Quality, core values and the general practice consultation: issues of definition, measurement and delivery

JGR Howie\(^a\), D Heaney\(^b\) and M Maxwell\(^c\)


Introduction

Doctors working in any branch of medicine aim to provide and to improve quality on a continuous basis. Teaching and research are intended to underpin these processes. Quality measurement attempts to check that these aims are being met. In the UK, for general practice, within-profession initiatives served the public adequately until well into the 1980s, as testified by the founding of the College of General Practitioners in 1952, the establishment of Departments of General Practice throughout the 1960s and 1970s, and the ‘GP Charter’ of 1966—all of which were responses to the groundbreaking exposure of the state of UK general practice of the early NHS years in the Collings Report of 1950.\(^1\)

The discipline’s ill-considered rejection of the government’s ‘good practice allowance’ initiative in 1985 marked its failure to recognize the growing wish of public and government for more explicit quality accountability and the guaranteeing of minimum standards of care and competence. The ‘imposed’ 1990 Contract and the series of initiatives around clinical governance which have followed have been a direct consequence. The creation of NICE (the National Institute for Clinical Excellence), of clinical guidelines, of the National Service Frameworks (initially for cardiovascular disease, cancer and mental health), and moves to establish a workable basis for re-accreditation have all highlighted the real difficulty in finding ways of conceptualizing and measuring quality of care in ways which capture the full range of issues that matter to patients and can be applied in day to day practice.

Campbell and Roland\(^2\) have proposed a categorization for conceptualizing and measuring quality which describes access and effectiveness as its two principal components, and subdivides effectiveness into clinical effectiveness and interpersonal effectiveness (efficiency and equity are added as separate issues). That categorization has similarities to, but important differences from, the division of effectiveness into technical and interpersonal effectiveness originally proposed by Donabedian.\(^3\) This essay argues, amongst other things, that the importance of inter-personal effectiveness—the more difficult component to define and measure—is, because of the difficulty in operationalizing it, in danger of being lost under the weight of material on the biomedical component of clinical effectiveness.

This essay first describes the evolution of thinking within the discipline of general practice about its ‘core values’. It then discusses the definition and measurement of two of these ‘core values’ (‘patient-centredness’ and ‘holism’) in more detail. Next, it traces the development of the Consultation Quality Index (CQI), an opportunistically developed instrument designed to capture and measure a range of quality issues (most successfully at doctor level) at the interface between clinical/technical and interpersonal effectiveness, and suggests a number of ways in which it might be applied. Finally, the essay discusses how current and future work might strengthen the CQI and help ensure that the importance of inter-personal care will not be lost from the ‘quality agenda’ in general practice.

The discipline of general practice

The work of Michael Balint\(^4\) in the 1950s brought prominence to the importance of defining patient and doctor (as well as illness) factors in constructing and analysing general practice consultations, and his influence was strongly apparent in the seminal book, The
Future General Practitioner, which underpinned so much of both undergraduate and postgraduate teaching in and about general practice from the 1970s on. About the same time, the new leaders of academic departments of general practice in universities were staking out the boundaries of their much-contested territory. McWhinney first described four criteria that an academic or independent discipline had to meet, namely having (i) a unique field of action; (ii) its own skills; (iii) the ability to support research; and (iv) control over its own postgraduate training. Richardson also identified four criteria, omitting McWhinney’s ‘control over postgraduate training’ and adding instead the possession of an ‘identifiable philosophy’. McWhinney’s ‘skills’ included the ability to elucidate undifferentiated clinical problems, and his attitudes included an overriding interest in people before their diseases, emphasizing, as Balint had done before, the part played by the doctor’s personality in the dynamics of the doctor–patient relationship. Richardson’s ‘skills’ included recognition not only of the pathology of the illness but also of the psychology and sociology of the patient. His ‘philosophy’ emphasized personal and continuing responsibility, and a balancing of values and judgements. In 1974, the Lecuwenhorst Group listed in its definition of the role of the GP, the integration of physical, psychological and social factors in considerations about health and illness, and referred to continuing management and the ability to gather information and make relationships at a considered pace over time.

The term ‘patient-centred’ first appeared in the early pages of The Future General Practitioner, presented as an approach which encompasses ‘the patient’s total experience of illness’, and it has come to represent the defining philosophy of general practice, emphasizing the importance of taking patient beliefs and characteristics into consideration when making clinical decisions. Given the (correct) implication that such issues and influences have been under-represented in the traditional teaching and training in medical schools by recent generations of hospital specialists, it is not surprising that this philosophy has in recent years underpinned much of both undergraduate teaching and postgraduate training in the setting of general practice. (Paradoxically, claiming that the patient-centred approach is a defining characteristic of general practice has harmed the development of partnership between those who practice in the community and those who work in hospital, patient-centredness having come to be seen as the obverse of having special clinical knowledge, the implication being that GPs are ‘people’ doctors whereas hospital doctors are not.)

When Kuhn wrote his classic treatise The Structure of Scientific Revolutions, it was McWhinney who first extended its logic to medical practice, arguing that for medicine, its ‘paradigm shift’ would be away from disease-centred biomedicine and into a more patient-centred alternative. His team in London Ontario published a ground-breaking series of papers on ‘the patient-centred clinical approach’, and Moira Stewart, whose work is referred to in more detail below, became the most influential writer on this theme for the next two decades.

From these early writings, two ‘core value’ themes emerge. The first is that decisions on diagnosis and management should be framed to reflect what is now known as the ‘bio-psycho-social approach’ to clinical medicine. In the absence of a better term, we will define this as ‘holism’ in the text which follows. The second is that in order to reach appropriate clinical decisions, the patient’s priorities must be identified and respected, this process being facilitated through the development of good doctor–patient relationships—in turn the product of using good communication skills. Until recently, this corpus of ideas appears to have been comfortably assumed within the term ‘patient-centredness’ but, more recently, attempts to divide the concept into one part which is about doctor behaviours (patient-centred consulting skills) and a second which is about patient participation in decision making have added a new dimension to the field. A third stream of literature about identifying patient priorities, overlaps both. For the purposes of this paper, we are nevertheless keeping these various strands together under the familiar generic heading of ‘patient-centredness’.

The burgeoning literature of general practice over the last three decades confirms the appropriateness of these choices of key core values. Stott and Davis, in what is perhaps the most quoted paper written on the consultation, highlighted the ‘exceptional potential of every primary care consultation’ to address co-morbidity, offer health promotion and to negotiate help-seeking behaviour with patients. The long series of Mackenzie and Pickles Lectures have frequently reflected their importance; and an Occasional Paper has been devoted to the theme ‘What is good general practice’. In 1996, the Royal College of General Practitioners (RCGP) produced a Report entitled The Nature of General Practice looking at the key components of being a GP. Included in its list of characteristics that ‘distinguish effective and efficient primary care’ were ‘its co-ordinating function for integrated patient care’ and ‘its focus on the individual’. The next task is to explore how these central ‘core values’ have been defined and measured in the literature of the discipline.

The core values: definition and measurement

Patient-centredness
Patient-centred consulting skills. Stott’s recent definition of patient-centredness has five components:
exploring patient’s concerns and need for information; having an integrated understanding of the patient’s world; finding common ground on diagnosis and management; enhancing prevention and health promotion; and enhancing the continuing relationship between patient and doctor. The most significant challenge has been to show that patient-centred clinical practice brings benefit to patients. The majority of workers in this field have defined patient-centred practice as being present when various attributes of doctor behaviour are found when taped interviews between doctors and patients are analysed. These include paying particular attention to patients’ ideas, concerns and expectations. Positive scores have been allocated, for example, to asking open-ended questions, picking up and addressing concerns voiced by patients and maintaining silence to allow patients to restart dialogue; all features known to be valued by patients and emphasized to doctors in training.

A number of researchers have attempted to show benefit when consultations are carried out in this way, or to demonstrate that training health care professionals to consult like this improves patient outcomes.21–24 Stewart20 has reported finding 69 papers on patient-centredness in the literature between 1995 and 2000, of which half were research based, and the others related to theory, education and the description of training programmes. Of the 38 research papers, five were randomized controlled trials (RCTs), six measured health outcomes and 22 measured patient-centredness, mainly either by direct observation of consultations, or patient perception questionnaires or both.

The five RCTs, including the two most widely quoted from Kaplan and Greenfield,21,22 explored patient experience of illness, both in biomedical terms and in terms of patients’ feelings about their consultations. These studies, as with another by Kinmonth and her colleagues,23 and also working with patients with diabetes, involving nurses and doctors trained in a patient-centred method, have been able to show only relatively small levels of ‘medical’ benefit (to glucose control) in patients looked after by the trained professionals, despite, in some cases, considerable inputs to the intervention arms of the studies.

However some benefits in terms of patient satisfaction were also noted. Similarly, Kinnersley’s team,24 after an elegant series of experiments, was able to demonstrate benefit to patients managed using the patient-centred method in only one area of six tested, i.e. patient satisfaction.

These relatively disappointing results suggest that either patient-centredness is not as obvious a ‘good’ as most clinicians and academics believe, or that the methods of measuring it and evaluating it and its impact are either not strong enough, or are misconceived, or are being applied inappropriately.

Important work by Mead and Bower25 has shown that three different measures of patient-centredness have used criteria different enough to lead to different categorization of the same consultations, and has argued that none of the work describing them had adequately checked for test/re-test comparability, or for observer consistency. In short, the proposed behavioural criteria for measuring patient-centredness are not being or cannot be applied uniformly and reliably. More recently, Mead and Bower26 have presented the results of a major study attempting to see whether ‘patient-centred’ consultations increased patient satisfaction and/or patient enablement. Their conclusion that there were no associations between these processes and outcomes needs to be weighed against a number of methodological issues. Apart from only being able to operationalize three of the five of Moira Stewart’s criteria they had hoped to include, one of those they did include, ‘involving the patient’, was defined, contestably, as being present on the basis of the quantity of information given by the doctor to the patient. In addition, Mead and Bower defined consultations as having resulted in ‘enablement’ when any positive score was noted, instead of using the higher cut-off points used in most other work employing this outcome measure (see below). This resulted in two-thirds of their consultations being classified as ‘enabling’ as against a much lower figure of around one-third which would have resulted from adopting more commonly used cut-off scores to define enablement.27 Mead and Bower’s work thus seems to confirm the difficulty of trying to operationalize ‘patient-centredness’ through analysis of video-taped consultations, rather than demonstrating that patient-centred consultations do not provide benefit to patients.

The difficulty of measuring patient-centredness has been demonstrated further in a study of candidates sitting the MRCGP examination where, although four out of five candidates demonstrated some of the competencies of patient-centred consulting, relatively few achieved the full preferred criteria of ‘patient-centred performance’, despite having offered their ‘best’ consultations for assessment.28

It is, of course, possible to attempt to assess the quality of patient-centred communication through asking patients to evaluate the consultations they have received, and indeed Stewart has herself drawn attention to the fact that patients’ perceptions of patient-centredness are stronger predictions of positive outcomes than are ratings of observed consulting behaviour29. Little has recently carried out a substantial study, first asking patients to value statements about good consulting behaviour, and then asking patients, after their consultations, if these consultation processes had been experienced. Patients were also asked to evaluate a number of consultation outcomes including satisfaction, enablement (see below) and ‘symptom burden’.29,30 Little’s ‘patient-centredness’ has three components: (i) communication and partnership;
(ii) personal relationship; and (iii) health promotion, and in his evaluation of intermediate outcome he has added consideration of the doctors’ ‘positive and clear approach to the problem’ and ‘interest in effect on life’. Achievement of two of his five ‘process’ components increased satisfaction, and achievement of three increased enablement. Skelton has, however, criticized this work, with some justification, as having been based on a method of defining patient-centredness which was inherently self-fulfilling. Greco’s DISQ (the Doctors’ Interpersonal Skills Questionnaire) is a further measure which asks patients to assess doctors’ consulting skills. Although it has not been evaluated against specific outcomes, it is simple to use and could be developed to help to increase understanding of the determinants of this aspect of quality of care.

**Patient priorities.** The key paper in the field of defining patients’ priorities at consultations is Wensing’s ‘systematic review of the literature on patient priorities for general practice care’. The 10 items that featured in half or more of the papers which his team reviewed include: humaneness; competence/accuracy; patient involvement in decisions; time for care; availability/accessibility; informativeness; exploring patient’s needs; relationship and communication; special services; consequences of care for patient functioning; and continuity.

Although work has been published measuring each of these features individually, no work has attempted to measure the achievement of meeting patient wishes as a single outcome. Insofar as ‘satisfaction’ is an outcome measure which tries to capture whether patients wishes/expectations have been met, there is of course a measure which tries to capture whether patients’ priorities at consultations is Wensing’s. This has been developed in the USA as the Primary Care Assessment Survey (PCAS)—which originally was developed in the USA as the Primary Care Assessment Score (GPAS)—has been adapted for use in UK general practice, although thus far at practice level rather than at doctor level. It measures achievement on seven subscales including access, technical care, communication, inter-personal care, trust, knowledge of the patient, and nursing care. These subscales together capture many of the issues referred to in Wensing’s review, and can be presented as a summated score.

**Sharing decision making between patients and doctors.** Although both Little and Wensing have incorporated ‘shared decision making’ into their definitions of quality in relation to patient-centredness and patients’ priorities, a separate stream of literature on shared decision making is emerging. This includes a number of papers on drug prescribing and taking, clearly separating the concepts of compliance and concordance, and confirming the considerable difficulty of identifying generalizable definitions or determinants of ‘goodness’.

Elwyn used qualitative methods to propose a set of competences that would enable GPs to undertake shared decision making, his clinicians agreeing that ‘involvement of (patients) was an implicit ethos that should permeate medical practice’. In subsequent work with Wensing, he has attempted to ‘deconstruct patient-centred communication’ using the MASS (Maastricht History-taking and Advice Checklist). Patient-centred communication and shared decision making were found to be significantly but weakly associated ($r = 0.25$), confirming the authors’ hypothesis that the two concepts could be differentiated.

**Overview (patient-centredness)** ‘Patient-centredness’ is a multidimensional concept which is widely regarded as important, but is difficult to define and difficult to measure. Its goal is generally accepted as being the appropriate involvement of patients in making decisions about their own care. From the doctors’ point of view, it implies valuing that same process and developing and using the skills that allow it to happen.

McKinstry has demonstrated that patients do not all or always want the level of involvement in making decisions at consultations that some proponents of the benefits of patient-centred consulting suggest, confirming findings from previous work by Savage and Armstrong based on a different methodological approach. McKinstry found that older patients and those with more ‘medical’ problems were more likely to prefer doctor-led decisions, whereas younger patients and those with chronic health problems or psychological problems tended to favour having greater participation in decision making. Stewart also has stated that it is a misconception to believe that being patient-centred means that all information and all decisions need to involve patient participation; being patient-centred ‘actually means taking into account the patient’s desire for information and responding appropriately’.

Given the wide range of issues outlined above, the added problems of commenting on the influence of case mix, and the individuality of patients and their relationships with their doctors, it is clear that any measure of patient-centred practice that is based on analyses of small numbers of selected consultations will be unlikely on its own to be a reliable statement of a doctor’s general consulting ability. The hope must be that over a realistically sized series of unselected consultations (which will be greater than the number normally available in studies using analyses of video-tapes of consultations), the effect of such influences will even out, allowing a reliable overall picture of consulting patterns to emerge. From more representative samples, it should then be easier to explore the distribution and determinants of patient-centred consulting practice more generally.
Holism
In the review of early literature above, it is evident that an important feature of good general practice is agreed to be the construction of diagnoses in biopsychosocial terms—which is how we have defined holism in this paper. Early in our own series of researches, described more fully below, we needed to define criteria of quality processes and outcomes, and we chose, amongst others, the recognition of relevant co-morbidity (continuing health and psychological problems), and the greater likelihood that, once such problems had been recognized, they would be dealt with. We also included in our definition of quality the desirability that health promotion would be more likely to take place. We found in two studies with different populations of doctors that longer consultations were more likely than shorter consultations to achieve these outcomes; and that doctors whose mean consultation length was longer as against shorter not only had more longer and fewer shorter consultations than did other doctors, but also had patients who felt more ‘enabled’ (see below) than were the patients of other doctors. Doctors’ performance appeared to be independent of the case mix of the patients they saw. On the basis of these findings, we proposed that consultation length might be used as a proxy measure of quality at consultations.

In the UK, consultation length has been widely recognized as being too short to allow the agenda of modern quality consulting to be achieved. Wilson has recently completed a systematic review of the influence of consultation length on the processes and outcomes achieved. He studied 14 papers describing 11 studies, and concluded that doctors who spend more time with patients were more likely than others to have consultations which covered wider patient care agendas. We have also been aware that consultation length and continuity of care are likely to be aspects of care that can be traded-off against each other, in that for a given problem, a shorter consultation may achieve similar benefits when the doctor and patient know each other already. Freeman and Hjortdahl, in a series of papers on continuity of care in general practice, have shown that ‘knowing the doctor’ was a more important correlate with quality than simply seeing the same doctor, and was strongly associated with higher patient satisfaction. Although there is surprisingly little research evidence directly linking better continuity with greater holism, Becker’s classic study demonstrated that, when continuity is greater, patients are more likely to reveal key personal information to their physician; an essential part of the process of providing holistic care as defined earlier in this section.

Summary (core values)
The first part of this essay has shown that in ideal circumstances, general practice and GPs emphasize the biopsychosocial model of care compared with the purely biomedical model. The biopsychosocial model is biomedically represented by the values of holism (representing the ‘what’) and patient-centredness (representing the ‘how’). We have described the difficulties of demonstrating benefit from holism, and of operationalizing patient-centredness and demonstrating benefit from its application. These difficulties present a significant challenge to the discipline. In parallel with much of the work which has been referenced in this paper, we have ourselves been researching the definition and delivery of quality at general practice consultations, and we believe that what we have done offers opportunities to move forward on the fronts of both process and outcome of care. Our work is described in the text which follows.

Quality at consultations—a research programme
Our own interest in quality of care as a research theme dated from work in the early 1970s on the nature and causes of variation in antibiotic use by GPs. In the early 1980s, when more general interest was being expressed in the quality implications of the wide variations in clinical behaviour between doctors, we decided to explore the determinants and effects of variation in consulting practice within and between doctors at different times in their working days. We hypothesized that doctors provided poorer care when working under stress than at other times, and that stress would be related to running late and then providing shorter consultations than was the doctor’s preferred pattern. To define ‘quality’ in terms of quantifiable outcomes, we hypothesized that shorter consultations would lead to a lower proportion of co-morbidity (continuing health problems and psychological morbidity) being recognized and a lower proportion of what was recognized being dealt with. We also hypothesized that fewer opportunities for health promotion would be taken up. In order to capture patients’ reactions after their consultations, we developed an instrument based on a review of the then available literature on patient satisfaction, and on an analysis of interviews with groups of patients (consulting and non-consulting) with continuing health problems.

In a study of 87 volunteer doctors, longer consultations were significantly associated with better outcomes than were shorter consultations. Six ‘satisfaction’ questions from the post-consultation questionnaire (about whether, as a result of the consultation, patients felt they understood their illness better, felt more able to cope with illness and with life, more confident about their health, more able to help themselves, and more able to keep themselves healthy) discriminated between doctors with longer as against shorter mean consulting times. We called the concept captured by these six questions ‘enablement’, and developed the Patient...
Enablement Instrument (PEI) to measure it. The theory behind enablement is that adjustment and coping are important modifiers of outcome, and that ‘what is important in predicting outcome is how the respondent actually feels and perceives life’ (Lazarus and Cox). We have shown that although enablement correlates well with standard measures of satisfaction, it nevertheless seems to represent a distinct concept.

In a second study (the Scottish ‘shadow’ fund-holding evaluation project), involving 49 doctors collecting data on three occasions over 18 months, we again used enablement as an outcome measure. The doctors who were more enabling were again those who took more time at consultation. Mean consultation length and enablement both proved to be relatively stable measures.

At this stage, we proposed a theory to unite the apparent determinants of good consulting practice which were emerging from our observations. The first of the three components of our theory of effective consulting at unselected consultations was that better quality can be summarized as the achievement of better outcomes for patients with similar needs. The second component was that for the proper identification of needs, there requires to be a positive interaction between the values (and beliefs) of patients and doctors. The third component was that this positive interaction can either be helped or hindered if the context within which consultations take place is favourable or unfavourable (e.g. in terms of the contracts and incentives which apply to the doctor, the doctor’s workload, or the presence or absence of an effective primary care team). When we originally proposed the theory, we saw ‘context’ as constraining the expression of ‘values’, which in turn constrained the way ‘needs’ were identified. It is of course also possible that it is ‘values’ that influence the way ‘context’ is created or managed. (At this time, we also refined our definition of an effective consultation to include the need to list, prioritize and negotiate needs with patients and family.)

In a third and later group of studies about quality of care in general practice (involving 221 doctors in 53 randomly selected practices in four contrasting regions of the UK), we added a proxy measure for continuity of care, asking patients how well they knew the doctor they were seeing. Once again, doctors who enabled more were those who took more time, and they were also those whose patients knew them better.

Thus, as our work has developed, we have continued to try to operationalize ‘quality’ in terms of what we believe are the two principal core values of general practice, focusing on ‘patient-centredness’ and ‘holism’. ‘Consultation length’ and ‘how well the patient knows the doctor’ seem to be credible and measurable proxies for holism, and ‘enablement’ captures important elements of what patient-centredness is intended to deliver. In order to study the epidemiology of the determinants of the delivery of quality in terms of these core values, we created an amalgam of these three proxy measures, which we have called the Consultation Quality Index (CQI).

The Consultation Quality Index (CQI)

The CQI was developed from the third study referred to above. Stable mean values for each of its three components (consultation length; how well the patient knew the doctor; and enablement) and for the total CQI score were obtained after collecting 50 consecutive consultations with patients over 12 years of age (excluding consultations with patients who spoke languages other than English at home; see below). From the 171 doctors with adequate data for analysis, we created a grid in which doctors’ scores for each component were divided into equal sixths and allocated points accordingly (ranging from 6 for ‘best’ to 1 for ‘least good’). Scores for the three criteria were aggregated and a CQI score out of 18 calculated. Doctor rank order on the CQI correlated strongly with doctor rank order for mean enablement score ($r = 0.82$), mean consultation length ($r = 0.62$) and mean ‘knowing the doctor well’ score ($r = 0.61$).

Although the individual components of the CQI were related to case mix and the experience of the doctor, total CQI scores appeared to be independent of case mix (assessed by a ‘health needs and consultation expectations’ instrument administered before the consultation), deprivation category of the address where the practice was based, whether the doctor tended to meet patients’ wishes for a prescription, and the experience of the doctor. Patients who spoke languages other than English at home had generally shorter consultations, but reported higher enablement. This was particularly apparent when they consulted in their own language.

It was also interesting that, even although the CQI includes a proxy measure of continuity likely to count against doctors new to a practice, Registrars in training generally scored as well on the CQI as do established doctors. This is because they have longer mean consultation lengths and achieve higher enablement scores. In contrast, new partners try to work at the rate of older doctors, achieve lower enablement scores and also lower CQI scores; much the same also applies to locums.

(A one-page version of the CQI has been developed, along with notes on its use in practice. This is available from the first author of this essay.)

Applications of the CQI

Clinical governance

The CQI has the potential to assess quality of care at several levels. This is of relevance to issues relating to sick
Doctors. Of 13 doctors whose CQI was located in the lowest of six CQI groups (CQI scores were normally distributed around a median of 9), five (3%) scored 4 points and eight (5%) scored 5 points out of a possible 18. Apart from two locums, none of these low scoring doctors had been in their practices for <3 years, and 10 of the 13 doctors were in the lowest two sextiles for both enablement and consultation length. One doctor who scored 4 went off work with a depressive illness soon after the study period, and another who scored the same mark had expressed serious disillusionment about his clinical work. The depressed doctor had the shortest mean consulting time in the study, a feature which would have gone unnoticed had booking length been the measure used, as, despite his having 10 min booking intervals, he interspersed short periods seeing patients with longer periods when he sat alone in his surgery.

Practices. Practices were mixtures of doctors whose scores were often strikingly different, suggesting that measures which purport to assess practices as complete units may be blunt tools when used to try to understand the determinants of quality at doctor level. In two of the 56 practices we studied, no doctor reached a score higher than the median CQI of 9. In one group, one doctor scored 16 (he left the practice shortly afterwards), another 10 and the other seven scored 9 or less. On the other hand in another large practice, all eight doctors scored 10 or more. In another practice the four doctors had CQI scores of 15, 13, 12 and 4; the doctor scoring 4 was a frequently used part-time locum, who—following feedback of these findings to the practice—was replaced by a fourth full-time partner. The selection of training practices has attracted particular attention in recent years. We noted that the mean CQI of doctors in 21 training practices was 10.5, compared with 10.1 in 29 non-training practices. Whereas in one training practice all seven doctors had CQI scores of 11 or more, in another all six had scores of 9 or less. It seems reasonable to question whether the second of these training practices would have been appointed had the CQI been used as a part of the selection process.

Research and development
Ethnicity. Earlier in this paper, note was made of the different patterns of enablement and consultation length which applied when patients who spoke ‘other languages’ at home were consulting, and particularly when they consulted in their own language. Although few doctors saw enough ‘other language’ patients to allow a reliable comparison between their CQI scores when seeing ‘other language’ and ‘English’ patients, the available information suggested very similar doctor rankings for the two patient groups. We note with interest that although we found that ‘other language’ patients recorded higher enablement scores than did ‘English’ patients, Campbell63 has reported recently that ethnic minority patients reported lower satisfaction scores (using the GPAS) than did other patients. Further work is needed both to explore the meaning which the concepts of satisfaction and enablement have for different cultural groups, and to help understand the effect of different organizational features within practices on the overall experiences patients report.

Practice size. Considerable interest has been shown recently on the effect of practice size on quality of care. Baker and Streetfield64 have shown that patients prefer smaller practices. Stephen Campbell and colleagues37 have published results which suggest that ‘clinical care’ may be better in larger practices, but that access and inter-personal care are better in smaller practices and, in a separate project, John Campbell’s team65 has also shown advantage in terms of access and features of inter-personal care in smaller practices. In our own work referred to above,66 we noted that CQI scores fell as the total list size of the practice rose. Partly this reflects less continuity in large practices, but it is also associated with generally shorter mean consultation lengths in larger practices. Given the complex interaction between small practices, deprivation (which seems not to be an independent correlate with CQI, but is with other measures of performance such as health promotion targets met, and prescribing patterns69) and larger numbers of ‘other language’ patients (who score enablement differently from ‘English’ patients and receive shorter consultations), it is clear that much work has still to be done to make performance measurement into a culture-sensitive and equitable science.

Discussion
Pendleton and King67 have defined values as ‘deeply held views that act as guiding principles for individuals and organisations’. Summarizing their recent article on what medical organizations and those who work in them can learn from commerce, they make two important comments. The first is that medical organizations rarely declare their values, and this can leave their members unclear about what their organization stands for. The second is that, in order to address the current problem of low morale within the medical professions, it is necessary to define the vision that organizations are working towards, and the values that will guide the journey.

This essay has reviewed the history of the evolution of ‘core values’ in general practice, focusing down on two that have been widely regarded as of defining importance, namely ‘patient-centredness’ and ‘holism’. Our review has demonstrated how difficult it is to define and measure these concepts, and has identified substantial contributions towards these ends from many
Doctors or consultations?
At times in this essay, we have focused on ‘consultations’, and at other times on ‘doctors’. Although it seems generally true that consultation length is a determinant of enablement, consultation length explains only a very small portion of the variation in enablement at consultations. On the other hand, it is apparent that some doctors enable more than others do, and those that are higher enablers are also those who are more likely to have longer consultations and to see patients who know them better. Although enablement is higher both for more enabling and for less enabling doctors as the length of their consultations increases even the short consultations of the most enabling doctors outscore the long consultations of the least enabling doctors. Thus we see the CQI as being at its most useful as a measure of what doctors do and achieve, rather than as an instrument for commenting on the merit of individual consultations.

There are other ‘personal’ determinants of higher enablement scores. Male doctors spend shorter times with patients who do not ‘know them well’ than do female doctors, and this is reflected in enablement scores. Patients from different cultures score ‘enablement’ differently, and the difference is more marked when these patients consult a doctor using their own language at the consultation.

Given that ‘the doctor’ seems to be one of the important determinants of enablement, it is scarcely surprising that analysis of doctors’ taped consulting behaviour has proved so disappointing (in research as against in teaching terms), not least because most such studies have depended on <20 consultations per doctor.

The CQI as a measure of core values
The CQI is one of an increasing number of instruments designed or adapted to assess quality of care at general practice consultations. Many of the longer established instruments, such as the CSQ and MISS, are simple measures of patient satisfaction (itself one form of outcome). Other examples include the WONCA (World Organization of Academies and Colleges of General Practice) CO-OP charts, and the Nottingham Health Profile (NHP), both of which have been adapted from being health status measures to outcome measures.68,69

Campbell et al.2 have suggested that quality in general practice has two streams—access and effectiveness—and that effectiveness divides into clinical effectiveness and effectiveness of personal care. We believe that Campbell’s two aspects of effectiveness overlap to an important degree, as poor inter-personal skills obstruct the proper identification and thus management of clinical problems. Thus we prefer Donabedian’s division of effectiveness into technical effectiveness and inter-personal effectiveness.

Campbell’s team has advocated the use of GPAS as a means of assessing the quality of a practice’s non-biomedical profile, although it has still to be related to the performance of individual doctors or to clinical outcomes.37 A second newer version of GPAS includes three of the six items in our ‘enablement’ questionnaire as a new subscale, and recent work has found a good correlation ($r = 0.51$) between a cluster of GPAS items described as representing ‘patient-centredness’ and enablement, but only a weak correlation ($r = 0.21$) between the same items and patient satisfaction.70

We believe that the CQI is a way of sampling from both the clinical and inter-personal agendas, and of capturing the essence of the issues which Stewart and Wensing have identified as important to patients. Holism is the more easily measured of the two core values this paper has focused on, and the CQI appears to be a satisfactory way of capturing its achievement by doctors. Patient-centredness remains a more difficult issue; until it can be defined in a way in which it can be measured which is credible to all with interests in seeing it promoted, it will remain an abstract concept and beyond implementation. Again we believe that most of the key components it subsumes are reflected in the components of the CQI.

Empathy
Although we have based this essay on the premise that patient-centredness and holism are the key core values of general practice, we are aware that ‘empathy’ is an equally important concept/value in the armoury of a good physician. Empathy, like patient-centredness and holism, is a difficult concept to measure. Interesting work by Mercer71 studying doctors’ empathy (using a scale adapted from one used in the USA in the field of psychotherapy72) and patient enablement in consultations at the Glasgow Homeopathic Hospital71 has shown a correlation between empathy (as perceived by the patient) and enablement. In a further study involving 25 GPs working in Glasgow, doctors’ mean empathy and enablement scores correlate well (Spearman’s $r = 0.66$), and empathy, consultation length and ‘knowing the doctor well’ explain 51% of the variation in mean enablement scores in a multiple regression analysis (SW Mercer, personal communication). Interestingly, in deprived practices in that later study, doctor-perceived stress has correlated negatively with enablement as well, giving credence to our original hypothesis that stress would be related to poorer quality of care at consultations.73

Mercer’s work suggests that the CQI, as a measure of the delivery of core values, would be strengthened by
inclusion of a measure of ‘empathy’. This would effectively cover most of the Wensing/Stewart issues\textsuperscript{20, 33} not encompassed by continuity, the wider agendas linked to more time, and the improvements in understanding and in ability to cope, as covered by enablement. We hope that further work will be put in place to explore this possibility.

However, even without the inclusion of an ‘empathy’ component, we still believe that the CQI is presently the best grounded and most easily operationalizable measure available to unite our conceptual understanding of what is meant by ‘core values’ in the general practice consultation, the development of best consulting practice, and the political agenda surrounding quality control and accountability.

The ‘context’ of consultations

Using our theory (that quality of care is influenced by interaction between the core values of health professionals and the circumstances in which they are working) to predict the provision of good quality care in the future, we believe that more attention needs to be given to issues of ‘context’ than has been the case until now. At the time of writing this paper, it is generally agreed by GPs that the rewards/incentives in the current general practice contract do not promote the delivery of services which are based on the expression of the core values of the discipline.

Current issues about governance and professional accountability (including, for example, the implementation of guidelines and of the various National Service Frameworks) appear likely to confirm the pre-eminence of the ‘biomedical’ rather than the ‘biopsychosocial’ model of care, rather than help achieve the healthier balance between clinical/technical effectiveness and interpersonal effectiveness that we believe patients as well as health professionals generally want. Whether the emphasis on chronic disease-centred incentives in the next iteration of the general practice/GP contract will help the achievement of that better balance in the future remains a matter for conjecture, but the theoretical model which we have suggested as a way of predicting the delivery of more patient-centred and more holistic outcomes would tend to suggest that it will hinder rather than help that process. If that proves to be the case, we can only hope that before too long there will be another chance!

Throughout this essay, we have used the term ‘general practice’ to describe our disciplinary locus. To a large extent this is because ‘general practice’ historically has been the place where UK primary care has been delivered, but it is also because our own researches have focused mainly on the work of GPs and we have not used research-based material covering the roles of the other providers of primary care who are now making increasingly important contributions to the work of general practice teams. Although our essay has been written from a UK perspective, we believe that the ideas and content which it contains have both an international and a timeless relevance.

Summary

Our essay starts by tracing the early history of general practice under the NHS, and identifies patient-centredness and holism as the two concepts which appear to best represent the ‘core values’ of the discipline of general practice. The difficulties of defining and measuring them are discussed, and in particular the presence of three potentially different components of patient-centredness is recognized.

In the second half of the essay, the history of a series of researches carried out in Edinburgh into the definition and delivery of quality at general practice consultations is described, and a new measure of quality called the Consultation Quality Index (CQI) is presented. This measure combines two process measures (consultation length and ‘how well the patient knows the doctor’) with one outcome measure (patient enablement). Information is presented to show how the CQI can contribute to clinical governance (at practice and at doctor level) and how its use as a research tool offers insights into issues including the influence of ethnicity on patients’ evaluation of care, and debate over the optimum size of practices.

‘Good’ quality in general practice is both hard to define and hard to measure. One reason for this is because effectiveness, a principal component of quality, divides into clinical/technical effectiveness and interpersonal effectiveness. This essay has argued that interpersonal effectiveness—the more difficult component of quality at consultations to define and measure—is, because of the difficulty in operationalizing it, in danger of being lost under the weight of material on the more biomedical domain of clinical effectiveness.

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