Scenes from Postgraduate Life

Quality

The King's Fund launched its Quality Assurance Programme in 1984. In the 1900s it was already inspecting hospitals which sought its financial support. Hospital doctors in the 1980s are being exhorted to look at quality, cost-effectiveness and their managerial, as well as professional, commitment. A hundred years ago medical officers at the Royal National Orthopaedic Hospital had to clock in for outpatients and had to sign a card on the patient's bed each time the patient was seen.¹

I recently attended a meeting at which the results of a Monitor project to assess the quality of nursing care were presented; hundreds of questions had been asked in order to analyse different aspects of the nursing process. 'The story of my life', I said to the Director of Quality Assurance. 'In the 1960s it was "O&M" (Organisation and Management): they spent weeks on the wards following the nurses with their clipboards and writing down everything they did'. 'Ah, but the difference now is that nurses are looking at nurses', he replied.

With this continual need to re-invent the wheel, perhaps doctors are justified in being sceptical about attempts to impose quality. Besides, they say, we have always regulated our own practices both by peer review and by responding to public expectations. Conditions change, however, and create new demands for evaluation: high technology medicine and the quality of life is a good example.

We all know what quality is about. Quality control, for example, has been used for many years to ensure uniformity of measurement in laboratories. Moreover, the concept is not confined to medicine; it is an integral part of most commercial operations and many other professions. Quality assurance goes a step further: it observes (i.e. measures) a particular practice, compares it with expectations or results obtained by others, investigates any differences, and if necessary, changes the practice and monitors the result. Embodied in this process are both professional expectations and consumer satisfaction, which may differ markedly, as doctors know only too well. In addition, the quality of a service may be seen differently by individuals as compared with institutions and nations, as is obvious in the continued debate about health services. Finally, quality assurance depends not just on professional standards but on the morale of the workers providing the service. Senior nurses, for example, emphasize the importance of nursing morale in patient care, yet I know of nurses looking after children with cancer who

have never had support or encouragement from their superiors, let alone psychological help to deal with the stress.

Quality assurance then is about standards, and the dictum of Robert Maxwell *et al.*,² 'Evaluate, consult and educate', brings it firmly into the realm of professional continuing education, as well as emphasizing the link with operational research. Audit is the professional part of quality assurance, clinical audit being applied to a particular service involving, say, nurses, operating room staff, physiotherapists, secretaries and surgeons, while medical (or surgical) audit would signify evaluation of the outcome of a particular professional practice. Alternative names like peer or performance review may be more acceptable since audit has overtones of compulsion.

Data are needed in order to do anything, and they are at present the weakest link in the chain. Any clinician who has tried to assess the work of his own unit will recognize the frustration of having to rely on case notes or Hospital Activity Analysis (HAA). Indeed, case notes would be an ideal vehicle for auditing ward practice; any number of questions could be prepared from the information that is supposed to be obtained. So far performance indicators have had a mixed reception but it may be that as questions are refined (see for example, those related to geriatrics) and as Körner data begin to accumulate we will be able to evaluate what we're doing. In the meantime enthusiastic clinicians generate their own data, preferably prospectively and with specific and limited objectives in mind.

The need to assess professional standards seems obvious, but on the whole doctors still have to be convinced. Generally accepted practice, as defined, for instance, by consensus conferences (how much are these influenced by vested interest?) and what actually happens in treating patients are by no means always the same thing: management of hypertension and bronchial asthma are well known examples. National surveys like those carried out by the Royal College of Physicians Research Unit into deaths in patients under 50 or in diabetes can alert doctors to specific areas for improvement. Where things do go wrong it is nearly always either a failure to act rather than ignorance of what to do, or else poor communication with colleagues or patients. Individual audit may bring about change, but equally important, it promotes a healthy atmosphere of questioning and self-criticism.

Begin, say the experts, with things that are easy to

count. Doubting Thomases could do worse than read John Yate's classic *Hospital Beds*.³ Many different bodies already inspect hospitals so there must be a great deal of information: has this been put together so that we can assess and compare data about service and training, as is increasingly being done in hospital accreditation schemes throughout the world?

Making the effort to assess performance requires time, tools, possibly money, and support. At the moment it is mostly done by enthusiasts, often with microcomputers. If it is to become a way of life, the consultant medical staff must provide the commitment and leadership, while management will have to see that clerical and record services are expanded. If it is conceded that it is an educational exercise, it should be fostered by clinical tutors – some postgraduate centres already have research secretaries and microcomputers. And presumably managers have

sufficient interest in the well-being of their institutions to be sympathetic towards quality assurance.

Doctors must not be complacent. But they must not be panicked into slick solutions by pressure of public opinion. Proper answers require a good deal of effort, and the methods by which they are obtained must satisfy not just their peers but public, planners and politicians, as well as patients. In the words of a participant in the King's Fund initiative, they should be 'non-bureaucratic, non-invasive and non-disruptive'.

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