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Special interview

Professor Richard Grol

To mark the launch of the journal as *Quality in Primary Care*, we publish an interview with the leading light in the field. Richard Grol, from the Centre for Quality of Care Research at the Universities of Nijmegen and Maastricht in The Netherlands, has researched, promoted and stimulated quality improvement activities in many countries worldwide over several years, and no one has better knowledge of past progress and future challenges.

Interviewer: Professor Richard Baker
Editor-in-Chief

How did you get involved in work on quality improvement in primary care?

It goes back to the 1970s. I started my work in the Department of General Practice when graduating from a psychology study. I was interested in social sciences, and was on the verge of becoming a psychotherapist but it was a coincidence that I was appointed to a part-time job in 1977 in a project focusing on performance of doctors. This project allowed me to do many, many observations in practices and listen to about 1000 or 2000 consultations on tape, leading to the development of models for assessing performance of general practitioners [GPs]. I became quite enthusiastic about this type of work and developed a framework for assessment. In fact, we started to develop the first guidelines for general practice. We developed criteria for communication with patients, for looking at practices in practice visits, and so all the elements of quality improvement that later became more extensive were already in that project. I wrote about this work in a book, *To Heal or to Harm.*[1]

So that was one stimulus. The second was that I became involved in the vocational training scheme for trainees and trainers, and therefore in education and behaviour change. From the very beginning I started a group for trainers for whom we tried to assess their performance and change something. So the model of quality circles, called then peer review groups, was already in operation by the end of the '70s. We decided then that this would become my PhD project and I worked on it between 1979 and 1985. I had about 300 practising doctors in quality circles. We did practice visits, and these doctors visited each other, we used guidelines and protocols; we assessed performance; we looked at audiotapes and video tapes; so all the elements were there at that moment. That was my education in quality improvement.

You clearly became highly motivated very early on, what caused that?

I was always very interested in behaviour change, and have become motivated to study the crucial determinants and what cause doctors to change or not to change, and improve their care. I did a law degree originally, but at the end of that I had already moved towards social sciences – it's my crucial interest in behaviour change.

And behaviour change among general practitioners in particular?

Yes, that was the field I was working in. My interest is wider, involving all types of disciplines but I have always enjoyed enormously working in general practice, and over the years this became my field of work.

What prompted you to see that there was an issue for Europe and to create a working party for Europe?

I think probably two factors. The first was the further progress in the type of work I was doing, resulting in two main developments. One was the spreading of quality circles throughout the whole of the Netherlands, as a consequence of which I developed training for quality improvement and leadership of quality circles. The other factor was that we decided to develop national guidelines instead of regional and local guidelines, with the Dutch College. My research resulted then in all these activities and in a Research Centre with a focus on quality of care.

But at the same time I went to different conferences in Europe. People invited me during the 1980s to the UK, I was asked to go to countries such as Belgium and Germany to present my thesis, and many other countries. Then gradually I became more and more involved in WONCA [World Organisation of Family Doctors] and took the initiative to create a quality committee with John Marwick from New Zealand. I went to some EURACT [European Academy of Teachers in General Practice] meetings and presented my study and my approaches. At the beginning of the 1990s I spoke about it with some people – Michael Boland and you, and Goran Sjonell who were interested in the idea. I think it was my interest to see what was going on in Europe, and also my personal motivation to tell a little more what I had done, what I had achieved in my own country at that time.

What did you perceive as the state of quality improvement in primary care in the early 1990s?

It was very, very limited, particularly in the 1980s. The only countries that were really making progress, but not on the right scale, were the UK and the Netherlands, with some incidental activities elsewhere like the Audit Project Odense [APO].

Did you start with a clear idea of what you wanted to achieve?

Probably we had some significant objective, but I think it was a global implicit objective of getting the topic of quality of care on the agenda and taken seriously. If I look to what I have done most of during these past twenty years, it was getting the subject of quality improvement on the agenda and taken seriously.

Were there particular obstacles that had to be overcome?

Mostly disinterest and lack of knowledge – let's say the practitioners were not so much interested in the issue. Researchers were not interested in quality improvement research. Classic continuous education was seen as quality improvement. People involved in CME [continuing medical education] were thinking that they were doing very good quality improvement.

What do you think has been most successful in overcoming attitudes?

Research and practical work. EQuiP [European Working Party on Quality in Family Practice] has shown in Europe that there are specific methodologies that you can use, that come closer to the heart of what the doctor is doing. For example, audit activities in the United Kingdom, or quality circles in other countries were of enormous importance. By repeating the message, and just by being there and having such a successful group; it was clear that you couldn't ignore such a successful group. So we just had to say to WONCA and to the European Society of GPs that something for research was needed, something for education, and also something for quality improvement, and it was acceptable.

What is your impression of progress in Europe since EQuiP was founded?

The progress in the field of quality improvement in the last ten years is enormous. In the 1980s this was something done by specific persons and institutions that were interested in it, and it was mostly restricted to audit and to consensus guidelines and group meetings. But in the 1990s we had enormous developments, like the evidence-based medicine

movement, total quality management movement, the patient empowerment movement, and the accreditation movement. All these developments are based on basic ideas about quality improvement. Nevertheless, they were promoted by people with different backgrounds. In the 1980s it was a hobby of a few enthusiasts, but now it's a basic element in the health policies of almost all western countries. We have specific journals now and research programmes for it. I don't say that EQuiP was at the root of all these developments within general practice, but at least it contributed to making these ideas available within general practice.

What has been the role of the professional organisations?

This differs for different countries. National colleges, associations or equivalent organisations were already there for quite a long time in some countries and also reasonably well functioning, sometimes better, sometimes worse. But the formation of GP organisations in some countries, for instance countries like Germany, Eastern Europe countries, or in Portugal or Spain, has had an enormous impact on health policies and on quality improvement policies. A nice example is Portugal, where some people in the Portuguese Association had serious interest in quality improvement and this has had a major impact on what they do now.

So in general it's quite important that a college of GPs has very clear policies and something to offer to doctors, something they feel that 'this is helping me'. For instance, in the Netherlands we had quite some debate about national guidelines in the '80s, but the debate only lasted for a short time because when the first guidelines came, doctors felt that they supported them in their daily work. They increased their status within the medical professional community. Some criticism went on during the 1990s, but on the whole I would say that the choice of the Dutch College to offer these guidelines to their members has increased the identity and cohesion of the profession enormously.

Different countries appear to take different approaches. In some countries the profession has a lead, but in others the health service has taken the lead. Do you have a view as to which is the most helpful?

That's very difficult to say because one solution probably won't work everywhere. My feeling is that every country gets the quality system that it deserves. In the UK, you have a Beveridge healthcare model. Such a model pushes in the direction of considerable government input into the system. The advantage is that sometimes you could give just enough pressure to guarantee that something new is happening. On the other hand, you can say that some developments in the Netherlands are slower but sometimes better because they are based on consensus within the profession and are more owned by the profession. Sometimes, in order to get real change in the profession, you need more pressure. Therefore, I wouldn't say that one approach is better than another.

Cultural factors play an important role. A typically UK Anglo-Saxon approach is great emphasis on data collection. In the Netherlands, we use a consensus model with people coming together, to discuss as long as necessary to define what we really want with our care, so it takes a lot of time, guidelines result from that. So, the focus is different on the basis of cultural differences.

Have there been any particular surprises?

One of the major developments has been the wide and rapid adoption of quality circles and peer review groups. This is a major model for quality improvement, especially where GPs work more or less isolated. A basic principle is that quality improvement can only happen when it satisfies some basic needs of the doctors involved, and this is one of these methods that meet such needs. The other thing now is the really fast progress in many countries in defining guidelines, indicators and assessment instruments. Following these developments, there is an enormous movement in data collection now, in terms of assessment instruments, practice visits, accreditation schemes, or balanced score cards.

What do you see as the outstanding issues for developing quality improvement in primary care in Europe?

I don't know whether I am comprehensive here but there are at least a few issues that are important. First of all, there is a challenge to ensure that more health professionals in different countries have not only the clinical content knowledge required for quality improvement, but also specific quality improvement knowledge and skills. The other thing is that in all countries practices will become larger, there will be more disciplines involved, there will be task substitution, etc. In consequence there is an enormous challenge to implement continuous quality improvement systems in general practice and in health centres. You need specific knowledge and skills for doing so. Therefore, practices need support from outside.

Is patient involvement significant?

I see a challenge throughout Europe for all countries to find tools to make general practice more externally accountable. We need to take care that general practices identify and implement these tools and indicators themselves before others do it. We also need to find new ways of better meeting the demands of patients. Only a limited group of researchers is studying how patients can be involved better. There is not yet a deep interest among professionals and professional organisations in enhancing the role of patients.

Do you see that there are a few key issues for research in the quality improvement field?

The main research questions are related to three topics that I have mentioned. One is the increasing size of practice, the new disciplines, new ways of collaboration, new ways of organising general practice care. For instance, in Holland, call centres are being introduced, as well as central doctor emergency organisations, new disciplines and new task divisions between physicians, assistants, nurses, etc. This development will influence Europe gradually. Research is needed on quality improvement and quality assessment of the new general practice of the future. Secondly, we need research on new systems for internal and external accountability, and thirdly, research is required on new models for involving patients better in their care. Shared decision making for instance, patient education and designing of care on the basis of demand of patients are challenging issues for research.

REFERENCE

1 Grol R (1983) *To Heal or to Harm: the prevention of somatic fixation in general practice.* Royal College of General Practitioners: London.

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