Setting up consensus standards for the care of patients in general practice

THE recent changes in the National Health Service have exposed the medical profession to demands for greater accountability for clinical care and to increasing pressure from consumers.[1] However, no clear guidance has been given on how to judge either the quality of care, or the appropriateness of medical decisions. The management of patients with chronic diseases such as asthma, hypertension and diabetes is of particular interest, because the conditions are relatively common, they may cause prolonged disability, and can restrict the lifestyles of sufferers. There is general agreement that the quality of care offered to these patients can be enhanced by setting standards and criteria, which can be subsequently reviewed.[2-4] Until recently, there has been an emphasis in general practice on setting standards in small groups or within individual practices. However, a suggestion has been made that a body should be set up to devise policies for clinical care at a national level on which local guidance could be based.[5] As the development of clinical policies is likely to dominate the work of the medical profession over the next two decades,[6] it is an appropriate time to consider whether such policies for clinical care are helpful.

The Dutch college of general practitioners has chosen to set national standards, which are meant to reflect the 'state of the art' in family practice and to be used as guidelines in medical audit.[7] The setting up of the standards is a three stage process. First, groups of four or five experienced general practitioners, usually with an academic research interest in the field, are asked to write a draft paper. This draft is then sent to 50 other non-specialist doctors, chosen to be representative of the average practitioner, to make 'grassroots' comments about the acceptability and feasibility of the standard. Finally, the standards are revised and then reviewed by a scientific committee, representing all political interest groups, before being published. These standards have been welcomed as a basis for daily work, and as a means of encouraging colleagues to work along the same lines. However, a majority of participating doctors felt they should not become obligatory.[8]

The National Institutes of Health in the USA have taken a different approach. They have organized over 60 consensus conferences aimed at facilitating the transfer of research results to clinical practice. These conferences involve a series of presentations to a panel of experts, who then put forward their opinions. This method has been criticized because the variability in both the availability and the quality of the evidence offered has sometimes led to inappropriately strong conclusions being drawn.[9] However, research based evidence has played a greater role in more recent conferences and has been better integrated into the policy statements.[10]

Another technique used in the USA, which contains elements of the Dutch technique and the consensus conference approach, is the 'modified Delphi technique'.[11] This involves preparing a literature review, and then asking a panel to judge the appropriateness of performing a series of procedures. The results are subsequently collated, and the panel convened to discuss the rankings and judgements that have been made. Unfortunately there is often little objective data on which these policies can be based. Standards are therefore derived from the opinion of a group of interested participants. One risk of this method is that, in the process of reaching a consensus, widely accepted ideas become consolidated and new ideas are supressed. There is also no incentive for doctors to find the means to provide the best possible care for patients within the available resources.

One way to provide this incentive may be to base policy formulation on research studies, which provide objective information about outcomes that patients consider important. Eddy has described the steps that may be taken to analyse a clinical problem in order to formulate a policy.[12] First the outcomes of the proposed intervention should be identified and judgements made about their desirability. The effect of the intervention on relevant outcomes should then be estimated, and the extent to which outcomes vary with different patient characteristics also estimated. These estimates should be based as far as possible on experimental evidence. The desirability of the different outcomes should be based, where possible, on actual assessments of patients' preferences. The final analysis of the data can then be carried out in different ways; by using a formal technique such as decision analysis,[13] by convening a group of doctors to discuss the evidence, or simply by presenting the data in a form that the patient can understand and discuss with the doctor. A formal policy document developed following these steps would have several advantages: it would provide doctors with specific information about the consequences of adopting different approaches to a problem; it would provide information valuable in tailoring the policy to different patient groups; it would provide a means of linking costs of interventions to the outcomes; and it would open the policy making process to review by all the interested parties.

Many published protocols do not differentiate between recommendations that are based on clear evidence of benefit and recommendations that are offered as a pragmatic solution to an area of controversy. Eddy has suggested that the status of policies should be made clear by classifying them into three groups: standards, guidelines and options.[14] Clinical standards would be based on clear scientific evidence, where there is no disagreement about the preferences of patients. Guidelines would be more flexible and would reflect firm scientific evidence about the outcome of interventions, although a minority of patients may disagree about the desirability of the proposed outcome. In this area patients might want to make their own judgement about the desirability of the outcomes resulting from an intervention. Finally, a policy would set out a series of options if the preferences of patients varied or were unknown. A policy would also be presented as a series of options if there was no information about the outcomes of an intervention, although such interventions might generally be avoided. Again, patients would have an important role in determining their treatment by discussing their attitude to the outcomes, unless research showed that patients had no strong feelings about the different outcomes.

Many groups and organizations, such as the royal colleges, district and regional health authorities, the Department of Health, pharmaceutical companies and charitable organizations, have an interest in influencing the care offered to patients with chronic diseases. General practitioners should view the advice offered with scepticism. Policies are sometimes motivated by a desire to save costs at the expense of standards of care; hospital specialists, with limited knowledge of the problems of the community, may try to impose priorities on primary care; more often a policy fails to recognize fully the extent to which patients present their problems in different ways and vary in their response to, and expectations of, medical care.

Good policies for general practice must take account explicitly

of the outcome for the patient and of the existence and strength of supporting scientific evidence. They must also take account of the views of patients and be applied correctly. There is a danger that, in adopting an approach to policies based on outcomes, unrealistic expectations of scientific methodology may replace uncritical acceptance of conclusions reached by consensus. However, the introduction of critical appraisal skills[15] into vocational training for general practice will lead to a more thoughtful evaluation of policy statements. It is also important to remember that written policies are only part of a range of interventions that can be used to improve the quality of care, although their statement of objectives and plan of care underlie other efforts to bring about change.

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Medical confidentiality and records in general practice

TAKING a personal history from the patient is fundamental to the practice of medicine, especially in general practice, involving as it does, consideration of the physical, psychological and social aspects of a patient's problem. Much sensitive information will pass from patient to doctor, and this may involve information about third parties who do not know that they are being talked about. Patients are likely to provide details of personal and interpersonal history on the understanding that confidence will be preserved, and that the information will only be used in connection with their own medical care.

The principal of medical confidentiality is one of the oldest obligations upon doctors, and one to which much lip service is paid. Many patients are under the impression that it is absolute. Yet in 1982 an influential Chicago physician, Siegler, wrote an article entitled 'Confidentiality in medicine: a decrepit concept'.[1] Since then, anxiety has been expressed by patients, both individually and through various organizations, about the subject of confidentiality, particularly in relation to access to records, the use made of the results of investigations and the prescription of drugs to people who may not be able to give full, informed consent. In addition, patients are increasingly asking for information already in their records to be removed, on the grounds that it may prejudice future doctors or other health care workers. So how does the principle of confidentiality stand at the moment?

Havard,[2] in his Green College lecture stated that 'It would be difficult to name a democracy in the Western world that pays less respect to confidential medical information than the United Kingdom'. In England, only the Roman Catholic confessional is subject to the rule of absolute confidentiality whereas in France the absolute confidentiality of medical records is enshrined in law, even if the patient were to gain advantage from it being broken. The General Medical Council's 'blue book'[3] lists situations when medical information may be revealed:

1. When the patient or his or her legal adviser give written and valid consent.
2. When other doctors or other health care professionals are participating in the patient's care.
3. When the doctor believes that a close relative or friend should know about the patient's health but it is medically undesirable to seek the patient's consent.
4. When the doctor believes that disclosure to a third party other than a relative would be 'in the best interests of the patient' and when the patient had rejected 'every reasonable effort to persuade'.
5. When there are statutory requirements to disclose information.
6. When a judge or equivalent legal authority directs a doctor to disclose confidential information.
7. When the public interest overrides the duty of confidentiality, such as, investigation by the police of a very serious crime.
8. When medical research approved by a 'recognized ethical committee' is being carried out.

Given these exceptions it is no wonder that patients are anxious about divulging sensitive information.

Difficulties relating to the issue of confidentiality may arise in many areas, for instance where the doctor's duty to society or to another patient conflicts with the duty to the individual, but the area I would like to consider in particular is medical records.

It seems almost axiomatic that to treat patients as whole persons within the context of their families and society, we need adequate information about them. In addition, with the