

seems vital that such structural components are in place or audit risks becoming merely an additional task for an already overstretched workforce—which does little to enhance the quality of care.

While audit can go part of the way to ensuring that the best standards of care are delivered, actually *quantifying* many aspects in the care of stroke patients can be problematic. Indeed, it can be difficult to make sure there is even a shared understanding of the definition of some components of a stroke service.⁶ The fact that provision of information for patients and relatives is one component of the audit exemplifies this issue. It might seem intuitive in this situation that “more is better”, but this is not necessarily the case. Certainly, along with others we have found that the appropriateness, timeliness, and manner of information provision heavily influences whether that information is useful.⁷ To be certain that there has been a meaningful improvement in such a process, clarification of the types of information and the manner in which it should be delivered might be required.

Although this study demonstrates an overall improvement in the achievement of a number of standards of care, there is much room for further progress. Less than half of the patients received a formal cognitive assessment, only a quarter had their mood state documented, and the needs of carers were assessed separately in only just over a third of cases. These issues are crucial to the provision of a high quality service. There are also disappointing findings with regard to frequency of team meetings, the attendance of social workers at such meetings, and the in house education of staff. Such factors are usual indicators of good communication and fundamental to truly interdisciplinary teamwork.

There is no doubt that increasing the number of patients who receive the bulk of their care in a dedicated stroke unit is vital if we are to achieve the desired reduction in deaths and disability. All who provide, fund, and use healthcare services would do well to heed this message, made even clearer by Rudd and colleagues.⁴ The message is particularly relevant in areas where many patients continue to be cared for in general hospital wards or at home,⁸ and in countries (including New Zealand) where few dedicated

stroke units even exist. Failure to establish such services, and failure to ensure equitable access to them, is becoming a difficult standpoint to defend.

Finally, despite increased awareness that specialist stroke care improves outcome, investment in stroke research has recently been described as woefully inadequate⁹ and many important questions about the best interventions for acute stroke remain. This is also true in rehabilitation where more research is needed into what constitutes the most effective approaches to goal setting, teamwork, and other key components of practice.¹⁰ We agree with Rudd and colleagues that there should be ongoing funding for audit, and that audit can and should be a mechanism for improving what we do. However, it is also important to avoid assumptions that we might know all we need to about which processes to audit. If we listen to people who have had a stroke and their families, we still have a lot to learn about what comprises best practice and indeed “best outcomes”.

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Quality of clinical care in general practice

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As quality of care is so high on the agenda of practitioners and policy makers, it is surprising that there are no systematic reviews of studies of the level of quality provided by healthcare services. In this issue of *Quality in Health Care* Seddon and colleagues report a systematic review of studies on the quality of clinical care in general practice in the UK, Australia, and New Zealand.¹

The authors found that many published reports were methodologically poor and therefore only limited conclusions could be drawn from the findings. Around 90 papers were identified and, not surprisingly, the majority related to management of chronic care and only two related to acute conditions. Practices that took part in the studies were often self-selected, and many of the reports were from single practices. Despite publication of numerous evidence based guidelines in recent years, the authors found that clinical care in general practice consistently failed to meet high standards in all three countries.

Can the findings be assumed to apply to primary care throughout Europe? We can only speculate, but it would be surprising if care in other European countries was found to be substantially better than that revealed in the review. It is more likely that the range of quality would have been wider if a greater number of countries, with diverse healthcare systems and different levels of funding, had been included. The key question in response is: “How can variation be reduced and quality improved?”

The review does not provide information on methods that have been successfully used in general practice in improving quality of care, nor does it indicate whether the drive for monitoring clinical care came from the practices themselves or from other local or national initiatives. Various methods are likely to be used for monitoring the quality of clinical care. However, monitoring must be used in conjunction with a wide variety of methods of implementing change.² The recent proposals for improving the use of

information technology in primary care in the UK will make a wealth of anonymous and aggregated data available for monitoring and reporting aspects of quality of care. Linking variations in care to practices should allow the identification of obstacles to improving quality and therefore inform the choice of strategies to be employed to bring about improvements.

Previous research has identified obstacles to effective health care including clinical, patient related, and resource related categories.³ This study also showed that the main sources of information used in situations of clinical uncertainty were general practitioner colleagues and hospital doctors. In another survey, promotion and improvement of access to summaries of evidence were suggested as more appropriate methods of encouraging evidence based general practice than teaching about the skills of literature searching and critical appraisal.⁴

The combination of adequate monitoring and targeted implementation strategies implies that healthcare services require well developed systems for managing primary care. In many countries, however, the management of primary care is not a high priority since the vast majority of healthcare spending is accounted for by secondary care. Furthermore, the funding mechanisms in different countries have variable effects on management systems. This is both a problem and an opportunity. The problem is that, until the management of services is adequate, levels of quality are unlikely to improve dramatically. The opportunity is that the diversity in European healthcare systems makes possible evaluations of different systems. If nations were sufficiently motivated, we could determine which systems are associated with higher levels of quality.

Systems of quality assurance have been set up in most countries, but they use different methods which vary from inspection by external appraisers using explicit evidence based criteria at one extreme to informal discussions between colleagues at the other. Recent proposals in the UK have recommended a new framework to support

accountability, improve quality, and reduce variations in care. These include the National Institute for Clinical Excellence (NICE) that will provide national guidelines,⁵ clinical governance (“a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding of care by creating an environment in which excellence in clinical care will flourish”), and new systems for annual appraisal of all doctors supplemented by regular revalidation at longer intervals. In addition, an inspectorate has been set up and given the title of Commission for Health Improvements.⁵

Almost 20 years ago Sir Donald Irvine (now president of the General Medical Council) pronounced quality of care as the outstanding problem facing general practice.⁶ Seddon *et al*¹ have made it clear that this situation remains largely unchanged. If the new UK initiative finally resolves this problem, there will be valuable lessons for the health systems of other countries. If the initiative fails there will still be lessons, although they will not be so valuable.

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Getting journals rapidly to developing countries: opportunities through the internet

For some years it has been the policy of the BMJ Publishing Group to give free subscriptions to journals, including *QHC*, to people working in the developing world. An editorial in *BMJ* sets out the arguments for doing this very clearly.¹ We know that the gap between the rich and poor countries is widening but, while those of us in the developed world have information overload, in some developing countries libraries are empty. However, in practice there have been difficulties—for example, postal services may be very unreliable and getting the printed journal to its destination can be difficult and expensive and, to some places, impossible at times. The marginal costs of sending one year's subscription of *QHC* to Africa is around £25, but the marginal cost of giving access to the electronic edition of *QHC* is close to zero.

As many journals are now on line, the internet provides the opportunity to narrow the information divide. Under the auspices of the WHO, leading medical publishers including the BMJ Publishing Group have agreed to provide free access to electronic versions of journals to people working in developing countries.² Access to

electronic journals happens at exactly the same time throughout the world. By having access to a range of e-journals, colleagues working in developing health systems will be able to access what is relevant to them and not simply what is provided or what happens to make it through the postal system. Best of all, anyone with electronic access to journals, wherever they work, can participate in debate through the rapid response facility on the web site, something that was not possible in printed journals.

Access to the electronic edition of *QHC* will automatically be provided free to those from countries defined as poor under the human development index by the United Nations (URL <http://www.undp.org/hdro/HDI.html>). The BMA and several societies that co-own BMJ Publishing Group journals have funded the installation of Digital Island on all BMJ Publishing Group journal web sites. This clever piece of software recognises where a user is coming from and provides unrestricted access to the whole web site to those from countries we designate. BMJ.com will continue to be free to those in the developing world,