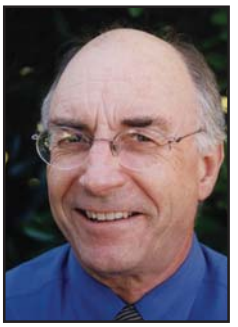
Editorial



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.

Aiming for excellence

Along with many other New Zealand general practices we are preparing for assessment. It is an interesting exercise. Although it is time consuming it has enhanced the team process and it has encouraged reflection on our practice systems, our practice tools and our resources. We have made some changes and we hope that these will improve the service that we provide to our patients. But will the effort that we have put into this exercise make a major difference to the quality of the care that we provide to our patients?

For this issue of the journal we have invited some of those most closely involved with Cornerstone to contribute. They describe the development and the implementation of Cornerstone, which is a tool that measures the organisational components of general practice care. It is process orientated and facilitates quality improvement. It is a tool in evolution. However, we need to remind ourselves that Cornerstone is only about assessing a part of general practice.

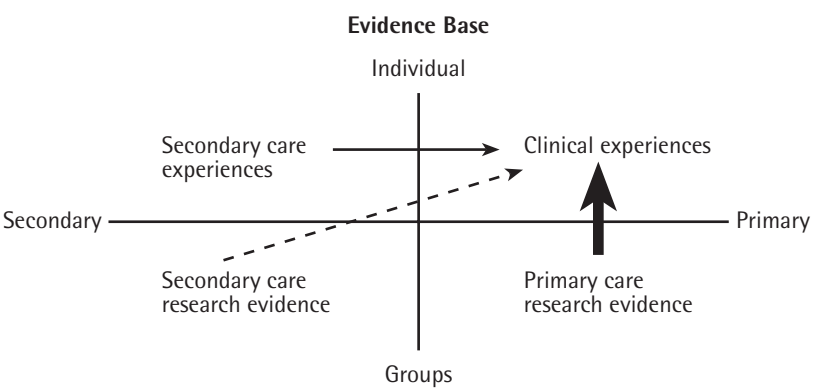
Excellence in general practice is not related solely to improvements in the organisational dimensions of primary care. Roger Jones, in his closing address to the 11th Conference of the European Society of General Practice/Family Medicine held in Greece in September this year,[1] emphasised the importance of considering the personal (what sort of doctor?) and the political (what sort of health care system?) as well as the organisational (what sort of practice?) components of primary care. The personal dimensions include communication and clinical skills, professional attitudes and values, continuing professional development and re-accreditation and re-validation. The political dimensions support strong primary care, which is comprehensive and continuous, with an appropriate relationship to secondary care. It must be supported by an evidence base, medical education and training, public education and participation and by political pressure. He pointed out that with the erosion of some of the personal and political dimensions of care, such as personal continuity and the introduction of multiple points of entry to the health care system, the organisational dimensions of care become even more important.

Pauline Barnett's paper, which is included in the theme papers in this issue, is an analysis of some of the political dimensions of care. She concludes *'GPs in all senses were the policy leaders that made the Primary Health Care Strategy possible. Its success, or otherwise, is also likely to rely, in the end, on that leadership'*.[2]

Why is primary care important?

This might seem to be a strange question for those of us who are professionally involved in the delivery of care, but we do need to be able to support our belief. Larry Green and his associates (including our own Susan Dovey) have revisited the ecology of medical care.[3] They showed that, 40 years after Kerr White's original publication,[4] the estimated proportions of persons reporting symptoms, visiting a physician, receiving care in a hospital, and receiving care in an academic medical centre have remained almost constant. Of 1000 men, women and children in the

Figure 1



United States, they estimated that 217 visit a physician in the office each month, 65 visit a professional provider of complementary or alternative medical care, only 21 visit a hospital-based outpatient clinic and eight are hospitalised. This research alone reinforces the importance of primary medical care and underpins the need for us to ensure that the service we provide is continuing to aim for excellence.

Evidence for excellence – why research is important

Aiming for excellence requires improvements to be based, if possible, on research evidence. Chris van Weel and Walter Rosser, who have both been closely involved with developing a primary health care research base, have claim that *'family medicine research helps sustain the proper functioning of health care systems and guarantees access to health care on the basis of individuals' needs in a framework of equity of access for all persons'*. They provide research evidence for this and go on to state that *'health care funders, planners, publishers, and others often have poor understanding of the current contribution of family medicine research and of its potential to improve health. To improve the profile and understanding of family medicine research in the medical research community, family medicine research must be more widely disseminated'*.[5]

The most important concept in this statement is family medicine research. Practising GPs are aware that much of the clinical evidence that they are expected to use in decision-making does not fit well with their patients' problems. As I read somewhere recently, general practice patients are the people that are excluded from clinical trials! We need an expanded evidence base for general practice that is relevant for the complex problems of dysfunctional interacting systems that primary care patients present with. This requires research methods that are suited to general practice and an acknowledgement that GPs need to be involved in research projects, not simply as data providers but as a source of knowledge, skills and wisdom gathered from their pooled experiences of working with generations of patients in the community over an extended period of time. Chris van Weel presented this need diagrammatically (Figure 1) in his keynote lecture to the WONCA Europe 2005 conference in September.[6]

What is excellence in health care?

I have already referred to the three dimensions of care described by Roger Jones but I would like to take a step back for a moment. When I worked in the Middle East there was a common belief that excellence in health care was associated with the provision of high tech services. Primary care was not only

undervalued but deliberately politically shackled by restricting the services that primary care doctors were able to provide. Patients demanded referral to secondary care services for comprehensive laboratory investigations and advanced imaging procedures. Their belief was that technology would detect potential problems more effectively than the GPs in their clinics and, to a certain extent, they were right. The GPs could not access these services directly, reinforcing the myth of incompetence. This phenomenon is not, of course, confined to developing health care systems. Some health care providers in the United States are now promoting whole-body CT scans as a screening tool for asymptomatic individuals who are prepared to pay for peace of mind. The FDA is concerned enough to have published a caution regarding this practice,[7] but this may have little impact on the public, many of whom have an obsession with high tech medicine. As Richard Neill states in a commentary in the 2005 *Yearbook of Family Practice*, *'sometimes I think it'll take the death of a public figure from a dye reaction while undergoing total-body CT before the dangers of screening are made apparent in the popular press'*.[8]

There is little doubt that excellence in health care will be assisted by the judicious use of technological advances but, particularly in primary care, their impact will be minimal. The *BMJ* in 2002 ran a theme issue on *'what is a good doctor and how can we make one?'*[9] They asked this question of their readers and had 102 responses. There was no shortage of suggestions describing the personal qualities required to be a good doctor, among them compassion, understanding, empathy, honesty, competence, commitment, humanity, courage, creativity, a sense of justice, respect, optimism and grace. The editor commented that *'defining a good doctor lies in the degree of difficulty somewhere between defining a good composer and a good human being. In fact, it's impossible!'* When it came to describing how to make a good doctor it was hardly surprising that there were fewer suggestions but some general agreement that we are doing poorly at the moment. Alison Tonks, in the same issue, paraphrased 13 responses; *'all we can hope to do is select students with the right gifts (not the right exam results) and somehow stop them from going rotten through overload cynicism and neglect during their training and early career'*. The editor of the *BMJ* reminded us that George Bernard Shaw, almost a century ago, said that good doctors must practise within a good system, free of perverse incentives that push *'wildly beyond the ascertained strain which human nature will bear'*.[10] Excellence must blend personal, organisational and political dimensions into a system of care that results in the best possible outcome for our patients. It will never be perfect.

References

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Linking Compensation to Quality

In testimony, McClellan said: "Medicare's current physician payment system pays all physicians equally for a service regardless of its quality, its impact on patients' health, or the efficiency with which services are furnished. Consequently, the current system does not provide more resources to physicians when they improve the quality of care or for preventing acute health problems. . . . Linking a portion of Medicare payments to valid measures of quality and effective use of resources would give physicians more direct incentives to implement the innovative ideas and approaches that actually result in improvements in the value of care that people with Medicare receive."

Iglehart JK. Linking Compensation to Quality - Medicare Payments to Physicians. NEJM 2005: 353:870-872.