Editorial

Tony Townsend has been a general practitioner for 30 years. Although he has dabbled in medical politics, medical ethics, community-based teaching, university-based teaching, quality improvement and assessment, his passion remains clinical general practice. He is currently a full-time general practitioner in Whangamata.

Assessing performance

I clearly recall that when I first started in general practice 30 years ago I very soon realised that I had neither the knowledge nor the experience to deal with the enormous diversity of problems that patients brought to the consultations. I knew that I had a lot to learn and that I would continue to learn for the rest of my general practice career. In those days no general practice training programme was available so I spent time in a couple of small rural practices before starting up on my own in a suburban practice. I learned quickly. I am still learning.

I am not sure when I first considered that I was a competent GP, but I have no doubt that after some years in practice I did. I knew that I still had a lot to learn but I believed that I had acquired the skills to ensure that most of the time I would meet the needs of my patients. If I, or in later years my practice team, could not personally deal with the patients' problems, we learned how best to refer to a secondary medical or community social care service that could.

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As with many of my colleagues, I had been the subject of review for College membership and teacher accreditation. I completed assignments and examinations. I was being judged by my patients, my students, my specialist colleagues and my peers. I know that I learned from all of them but it was difficult for me to measure how this changed my performance. In the end that is the bottom line. It matters little if I have regularly been involved in educational activities or passed examinations if this has not changed what I do.

In 1990 I read a paper that proposed that we should clearly distinguish between 'competence' (what a physician is capable of doing) and 'performance' (what a physician does in day-to-day practice).[1] The Medical Practitioners Act acknowledges this distinction in their definition of a competent doctor:

'A competent doctor is one who has the skills and knowledge required to practise medicine in accordance with his or her registration, and who meets the standard reasonably to be expected of a medical practitioner who holds registration of the type held by that practitioner.' (Medical Practitioners Act 1995)

However, they lump the two concepts together without emphasising that it is the performance, the standard reasonably to be expected, that is so important when it comes to the crunch.

It must be appreciated that unsatisfactory outcomes are not always indicators of poor performance. Inadequate systems such as those involved in publicly-funded secondary care referrals (for example the removal of non-urgent referrals from waiting lists to comply with government requirements), failure to present for treatment or screening (even the best recall systems will not capture all of those in need), patients' personal preferences and input by caregivers outside the general practice team may all contribute to unsatisfactory outcomes despite a high standard of general practice performance.

The theme for this issue is 'Assessing Performance'. Tessa Turnbull and Jim Vause are well known to New Zealand GPs. They have both been very much involved in efforts to improve the quality of care provided by GPs to patients. Their personal views on performance assessment introduce a series of papers by Ian St George that will appear in this and subsequent issues of the journal.

Ian is a general practitioner and a member of the Medical Council's Professional Standards team. In his role as Medical Advisor to the Council he is responsible for policy and medical assessment tools, as well as for advising the Council on individual cases and the decisions to do competence reviews. He is well qualified to comment on the assessment of performance.

These are important papers. It has been argued that the state as a major funder of medical services has

'a legitimate concern about quality and a right and responsibility to ask for accountability from the providers of services'.[2] With the introduction of the Health Practitioners Competence Assurance Act this year there is no doubt that the government believes that it is responsible for the safety of the public. Notwithstanding that we may all be involved in assessing our own performance, any one of us may become involved in a formal competence review. Despite reassurances, this is unlikely to be a welcome experience. Much will depend on how our performance is measured. Don Berwick has suggested that an important step to improvement in the provision of health care is that we learn to use measurement for improvement, not just for judgement.[3]

'The dominant use of measurement in health care systems is what I call 'measurement for judgement', not 'measurement for improvement'. Report cards, benchmark comparisons, accreditation processes, and employer-based performance surveys are all inspection-based systems, seeking data that can be used to make choices. The underlying strategy is to improve through culling, and it is a distant second-best to the real improvement that comes only through continuous effort and pervasive change. I fear the rush to collect information whose main effect will be to quell aspiration and invite dishonesty. Learning begins with curiosity, and curiosity is never totally safe. Public reports on health care performance may help to motivate change, but the responsibility to make changes that will actually help patients cannot be placed outside the system; it is we, inside, who must change.'

The assessment of the quality of a doctor's performance is also dependent on what is being measured as indicated in the WONCA guidebook *Improving health systems: The contribution of family medicine*:[4]

'Traditional quality indicators commonly address the accuracy of the diagnostic process and the appropriateness of the therapy for particular diagnoses. Although these are critical considerations, they provide an incomplete reflection of the complexity, richness and depth of patient-doctor interactions. Thus efforts have been made to supplement conventional indicators with approaches more focussed on patients' problems, their functional health status, their ability to perform activities of daily living and their health-related quality of life, including estimates of the years they would be expected to live in good health. These indicators improve capacity to assess the overall health of a population, judge the efficacy of interventions and make comparisons across populations.'

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The move to performance assessment has been proposed elsewhere. In the UK it has been stated[5] that *'the focus of professional revalidation is rightly moving from the requirement that practitioners merely provide evidence of participation in continuing education towards the requirement that they provide evidence that better reflects their clinical practice'.* The authors of this paper propose that all doctors should be revalidated by performance review, which would focus on the assessment of consultation competence, as this is *'the single most important event in clinical practice'.*

An international comparison of performance assessment programmes in four countries (Canada, Australia, New Zealand and the United Kingdom) has recently been published.[6] One of the main common concerns is the validation of assessment processes and assessment tools.

'The aim is to develop quality assessments that are valid, legally defensible, and sustainable within the limits of human and financial resources. Currently, programmes tend to deal with the possibility of legal challenge by ensuring the reliability and validity of their assessments, and by ensuring good communication with participants so that their processes are seen to be fair and transparent.'

We also need to be concerned about the nature of incentives for change and the penalties for not embracing these. It has been stated that *'in the end carrots and sticks may make general practitioners behave more like donkeys than doctors'.*[7]

I look forward to reading the series on 'Assessing performance'. I hope that some readers share my enthusiasm and I believe that some will also share my concerns.

References

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