Dutch family doctors – still in an early embryonic stage.
I have presented in very general terms two examples of divergent tracks and there are pitfalls: the planners and the government managers who want to support primary care by way of producing calculations and on a categorical basis quite opposite in itself to the integrated approach favoured by the profession, and moreover, still based on a outdated definition of health. The medical profession of primary care is still at the early stage of the ideological movement and the idea is ahead of reality. The planning and managing system is moving in a direction that is quite different and both groups speak a different language.
A fast covering of the distance between the two will have to be made by the emerging profession of primary health care. In other words the profession has to pay and invest.There is only one possible currency: research in and into primary care. In the meantime enough opportunity to change has to be offered by the planning and managing system of health care policy.
A lot of these developments and stated comments are far from new for you all and I think we should be aware of the inflatory nature of this kind of rhetoric. I remind you of the less pleasant effects of the current monetary situation. I hope that this conference will help to beat professional inflation in primary care and speed up the necessary development, not only in the Netherlands. For only the general practitioner himself can produce the needed professional elements for all well balanced primary health care system.

Engelse teksten

Tijdens het in mei 1978 te Montreux gehouden achtste WONCA-congres werden door enkele Nederlandse deelnemers voordrachten gehouden. Van de ons op ons verzoek toegezonden teksten waren er twee in het Engels, de taal waarin de voordrachten waren gehouden: Assessing the doctor, door P.V.M. Cromme en The family physician in 1978 – Dutch treat, door F.E Riphagen. De redactiecommissie vertrouwt dat haar beslissing deze teksten onvertaald af te drukken voor de lezer aanvaardbaar is.

Assessing the doctor

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Assessing the doctor could be misleading and perhaps it is wiser to explain a more logic aproach towards auditing, that is when our goal is a possitive and stimulating one. Assessing bears in it comparing and judging an observed value against a known and accepted standard. Assessing the doctor could mean that not only the professional part is looked upon but also a certain part of the person delivering this service, what seems to be logic, because the results of the health care delivering system depend partly on the relationship between recipient and provider of care. That second part also means that it is getting very personal and no one likes to be judged and rejected afterwards, so it is perhaps at this point that the fear for auditing starts and also a trace of restraint or perhaps even a passive resistance.

The fact that a medical audit system is not received as a heaven send gift can perhaps partly be explained by this existential fear and we can only try to convince those non believers with promises and some facts hope this feeling of fear will vanish.
It could be worthwhile to try a more positive attitude to auditing and develop the thesis that medical audit serves to find gaps in the health care providing system that can be filled by advises for postgraduate training and university teaching and organisation.

Goals of medical auditing

Medical audit on itself does have no value what ever, it is only in relation with postgraduate training and university teaching that its value exists. Medical audit serves to obtain better results from the health care providing system. These better results can be viewed upon from two different points:

firstly: a better result for the receiver, seen in the scope of ideal results as found in the patient expectation design from the health care providing system;

secondly: a better result in view of the satisfaction found in his work by the doctor.

What the user of the health care providing system does expect from this system is part of the ideas produced by cultural opinions. This again is an important point in the design for a medical audit system especially in search for standards. In this context culture is a group's design for living with a shared set of socially transmitted assumptions about goals of life and the appropriate means of achieving them. Such assumptions also relate to well-being and the human body.
Ideas about this well-being and the human body are reflected in the opinions about disease, health, death etc. It is partly by this mechanism that opinions about, tolerance for non well-being are formed, these opinions can form a possible problem when they differ to much from the task ideas of the doctor. Mentally, bodilly and socially well-being may be out ideal but the health care providing system has only influence on some of the conditions for this. In this system the general practitioner has a certain role, and some influence.

Litterature

Most of the litterature about medical audit consists of hospital auditing system or second line medical systems and it would be wrong to use the same standards for treatment in general practice as in hospital practice. It is only in the last ten to twenty years that general practice starts to identify itself in relation to hospital practice and starts to be science of its own. This lack of facts and figures about general practice

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forms a huge problem in the forming of standards and the finding of criteria.
Looking back into the history of auditing, the first clinical auditing was on results, as done by *Godman* in 1910-1920. Those individual efforts were mostly done on results and not on the way there results were made. In the fifties started the wispering about medical audit growing into a non avaible roar now. This roar however is perhaps largely based on political reasons like cost/benifit quotations and pure political power.

Elements of health care delivering system

The interest of the profession should be focused on quality promotion. The health care providing system can be devided, for auditing purpose, in elements forming a closed or partly closed circuit of data. *Donabenian* introduced the elements structure, process and outcome, into wich the health care delivering system can be devided:

Input: the stream of complaints, patients, money etc. entering the medical health care delivering system. The state of health when brought into the system: for instance stage of carcinoma etc., the numbers of workers in the primary care system.

Structure: the setting, the qualifications of the providers, the administrative arrangements and structural possibilies of the primary care system.

Process: the preventive, diagnostic and therapeutic actions taken by the provider of care what is being done with the input with the assistance of the structure elements (tools).

Outcome: the change in health status of the recipient of care.

Feedback: the counter current of information about how and to what extend the quality of care is delivered.

The outcome of cycle one is the input of cycle two, in other words: when we manage to bring the health status of a person on a higher level after going trough the system, than we have a better starting point for the next cycle and that is why the outcome of cycle one is the input of cycle two. This looks like a movement in one level, however we hope that the health care providing system does not work like a circle but like a spiral line.
If the effect is not what it should be, or the effect is satisfactory but the efforts to high or the way it is reached inacceptable, in other words when there is a reason for evaluating the care providing system, than it might seem effective to look at the whole system. Taking a closer look at one of the elements alone could influence the outcome of the whole system, but the relation between structure, process and outcome is being researched now; to what extend one element has influence on all the others is still unknown.
Accepting the theory about the circular movement or better still spiral line movement in the system, it works best to start questioning backwards or starting with outcome. Outcome measures health status directly, it is an effect measuring, and methodologicly it is the end of a chain of reactions.
Looking backwards with outcome as a starting point one gets the oppertunity to review all the elements of the system and after reviewing one can describe the gaps that are found, in order to work prospectively for the next cycle.

Gaps in the system

Let us take a look at some of the possible gaps in the system, for instance:

1. The expectation level of the care recipient is on too high a level.
2. There could be a discrepancy between the expectation level of the care recipient and the task conception of the care provider.
3. The process is dysfunctioning compared to ideal standards, or optimum etc.
4. The structure elements can be brought on a higher level or be better organized.
5. The input can be on a low level; for instance: whatever the amount of care on the highest level, a carcinoma stage IV of the breast is a highly incurable disease, with a five years live expectation that is very low.
6. The feedback is dysfunctioning.

Outcome is influenced by all these elements and the effect of auditing will probably be better when we hava an acceptable complete view on:

I. The value of the elements of the system seperately.
II. The relationship of and the influence into each other, of the elements.

Researchfields that are still not completely covered are:

1. What influence does the care recipient expect from the care providing system on his health/or this complaint/problem?
2. How is the relationship between health and well-being?
3. What is the task description of the general practitioner?

Knowing what is expected and what can be done it is possible to look how it is done and if the effect is reached in an acceptable way.

Way of auditing

A possible way of auditing is: to look at the effect, if that is acceptable to the care recipient and to the care provider and care payer than the evaluation of how the effect is reached is arguable. If the effect is unsatisfactory, the reason can be searched in: process, structure, input and cultural elements. The gaps that are found can result in:
– adviser for structure elements: in other words organisation/level of knowledge;
– a postgraduate training that is aimed at those gaps;
– university teaching changes.

That is, when the care providers are seperately willing to change. What brings us to the next question: why should one change his behavior?