted infections two weeks after the assault allows for incubation periods of gonorrhoea and chlamydial infection. A single genital screen misses up to 12% of infections,[9] but repeated—or even initial—examinations may compound the invasion of the assault. Clients at high risk of sexually transmitted infections but unwilling to be examined further should therefore be offered prophylactic antibiotics[2] to prevent serious long term sequelae, such as pelvic inflammatory disease.

Acquisition of HIV infection following rape is rare in low prevalence areas such as the United Kingdom; risks are increased if assailants come from high prevalence areas, if there is trauma (including defloration), or if the rape victim is male. Postexposure prophylaxis with antiretrovirals given within hours of occupational exposure significantly reduces HIV acquisition,[10] and is increasingly used after sexual exposure despite the lack of specific evidence.[11] The decision to start postexposure prophylaxis should be based on assessment of the individual risk and views of the client—local HIV services can advise further.

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