

Process and Outcome

Quality assurance: what now and where next?

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The questions most frequently asked about quality assurance are whether well-established practices already form adequate safeguards of quality of medical care or whether more formal mechanisms are necessary and if so what form they should take.

The Nuffield Provincial Hospitals Trust published in 1976 *A Question of Quality? Roads to Assurance in Medical Care*.¹ I was invited by the trustees to follow up this series of essays by ascertaining in an informal and personal way the extent and range of current activities. It was agreed that my initial approach should be to the presidents of the royal colleges and certain other national bodies and through them to individuals known to be interested. It is the factual part of this inquiry and my own thoughts on the subject that I can include in this review.

Nomenclature

There is still debate about the best name for the activity, and the choice of name is not unimportant if the procedure is to find general acceptance. "Quality assurance" is acceptable but describes the objectives rather than the process. "Quality control" is used in the laboratory specialties but may be accepted only while accuracy rather than interpretation is under consideration. In interpretation and in clinical practice "control" is thought to be threatening and does not find favour. "Medical audit" has a connotation of accountancy and accountability. "Patient care evaluation" seemed acceptable in 1967.² "Peer review" accurately expresses the activity but does not fall readily into everyday language.

I believe that despite some resistance "medical audit" will become the everyday term for the process and "quality assurance" for the subject in general. Cost containment (which is such a feature of the Professional Standards Review Organisation (PSRO) in the USA), utilisation review, and patient satisfaction are related and overlapping issues but should in the present context be kept distinct from assurance regarding professional performance. Adequate resources are essential, and sometimes the professional may have to declare that his performance will reach unacceptably low standards if resources are not improved.

The guardians of educational and professional standards

Traditionally the General Medical Council and the universities have been responsible for standards in basic medical education while the royal colleges have been and still are the guardians of professional standards. It will be interesting to watch how the General Medical Council under the Act of 1978

fulfils its new statutory "function of promoting high standards of medical education and co-ordinating all stages of medical education." Meanwhile, the colleges and their faculties have in recent years transformed the methods of initial admission to the specialisms from what were largely tests of factual knowledge to careful review of training programmes and to more advanced tests of competence. Approval of training posts is by individual colleges or by joint committees on higher training. I have been given the opportunity of reviewing all the application forms and the notes of guidance for visitors. So far only the Royal College of Pathologists asks specifically whether the laboratory seeking recognition participates in a quality control programme. All the application forms include questions about opportunities for attendance at clinicopathological conferences, postgraduate sessions, journal clubs, etc, but apart from the pathologists the nearest that any of the forms comes to questions of peer review is the inclusion by the Royal College of Surgeons of England in its educational criteria of the sentence: "Regular opportunities should be provided for consultants and trainees to meet together for the presentation of cases, x-ray conferences, and pathology meetings to enable comments and criticisms to be made of patient care and investigation" (my italics).

The colleges have long held educational and scientific meetings but only recently and only in some colleges have meetings on topics of quality of care been introduced. There have now been whole-day meetings on medical audit and similar subjects and several colleges have started including a session in a day's more general programme. This strategy ensures that those who might not be sufficiently interested to come to a meeting devoted to the subject may be persuaded that critical review of care should be part of professional practice. At least one college has set up a working group on medical audit, and other colleges are giving special consideration to the subject through one or other of their standing committees. Nevertheless, it would be fair to say that the colleges are still more concerned with the initial competence of the entrant to the specialty than with any measure of the continued performance of the established practitioner. On the other hand the colleges make an important contribution to health care by the publication from time to time of reports and statements.

The *Report of the Merrison Committee*³ stated, "There is growing interest in the country of tying continued registration to periodic tests of competence." It went on to emphasise the importance of continuing medical education but felt that relicensure could be introduced only on the basis of firmer evidence than was available. The Alment Committee's report *Competence to Practise*⁴ emphasised, "that the purpose of both peer group and self assessment . . . should be educational" and without sanctions, that, "it is a necessary part of a doctor's professional responsibility to assess his work regularly in association with his colleagues" but that, "There is as yet no evidence to justify general relicensure because a system of licensing could not be based on measurement satisfactory enough to justify it."

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Need for quality assurance

If you walk round an automated factory you come at the end of each stage to a section clearly marked "quality control station." It is high technology and automation that have led to the need for quality control in industry. The role of the doctor in society has been overtaken by high technology and by teamwork. The technological part of modern medicine is more amenable to audit and quality control than are personal relationships and the caring and communication roles of the health care team. It is easy enough to test knowledge or to insist on so many hours of continuing medical education (CME) but there is as yet no proof of causative correlation between CME as usually practised and the quality of care. It would be defeatist to limit audit to the technological aspects of medicine. The Royal Commission on Medical Education⁵ recognised this: "The very fact that the doctor is concerned with the most personal aspects of human health . . . will ensure a continuing high prestige for the profession; but the esteem in which the doctor is held by the community in general *will be determined more by his demonstrated competence than by the mystique of his calling*" (my italics).

Scrutiny of that part of medical care which is amenable to audit will inevitably influence also the less easily measurable qualities. If the medical profession does not demonstrate competence by some form of quality assurance, measures may be imposed from without as suggested in *The Times* of 8 September 1978: ". . . in parts of the profession at least there is a feeling that something must be done. That something might be an extended form of peer review or medical audit. In peer review a doctor's own colleagues review cases so that lessons can be learnt. Whether doctors move fast enough to satisfy public and parliamentary pressure or whether Parliament will decide it cannot wait long enough for doctors to put their house in order . . . are questions still to be answered."

Current practice

Many think that there are already sufficient safeguards of quality of care through statutory mechanisms, longstanding practices, and the very fact that we operate in a National Health Service. Safeguards include: appointments procedures with compulsory open advertisement and external assessors; the Health Service Commissioners and other complaints procedures; Community Health Councils (Local Health Councils in Scotland); the Health Advisory Service (Hospital Advisory Service in Scotland); visitation of hospitals and of practices by Royal College nominees during assessment of training facilities; incentives such as the distinction award system and seniority payments, the latter until recently being dependent on attendance at CME sessions; widespread provision of postgraduate centres; the increased tendency to group practice; and the increased use of peripheral hospitals and of general practices for teaching medical students and graduate trainees—perhaps the greatest single factor in promoting the maintenance of professional standards. Hospital doctors claim that every ward round with colleagues and trainees amounts to quality control and peer review, but a case conference is often on the bizarre, and true audit must be retrospective and on random or consecutive cases including the common conditions.

Turning to measures that have been specially introduced, one requires for quality assurance an attitude of mind, information, and in most instances the collaboration of colleagues. There are levels of audit from international (of which World Health Organisation statistics are a good example) through national and regional right down to the audit of a small unit or individual. Each has its advantages and disadvantages of scale, accuracy, immediacy of feed-back, etc. Randomised controlled trials are now standard practice for the study of new drugs or treatments but only a few have been done in respect of methods and quality of health care. Some specialties, such as those with clear-cut

events like childbirth or an operation, are easier to audit especially on a national basis than are others with less well-defined or less uniform factors. The best and most successful national audit in the UK has been the Confidential Inquiry into Maternal Deaths, which has been running since 1952 and which attempts to identify avoidable factors. More recently a similar study of perinatal deaths has been introduced, and the Association of Anaesthetists (with support from the Nuffield Trust and the Chief Scientist's Office in Scotland) has mounted a study of all deaths associated with anaesthesia. The Royal College of Radiologists has published a multicentre study⁶ of preoperative chest radiographs to determine their value and utilisation. There is an ever-increasing number of national or multicentre audits. For example, all major cardiac surgery units in Britain return full reports through the Society of Thoracic and Cardiovascular Surgeons, and each surgeon can compare his performance with that of his peers.

The Royal College of Physicians through the King's Fund has set up a Medical Services Study Group, and the first study to be reported⁷ was an examination in several regions of the cause of death among medical inpatients aged 1 to 50. In laboratory medicine the United Kingdom National Quality Control Scheme⁸ was started for clinical chemistry in 1969, and there are now similar schemes in bacteriology and haematology. The details are well known. They are voluntary but a very high percentage of laboratories take part. There is a difference of opinion whether their methods of quality control can be extended to areas of interpretation, but melanoma groups and lymphoma groups send round slides to colleagues and compare reports.

Several royal colleges have introduced voluntary self-assessment programmes and have also encouraged voluntary arrangements both in hospital practice and in primary care in which records are exchanged for independent confidential review. There are many local experiments and a growing number of publications in relation to audit in individual units, but these are still isolated. Audit of method or procedure is more generally acceptable than that of the individual. The single-handed or isolated doctor presents a particular problem. Isolated hospital doctors can be brought into a larger centre for a few months, and for the family practitioner there are various schemes of distance learning and peer evaluation, such as that recently described by Harden *et al.*⁹

The future

Despite numerous local initiatives and an increasing number of publications there has been very slow movement in general attitude over the past few years, and there are still those who believe that if you create a standard, however high, you stultify innovation and interfere with clinical autonomy.

The *Report* of the Royal Commission on the National Health Service¹⁰ devotes, in its section on primary care, eight paragraphs to "Quality of care" and, in its section on the NHS and its workers, thirteen paragraphs under the heading "Measuring and controlling quality." Out of these paragraphs three firm recommendations are made:

Recommendation 20—"General practitioners should make local arrangements specifically to facilitate audit of the services they provide and the health departments should check progress with these developments."

Recommendation 62—"The Joint Higher Training Committees for postgraduate medical education should approve only those units and departments where an accepted method of evaluating care has been instituted."

Recommendation 63—"A planned programme for the introduction of audit or peer review of standards of care and treatment should be set up for the health professions by their professional bodies and progress monitored by the health departments."

Whatever may be the Government's reaction to the *Report* in general the likely attitude of the profession to these recommendations can best be judged by the evidence given to the commission by key bodies. I have studied this, and the following examples are typical.

The Royal College of Physicians of London said, "The College is deeply concerned with standards of medical care. We have considered the general questions of medical audit and examined the various schemes proposed and in operation. We feel that a better method than any of these is to create a continuing investigation of the effectiveness of medical care."¹¹ The college went on to describe the Medical Services Study Group and referred to it as a means of "monitoring continued professional competence."

The Royal College of Surgeons of England said, "As far as surgery, dental surgery, and anaesthesia are concerned medical audit and peer review may well be most effective methods of examining procedures and of evaluating their effectiveness."¹²

The Royal College of General Practitioners, while emphasising the generally high standard of primary care, states, "Our picture of the assets of good general practice must be balanced by the frank recognition that care by some doctors is mediocre and by a minority is of an unacceptably low standard. . . ."¹³ And elsewhere, "The college believes that medical education needs radical reshaping to place much greater emphasis on continuing education and medical audit."

The British Medical Association in its evidence said, "Any supervision of the competence of an individual doctor to practise must be by the profession, and we reject any suggestion that there should be medical audit by the State. The three principal guarantees that a doctor is competent to practise remain:

"(1) a satisfactory system of admittance to the profession and a strict scrutiny of the standards for qualification;

"(2) provision for continuation of training and study throughout the doctor's professional life; and

"(3) the individual doctor's conscientious assessment of the standards of his treatment against the standards of his colleagues. . . ."

"We are not convinced of the need for further supervision of a qualified doctor's standard of care."¹⁴

The British Medical Association had, however, through its Central Committee for Hospital Medical Services¹⁵ and before the Commission reported set up a group to "explore actively methods of medical audit which should be of practical value and which should also be acceptable to the profession."

Since the Royal Commission reported, the proposals for medical audit have been welcomed enthusiastically by some and cautiously by others.¹⁶⁻¹⁹ Some writers^{20 21} are critical of the whole concept but have not fully explored the potential benefits. McNicol²² doubts the practicability of judging whether a unit has instituted "an accepted method of evaluating care." My proposal would be that a unit seeking recognition should be required to put forward its own proposals. Over-standardisation would be avoided, and new and more effective methods of audit would evolve.

My enquiry for the Nuffield Trust has also included a study of activities in other countries. These are not reported here, for I believe that we should not be unduly influenced by action abroad, where the circumstances of health care are very different. I believe that as a logical development of the increased complexity of medicine and in furtherance of the traditions of British medical care there is a need for the development of more formalised methods of quality assurance. The need for CME is generally accepted, and Merrison, Alment, and the BMA have all indicated that peer review should be part of CME. Initiatives have already been shown by individuals and by colleges. It is now for the colleges and their faculties, as the traditional guardians of professional standards, to follow up their own tentative moves by responding positively, strongly, and quickly to the call made by the Royal Commission and to ensure that quality of medical care is seen by society to be firmly and openly assured

by the professions themselves for the benefit of the community. At the same time the universities and the General Medical Council should see to it that practitioners of the future have instilled into them as students the attitudes of self and mutual criticism, which when followed through into practice will encourage the development and use of ever-improving methods of quality assurance.

I thank the Nuffield Provincial Hospitals Trust for the invitation to make this review. I am also greatly indebted to the presidents of the royal colleges and their faculties and to others who gave so much time and showed so much interest in the subject.

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What causes episcleritis and how should it be treated?

Episcleritis is a curious and usually nodular inflammation of the subconjunctival and superficial scleral tissues of the eye producing a painful, slightly raised patch of inflammation. Although it has been described in erythema nodosum and in several collagen disorders as well as gout, a specific aetiology is rare. Local steroids, salicylates, phenylbutazone, and other anti-inflammatory drugs have been used in treatment, but these are rarely successful in reducing the inflammation, which is, however, usually self-terminating, although recurrent. Fortunately, the disorder runs a benign course, although it may recur over a period of many years.