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Editorial

Personal reflections on quality

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I have been a doctor now for 21 years and I would like to offer some personal observations about quality of health care. When I was a medical student, I became aware that some institutions were better at training doctors than others were but I was not sure why. I also noted that some patients moved hospitals in search of better care and in some cases would travel abroad to see the 'right' doctor. During my postgraduate years, I noted that the quality and professionalism of doctors varied. I remember from my family's own experience of doctors in Africa, India and the UK the effect of the 'drug' doctor: a family doctor who would make my mother feel better without any specific intervention other than the doctor himself.

As a junior doctor, I remember with an eager sense of anticipation taking part in 'case conferences' and trying to explain clinical events in patients. Post-mortems were routinely done but in many instances, the answers proved elusive. I still remember some of the patients, their illnesses and the unresolved clinical course: Could something different have been done? I now recognise this to be an issue about what we mean by diagnosis and the process by which decisions are made about this.

I also began to wonder why some patients were admitted and others not, despite having similar presentations. As a senior house officer, with increasing confidence, I remember myself admitting some patients and not others. However, this was the source of a complaint – my first introduction to what I now understand to be risk management – in which I had had no formal training.

I remember disputes between senior doctors about whether a lumbar puncture should have been performed on a patient or not – in a climate of fear and intimidation as opposed to learning and significant event auditing. I vividly remember my first clinical error. The support given to me by a senior and eminent consultant was, in hindsight, remarkable: he gave an account of errors he had himself admitted and the importance of learning. This was the exception however, as in different settings I later encountered intense criticism, hostility and little support.

I clearly recall the exciting early days when the use of thrombolysis was becoming commonplace for myocardial infarction (MI). Nevertheless, I knew that in the unit where I worked whether a patient with a MI got the treatment depended on the day of the week, as there was an absence of a clear policy and a difference of opinion amongst the consultants. There was talk of a hospital policy being developed but, of course, there was no clear mechanism for doing so and for deciding which findings of research to implement both nationally and locally.

In addition, I remember a death on the operating table of a patient with a complex clinical condition and the intense sadness and highly charged atmosphere of the theatre and the distress of the family and the senior surgeon who was close to tears. I remember breaking bad news to a patient with cancer and informing her of a decision (later reversed) of the need for further treatment. I met her in the hospital shops and she proceeded to criticise me (justly) for misinforming her.

Moreover, I remember a doctor widely suspected of under-performing and the difficulties this caused colleagues. During GP training, we discussed the issue of criticising a colleague for underperformance and the professional culture and code that in fact discouraged this.

From my own personal reflections on quality, these issues can be codified as:

- The quality and training of doctors.
- The variation in the quality of care.
- Giving information and choice to patients.
- Support and governance of doctors.
- Systems of getting research into practice.
- Learning from patient safety incidents.

In recent years, we have seen major advances in tackling these issues within the NHS that now has its own national and local system for the quality of care. It is easy to forget what the situation was like only a few years ago. Of course, there is much more to do and major challenges remain but I would like to offer praise to NHS policy makers for their leadership and to NHS staff who have implemented the systems.

New and unpredictable issues have emerged such as health professionals abusing their position to murder patients. A disappointment has been the lack of routine and effective information systems for quality. Clear systems for monitoring outcomes in primary healthcare remain in need of development. I am pleased to see the

emergence of a strong patient safety agenda and work needs to continue on the engagement of clinicians in the quality agenda

This will be my last editorial as I take up the chair of the RCGP. I would like to acknowledge the support given to me by the staff at *Quality in Primary Care*. I am also grateful to authors and readers for their continuing support of the Journal. I wish my successor every success in the continued development of the Journal.