Quality care—commonplace or chimera

B. L. Donald and R. M. Southern

Abstract

Publicity for (and latterly increased economic stringency which makes more likely), failures of care in the NHS engender concern for care quality while its assurance remains the subject of a fragmented and unhelpful literature. A selective attempt is made to examine some underlying principles by posing and answering three questions. What is the quality of care? What basic principles must be followed in defining 'standards'? How then may quality be assured?

Any definition of care must be multi-faceted and in common use pervaded with the patients' pre-occupation with a search for cures. Nevertheless, it is argued that there are gains in restricting the technical use of the term 'care' to those systematic processes of health services and their culture which impinge on the personal experience of patients and which fashion their response.

In contemporary society care ought to be designed to restore and enhance the independence, dignity and choice of the patient. Although there is a contrary tendency to abandon problems of care to the professionals, standards for care should be judged ultimately not from the specialised professional but from the viewpoint of lay people whose behaviour in the outside world fashions those norms by which independence, dignity and choice are judged.

A number of difficulties in identifying and securing improvements in care are discussed. In particular, it is argued that such is the interdependence of the style of management of an institution and the style of care it provides that enforcement of high quality care is likely to be a contradiction in terms. Only trained and sensitive staff can act intuitively and pre-emptively to prevent even incipient deterioration in care. They cannot carefully foster at all times the independence and dignity of their patients unless they are treated in a similar way as professional employees.

As an initial step in improving the quality of care a simple start is urged upon implementing an inventory of checks. These are designed to establish the identification and operation of health care policies and practices which give appropriate recognition to the characteristics of care that patients and public expect, coming as they do from a lay rather than professional world. The article concludes with an appropriate inventory of questions to be put to professionals by those laymen who are

increasingly imported into health care management through community representation (in CHCs) and staff participation (in joint consultation) and whose interest and concern should be harnessed appropriately.

Introduction

Publicity about failures of care in the National Health Service, together with developments in the fields of corporate planning and community representation particularly within Community Health Councils have led us to consider problems of defining standards for assuring high quality care. The effects of economic stringency on the quality of care in the NHS are giving cause for concern. The idea of the quality of care generates more emotion and dogma than definition and enlightenment. Genuine commitment to quality enhancement is mixed with fears of additional, counter-productive bureaucratic controls alongside existing monitoring within a 'complex panorama of quality assurance'. Consequently we have found a piecemeal literature and attempts to look at the issue an 'ethical - conceptual - methodological and semantic jungle'. Elusive definitions and fragile concepts prejudice commitment to further practical improvements.

In a short article care quality control cannot be studied exhaustively. However, so as to move nearer the heart of the matter, three questions are posed and answers attempted.

Firstly, what is the quality of care? Cure may predominate among the patient's aims, yet care is probably best defined as the systematic response not to such a distinctively defined medical need, as to the basic human needs of anyone robbed of his independence by any temporary or permanent disability. It is intended to argue that the term 'care' should, in its technical use, be restricted to those systematic processes of health services and their culture which impinge on a patient's experience, fashion his response, and thus affect outcome in terms of his independence and autonomy. This constrains customary usage without intending anything censorious of professional jargon, which in practice deals appropriately with 'medical care', 'basic nursing care', 'health care', 'social care' etc. The restriction is proposed experimentally in any

attempt to clarify and test a possible development of ideas.

Secondly, what basic principles must be followed in defining 'standards'? Generally care is, and in our contemporary society ought ethically and economically to be, designed to restore and enhance the independence, dignity and choice of the patient. Such care should be judged ultimately not from the specialised professional but from the lay viewpoint which fashions the norms governing those values in society.

Thirdly, how then may quality be assured? A simple start is urged upon instrumenting a more effective monitoring of care from the lay viewpoint as an alternative to laymen being asked either to adopt specialised professional perspectives or leave the field.

Salient points are selected for consideration which seem to justify an essentially lay view of care. Quality assurance theory is approached most generally by the evaluation of structural provision and its utilisation, the excellence of professional activities or processes, and the effectiveness of outcome in the lives of patients, the latter being paramount wherever concepts are operationalised sufficiently and available data allow. Professional and technical ideas clearly predominate and suggestions have been made for broadening the approach by adding social acceptability to medical effectiveness and economic efficiency, terms which embrace structure, process and outcome.³ Subsequently, two components of 'social acceptability' have been identified.⁴ The first is public acceptance of the economic, social and psychological costs of the thresholds of dependence implied in particular, practical definitions of sickness and disability. The second is the impact on compassion and trust of the various psychological factors of the relationships of care. In the same vein, the adoption of a 'lay viewpoint' is proposed as a further experiment in clarification. 'Social acceptability' involves the values which determine efficiency and outcome in terms of independence and dignity and the will to recover independence is crucially dependent on trust and compassion. Without scientific assessment of the social acceptability of services there is a risk of effective and cheap services for preventing and curing disability which fail to care for it to the satisfaction of the public.⁵

A lay viewpoint is not proposed in antithesis to but as a complement of a professional one. The importance has been identified of an approach involving compassionate, professional, scientific and political instincts. Clearly such instinctive or attitudinal factors are dependent on morale particularly that of those caring directly for patients. Thus towards the end of this essay the emphasis is on both the psychological factors in quality and control and on the need for a consensus between professionals and lay representatives.

What is the quality of care?

In general there are many aspects of care which go towards constructing a definition. Care maintains or enhances the identity of the individual, his dignity, and his opportunities to choose, i.e. his worth as an individual.⁶ Care is doing *all* that is necessary to maintain the highest possible quality of life - physically, psychologically and socially - in the present, while promoting in the same terms the greatest potential for quality of life in the future. Care involves providing emotional compensation for those deprivations which arise through sickness or handicap in such a way that the individual can reach a state of psychological adjustment which enables him to act in or to accept what is in his own best interests. Care involves the individual patient, his doctor, the care team, the patient's relatives and friends and requires to be an explicit focus of the management system for the delivery of health services.

SPECIAL DIFFICULTIES

Inherent in such rudiments of a definition are the crucial overlaps with and distinctions between care and cure. 'Cure' and 'care' are commonplace in ordinary usage but they become the chimera of an adequate technical vocabulary. Cure generally implies the elimination of premature death, disease and disability. The overlap with care is easily recognised in chronic illness requiring special care to maintain and enhance the worth of the individual and his remaining capacities. With such chronic conditions the overlap occurs also in attempts to deal with discomfort and discontent which may be ineradicable. Here, too, the specifically technical and instrumental character of professional responsibility merges with more social and ethical aspects of care. On the one hand, much discomfort and discontent may arise for the patient from social and economic circumstances over which professionals can have little special influence, e.g. level of social security benefits. On the other hand, much discomfort, discontent, and thus attitudes towards disability, may emerge from aspects of the patient's personality and character. Ethically some of these should be beyond the scope of medicine, e.g. a puritanical conscience. These are all examples of special difficulty and confusion for it can be argued that social control is among the objectives of the health care system and, for instance, includes the legitimisation of sickness and the control of malingering.⁶

There are also special difficulties with the patient who is neither lucid, well-adjusted, nor capable of ordering his life. He may be unconscious, confused or beyond caring about his best interests. Such problems of confusion and disregard of self-interest are peculiar and acute with mental illness and impairment and again in some of these cases social control and community attitudes about deviance

intervene. Yet again, a few patients are robbed by physical disease of all choice and dignity and even their identity may be questioned in cases of purely medicated survival. Recognised terminal illness is pre-eminently a situation with its own peculiar needs and challenges requiring both the expertise and care of the professionals as well as the concern and resources only the lay community can make available.

For all such special cases, which though crucial are relatively less prevalent, we would argue for the adaptation of general principles. We fear that a claim for different treatment risks diminishing standards of care for those whose abnormality can be confused with mere animal survival or deviance. It involves the vulnerability of the professionals by isolating them with the determination of the special case, a decision which can misfire, e.g. child battering. Such a claim diminishes, in some way, the potential for maturity in communities and lay individuals which should be derived from dealing with life's extremities.

In general the informed patient will usually opt for the diminution of current comfort in favour of future enhancement of capacity, and this presumption must guide the activity of professionals who are responsible for those unable to judge their own best interest. There is a risk that the assumption will be made that fewer patients are capable of making the choices involved than is, in fact, the case. Experiments in care are showing that, within appropriately designed regimes, even the most severely handicapped can exercise more choice than is otherwise assumed.⁷ Where there is the capacity to choose, it is suggested that high quality care requires that patients be informed of the short- and long-term consequences of their illness and proposed treatment, so that a consensus about that treatment may be developed with them.

PERSONAL PHYSICIAN AND TEAM CARE

The tensions and emotional vulnerability of illness and handicap are best managed within an appropriate patient/doctor relationship. This clearly subordinates the role of all other parties, including health service management, to the discretion of the patient's doctor. He alone will decide when, where and how to admit, treat and discharge. Unimpaired clinical autonomy together with confidentiality is accepted certainly within medicine, health services and widely among articulate patients as a basis for patient/doctor trust. Such trust is the only assurance of patient compliance and continuation of treatment when inherent painful side effects or patient inclination put these at risk. The extent to which the reciprocal doctor/patient relationship encourages individual patient trust is an important indicator of the quality of care. This means the health team, required today by the complexity and advance of

medicine, must work to and through the individual doctor/patient relationship.

There are here at least two persistent paradoxes. The first concerns the need to relate clinical autonomy, subserving solely the needs of individual patients, with insatiable, unmet community needs, always exceeding allocated resources. A second paradox is related to the first through the need to manage scarce resources effectively in medical services such as radiology, through the departmental autonomy of another doctor, or, with greater potential for friction, through the managerial and professional autonomy of other paramedical professions and departments. As these develop technically beyond the ken of any but the specially qualified, and as the paramedical professions reach institutional maturity at a time when reorganised NHS structures ensure the coalescence of the professionals in larger specialist departments, the demand for self-management is encouraged. This is reinforced by economic stringency and staff shortages which make it imperative to deploy paramedical staff on cases where they are effective. Effectiveness in terms of the contribution to care and cure is not always beyond dispute. The autonomous clinician may feel the admittedly placebo treatment is good care but the paramedical head of service may feel, without direct and continuous personal knowledge of the patient, that it is bad departmental management. Rhetorical defence of clinical and professional autonomy is required rather less at this point than recognition of the operational problems of delivering adequate care for which explicit departmental policies are required. Care is a multi-disciplinary activity which, to be successful, requires the integration of the multiple aspects of diagnosis, treatment and basic care, not only in the hospital but also in the home, in the community, and between these. It is important that health management should promote an understanding by all groups of the contribution that they, and other staff involved in the organisation, can make to care. Management should strive to eliminate the discontinuities which frequently arise at the boundaries between departments and disciplines.

What basic principles must be followed?

IDEAL AND REALITY

In discussions of care there is a need for a distinction between normative and real standards, i.e. between what ought to happen and, typically, what does happen. Confusion springs from the considerable moral and professional imperatives associated with the golden rule of providing the best of care for every individual. This inclines professionals to perceive the realities of care selectively. It requires a considerable mental effort, on the part of the members of the caring professions, to discuss care on an empirical or objective basis. However, in

reality the golden rule can rarely be applied as stated. Medical convention permits the clinician within a reasonable margin to depart from this ethic when forced to do so (e.g. 'triage', the categorisation of mass casualties according to prognosis and requirement of relatively scarce medical aid).⁸

Whilst the public's attitudes and expectations have been heightened they seem willing to accept, in practical terms, that the contribution of doctors, nurses and other health care staff to the quality of care is limited by the shortcomings of the system. However, they seem unwilling to take the further step of recognising that the health care system is itself limited by the amount of resources which they, the public, are willing to see devoted to care.

IDEAL AND ROUTINE

Scarce resources can often be stretched and legitimate staff needs met by exploiting the advantages of routine methods. Adjustment to these routines frequently involves psychological, physical and, not infrequently, economic costs for patients. Adjustment by staff to meet the legitimate needs of patients is likely to involve similar costs for them. For example, the early waking of patients for basic nursing routines is largely dictated by the complete change of staff which takes place between night and day, it being exceptional for anyone to work through the changeover. Routines are primarily geared to the basic, largely physical, needs of patients. This often militates against an individual approach. The replies of discharged geriatric patients to an enquiry by the Hospital Advisory Service about their experiences poignantly depicts the deprivations and assaults on identity and dignity which arise from shortages of nurses and consequential rigid routines.⁹ Consequently good care should be marked by a genuine reciprocity and willingness to explore and review the needs of both patients and staff. Any erosion of individuality should be minimal, temporary and continuously under review.

THE IDEAL – INDIVIDUALISED CARE

Care and treatment based on the specified needs of the individual are clearly the ideal. This will be so as long as the individual's dependence is not exploited or publicised to fulfil some need for recognition, or emotional release for those who care. To be treated as if one's needs are unique is the quintessence of those values we encompass in the word 'care'. Not only is care on such an individualised basis a goal or value in a modern society it is a functional process in all cases where recovery and rehabilitation are possible. The effect depends on the encouragements of a positive response and improved motivation in the patient due to recognition of his value to those who care for him and of the obligation to respond to their efforts.

An important factor in the delivery of care relates to the abilities of the patient, including his capacity

to adjust to circumstances and environment; those to which he is accustomed; those he could reasonably expect had his life developed normally; and those that permanent impairment may thrust upon him. Whilst physical needs are obvious and are most likely to evoke a compassionate response, it must be remembered that psychological and social deprivation can be just as disabling, and most people respond less readily to them.

The process of providing care must ensure psychological reinforcement for a patient when he must curb his 'wants' in order to have his real 'needs' met. We refer later to the effects of cultural and individual differences in the capacity to deal with the deprivations of pain, illness and disability. Clearly patients differ in this respect and the need for care staff to discern between patient whim, a valid human need or legitimate expression of individuality is one of the more severe challenges to individualised care particularly when objective judgements are almost wholly precluded and the economics of care enforce their own stringency. The possible conflict between wants and needs is most acute where a patient's survival or effective rehabilitation depends on his motivation to overcome short-term, acute and, possibly, overbearing discomfort and difficulty. To the extent to which a patient's commitment is crucial, he retains control over his own destiny.

In a context of scarce resources, the legitimate needs of those relatives and staff who provide care and the quality of the patient's life must be integrated with careful and compassionate judgement. However, such shortages have led to an undue reliance on the attainment of minimum standards which is seen to be an end in itself. 'Such an attitude destroys any wish for further progress.'¹⁰ In such circumstances it is necessary to resort to intuitive judgements on the range, extent and relative priority of different needs. Regrettably, the coincidence of such judgements across professional, organisational and social groupings is at best questionable.

SUBSTITUTES FOR PATIENT CHOICE

If it is not possible to obtain the patient's view of the care which he wishes to receive, then it is important as a substitute for this view, that those having the most extensive and continuous relationship with him should participate fully in major decisions about care. Thus the importance of the role of the family and of the nurses involved is clear. Those providing basic nursing care together with those who knew the patient well before the onset of illness have the most extensive sample of the patient's previous behaviour and reaction to his illness from which to infer his wants and interests.

The unique contribution to care of the nurse who provides continuous and basic care for the patient is widely recognised. 'The unique function of the

J Med Ethics: first published as 10.1136/jme.4.4.186 on 1 December 1978. Downloaded from <http://jme.bmj.com/> on April 25, 2023 by guest. Protected by copyright.

nurse is to assist the individual, sick or well in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided had he the necessary strength, will or knowledge.¹¹ It is doubtful whether nurses are able to exert sufficient influence to ensure that enough resources are made available so that a level of basic care might be provided which is of an acceptably high quality. It must be admitted that staff, including nurses, sometimes fail to recognise factors which detract from the objectives of therapy and care because these factors are familiar or regarded as neutral. However, few professionals could say they would find life as a patient tolerable for long.¹²

CARE POLICIES

In order that the provision of direct care should be purposeful, well-organised and integrated, it must be supported by an organisation with formal 'care objectives' which appropriately detail and focus the responsibilities of each level for the delivery of care. Good care is both comprehensive and indivisible. Its integrated provision at the point of delivery is unlikely to be achieved on a piecemeal basis. While all policies should emerge from a tidal flow of discussion and consultation between upper and lower organisational levels, there are sound reasons for care policies emerging predominantly from below. These reasons are partly technical in that care staff have information and experience concerning the integration of services in the delivery of care. The reasons are also partly psychological and we discuss below the difficulties of adopting an authoritarian approach to policies and systems for care. Establishing care policies requires initially appropriate analysis and planning and subsequently monitoring and control in every department.

THE LAY VIEWPOINT

If high quality care, as well as being a question of skill, involves questions of sentiment or commitment it has psychological and ethical implications. It has been expected that laymen would usually flee from consideration of these matters. But we are now in a changing environment in which ethical, social and economic factors blur together in such problems as selection for extensive replacement surgery and adequate standards for the chronic sick. The intensification of the economic and technical dilemmas involved in clinical decisions may lead professionals to welcome informed and sincere contributions from laymen. It is important that no-one concerned with the NHS should remain apathetic or neutral on these issues. Neutrality in this context is callous, and the whole of society must come to grips with difficult and painful questions. In this spirit, we wish to put forward for discussion some principles and general guidelines.

We do this having worked with and shared some

of the confusions of Community Health Council secretaries in training. It is part of their role to enable public participation in health care decisions by facilitating the contribution of their Councils. These Councils are charged with monitoring the provision of health care and need to focus their feelings about care on a coherent basis. It is possible that health professionals working predominantly with the sick may well have a view of identify, dignity and choice which is fashioned by receiving their patients when they are at their most vulnerable and dependent. If there is such a bias, who better to counter it than the informed lay person with a view of life fashioned elsewhere?

The case for this lay or general view is well founded. Medical care is aimed at the restoration of economic and social function, the standards for which are determined in the non-medical world. While existing social norms tend to mean that usually laymen have little or no experience of personal care for others, it is nevertheless true that the professions cannot and do not claim a monopoly of responsibility for care. Asylum has for long shielded the wider society from understanding and accepting the disabilities and capacities of the handicapped; public tolerance is limited by ignorance and can be misjudged by professionals orientated to the care situation. Professional socialisation fosters a particular approach to care and its quality which must always be distinguished from the lay view despite the common humanity of all concerned. Given that the quality of care depends on a questioning approach, there is real need for such surrogates of the patient as the Health Service Commissioner, Health Service Advisory Service, CHCs and various patient pressure groups.

Moreover in the highly specialised world of medical care with its divided responsibilities, it must be remembered that all, in respect of a sector other than their own, may and should function relatively as laymen. Each specialist doctor, nurse or therapist immersed in the opportunities and threats of his own technology and skills, may too readily accept its demands and assumptions about patient compliance. Sometimes the incongruity of what is expected may be more obvious to the relatively uninitiated. A contemporary change, involving the search for greater participation in health management by all staff groups particularly ancillary staff through formal mechanisms for joint consultation, may be relevant here. With greater frequency such groups are expressing concern about some contemporary problems of care. It has been argued that in health care, programmes of participative management make best sense when focused on finding at a local level answers to the question 'What obstacles do you see in your work to the improvement of patient care?'¹³ The need is not to treat such manifestations as aberrations but by careful response to advocate and harness such concerns to

the tasks of developing and monitoring widely-based organisational policies for care.

How then may quality be assured?

Effectiveness in health care amounts to the maximum restoration and adaptation of physical, psychological, social and economic capacity, carefully balanced with the maintenance and enhancement, in the short and long term of the individual's identity, dignity and choice. Efficiency is the maximisation of effectiveness with the minimum of resources. In 1977 economic difficulties and their effect on organisation and morale threatened the quality of care. Redeployment and rationalisation induce, both in perception and in reality new levels of financial and resource shortages. Erosions of service are feared, discussed, planned, and happen in an emotionally charged setting. Unsolved problems in the theory and practice of measurement in health care encourage a dogmatic approach. Clinical autonomy, both as an organisational mode and a personal style, introduces confusion between perceived and real cuts in the quality of care as practitioners see requests, for economic reasons, voluntarily to curtail services as onslaughts on their autonomy. The confusion increases the damage to professional morale and commitment, themselves prerequisites of high quality care. In all of this, the checking or monitoring of quality is likely to become imperative if only to minimise confusion and the multiplier effects of bad morale.

The introduction and effectiveness of controls must depend on the validity and precision of technical criteria, the extent of discrepancies, and on the willingness of all concerned to respond either to the discrepancies or to the sanctions that may result. There are, we believe, many inherent difficulties in establishing any form of monitoring and control in health care.

TECHNICAL DIFFICULTIES

Some of the most intractable difficulties are those of measurement and control in health care management. For want of sufficiently precise, valid and acceptable yardsticks it is very difficult to differentiate the effects of care, as discussed here, from differences in outcome or cure, in treatment, in rehabilitation, in access to services or in the character of continuing primary care. In focusing deliberately and narrowly on direct personal care and the activities, relationships and sentiments involved we have to remember that such care is inextricably linked for the patient in one experience. The lay viewpoint would, in its compassion, both wish to embrace and differentiate in its judgements all those factors relevant to a patient's total experience. Such an ambition is doomed to failure given the complex interdependence of health systems, disease, treatments and the cultural or individual differences involved. Thus it is

that our concepts and methods of measurement and scientific control are, in health care, so piecemeal, rudimentary and frankly inadequate. The development and propagation of a genuinely lay view of care will require great patience and persistence not only on the part of those who seek to exercise the judgement but also of those who as professionals and managers would foster and inform that viewpoint.

PSYCHOLOGICAL DIFFICULTIES

If it is possible to define some standards, it is necessary that they should be monitored and controlled. This may be undertaken for punitive, educational or preventive purposes.⁸ An implicit or covert purpose will colour or constrain the process of maintaining or improving quality. Any hint of externalised enforcement or manipulation of care quality involves the hazard of legitimising an authoritarian approach to the management both of the health organisation and its patients. If it is assumed that care can be improved by imposing controls on staff, then the implication is that care improvements can be imposed on patients. It is against this background that punishment seems a motive for quality control that is singularly inappropriate.

Intervention in care may have similar overtones if it implies, as it usually does, warning signals of failure and the usurping or bolstering of those with primary responsibility. There is still the overt implication of authority, which is ill-matched with the caring relationship that must be developed for patients. Yet intervention is seen as the most obvious form of preventive control. Once care seems likely to deteriorate unacceptably, 'someone' should move in to prevent this deterioration. One unfortunate consequence is that someone has to move into the caring relationship to restore some aspect of its overt quality which will at the same time change if not shatter it. This intervention often produces a defence of the care staff by the patients who may be at risk and realise it, yet resent the intrusion and consequently defend 'their nurse' and 'their doctor'.

Whilst much can be achieved by appropriate resources, organisation and training characteristically good patient/staff relationships depend on the motivation of the staff to sustain commitment to the individual. This is sometimes against enormous odds of illness and handicap and against the tempting readiness of the patient to collapse into inarticulate dependency. Resource scarcities and an authoritarian reinforcement of threatened standards may, depending on the personality and training of the practitioner, induce a similar surrender to dependency on higher management. Such is the interdependence between the purposes and management style of an organisation that we would expect the ability to sustain a régime of care based on the

identity, dignity and choice of the patients, to depend on a management style which clearly espouses these values and applies them as well to employee/employer relationships.

Quality enforcement in practice is often characterised by the scheduled periodic review or the hasty remedy, following failure. Frequently ward and care staff are bogged down in the routines of meeting basic needs. Often we congratulate ourselves on performing the tasks which have been thought to be necessary but really we should be considering whether we need to engage in the activity at all. It may well be that when we consider factors such as the uniqueness, dignity and identity of the individual, his psychological needs and the reduction of institutionalisation, the amount of activity will be less. Where faults have already been openly recognised care staff are living with the anxiety and guilt of failure. The emotional pressure for nurses and care staff 'to do something about it' is considerable.¹² Unfortunately this pressure is frequently in an inverse relationship to the psychological and economic opportunities for doing anything constructive. The health care practitioner may gradually come to accept the provision of care that he believes to be below standard but which is beyond his personal influence. Frequently, the key to the log-jam in morale is an injection of fresh resources, often quite small, but now made more remote than was hitherto the case because of economic stringency.

How then can prevention and quality maintenance be articulated in ways that are not counter-productive? Education and training, apart from being intrinsically valued and attractive, are the preferred approaches. Such approaches are psychologically appropriate and avoid the unproductive use of authority. The renewal of awareness of care, its quality and the problems of maintaining it, is the only truly effective system of quality control and assurance. Education and training strategies lead to internalised criteria for care among staff at all levels. Perceptive, concerned staff are the most readily altered by incipient failures and the most prompt and skilful at applying speedy remedies. Any other system of interventive controls implies, even with sensitive monitoring devices, the onset of a problem recognised only retrospectively when something identifiable or measurable has begun to occur. Data, criteria and processing systems for the quality of care are not yet sufficiently sensitive to deal adequately with the incipient problem. Trained staff are intuitive and can act pre-emptively, systems are not and cannot.

An educational approach does not necessarily mean frequent, expensive 'off the job' teaching. Courses may be a requirement for initiating a departure in objectives or style with reference to quality of care. But the key to the self-motivated, self-regulated assurance of that quality is the now

familiar cybernetic effect characterised by 'knowledge of results'. This effect is inherent in the problem-orientated approach which is taught to many medical, nursing and paramedical students. However, such an approach requires time for detailed diagnosis and the formulation of care plans. This is more demanding intellectually than the maintenance of a routine which, once initially and appropriately selected, is a defence by the reasonable practitioner who is harassed by excessive quality control and malpractice litigation. Only the systematic, future-orientated patient plan can cope with the multiplicity of characteristic differences and particular needs of patients on an individual basis. The advantage of such thinking is that it is possible to inform and involve the individual patient, enabling him to make those judgements and decisions he may have to or may wish to make before the course of his illness or treatment shunts him into a crippling dependence.

THE POSSIBILITIES

The surrender to professionals of health problems, particularly those with an intractable and socially repelling element, such as sexually-transmitted diseases, mental handicap and terminal cancer, is to isolate the professionals from the understanding and support of the society which, through their patients, they serve. Such isolation can lead to a divergence in social and professional objectives. When, ultimately, failures of care break into public consciousness, the problems having been brushed aside for so long, are usually extreme. The resultant shock for both public and professionals disrupts the confidence and commitment on which improvements have to be built. We would argue for the involvement of a lay viewpoint which is not a particular or exclusive one, in contra-distinction to those of the professions, but is rather a sympathetic and general view seeking to select and balance the interpretations and judgements of the separate professions involved. This approach to the quality of care also balances the professional view as a whole with the view of the patient, his relatives, the health management responsible for the allocation of resources and the community responsible for meeting the monetary, real and opportunity costs of care.

FINAL QUESTIONS

The technicalities and complexities of the objective monitoring and control of care must, if professional and managerial objectives and activity are to receive sufficient popular support and resources for their effective execution, be related clearly to the pre-dominant values and needs of the wider society. This may appear to be a process of diluting professional judgement and popularising and oversimplifying complex matters. However, it can be viewed appropriately as an indispensable aspect of professional accountability within a compassionate

society and as an educational strategy to involve professionals and laymen in quality maintenance. With these needs and objectives in mind we tentatively propose an inventory of general questions which are designed to develop, from the lay point of view, an insight into the quality of care.

- 1) Is everything possible being done to maintain and enhance the quality of life in the short and long term, given the patient's expectations of life and life style and the level of resources available?
- 2) Are the erosions of the quality of life minimal, temporary, under constant review and the target for specific amelioration and management?
- 3) Is the maintenance of life and human functioning undertaken in an integrated way with the physical, psychological, social and economic needs of the patient considered as a whole?
- 4) Has the programme of care as well as of treatment been planned with appropriate regard to the systematic and comprehensive determination of personal needs and with sufficient regard to an individualised mode of meeting these?
- 5) Has sufficient value been placed upon the identity, dignity and choice of the patient? What part have the patient, his relatives and those directly caring for him played in the formulation of the care plan? Could the part played by anyone have been enhanced to the benefit of the patient?
- 6) Is every member of the care team identified and identifying with the care of the individual patient?
- 7) Are individual differences in adaptability, capacity and fortitude of patients viewed as opportunities or constraints?
- 8) Are innovations in individual treatment or the organisation and management of services always questioned for their effects on the basic nursing and care of individual patients?
- 9) Does the concern for direct care permeate and readily influence the hierarchy of support services and management?
- 10) Does every level of management concerned with the situation under review, have an explicit and practical policy for direct care? Do they monitor and control the operation of that policy?
- 11) Are economic constraints considered as permanent or dynamic, to be borne or to be managed, and, where possible, exploited?
- 12) Are those aspects of treatment and care which are regarded as professional prerogatives defended emotionally or explained rationally and willingly? Is a general or lay view of the problems of care encouraged or discouraged?
- 13) Is an acceptable element of idealism balanced with a reasoned and reasonable assessment of reality with its opportunities and constraints?

As statements or questions about universal standards, we believe that there will be few situations in which unqualified and acceptable answers to the above questions would be forthcoming.

The use of such a questioning approach from a distinctly lay viewpoint in what hitherto has been constituted as a highly defended professional reserve cannot be easy. Indeed as earlier we have defined care as doing all that is necessary to preserve the highest quality of life, it is inevitable that the result must be judged against a number of criteria, some professional, some lay, between which there may be a natural tension but not overt conflict.¹⁴ The difficulties must not be compounded by a dogmatic approach and a cavalier disregard for the subjective, multivariate nature of evidence in this field. Regard must be paid to these factors to avoid needless quarrels and the closing of minds and of debates. Given that the best approach to quality assurance appears to be to develop percipient professionals alert to care quality issues, the essence of success is to continue the debate at a level that affects reciprocally the attitudes of professionals and laymen alike. The final test of a strategy for lay involvement in the setting of quality standards is that such standards prevail and that the services are in every respect what people want for their fellows and would want for themselves. But as what people want embraces an interdependence of effectiveness, efficiency and humanity, the lay viewpoint must accommodate and be seen to accommodate to the technical and economic realities of health services.

The general or lay view will always tend to be short on the realities of care. It can never be directly appraised of the clinical and technical constraints which are only open to a trained and professional judgement. However, it can, and should, ask questions even at this point and weigh the answers not for professional and technical merit, but for what they reveal about the objectives and values of the professionals involved. The response to inappropriate answers should be to seek to understand and get inside the view of the other, rather than resist and defeat it. In the last analysis, the lay or general view of care will always be pursued with a view to establishing resources, organisation, management climate and professional attitudes which foster continuing progress as well as providing specific remedies for failures. High quality care is as elusive as any ideal. A degree of idealism is essential as a leaven for the personal relationships on which its achievement depends. Care without caring people and sufficient caring people without a caring community are unlikely.

If, in the interests of present and future patients, care is to be fostered rather than enforced, laymen and professionals must seek consensus rather than confrontation.

Acknowledgement

The authors are grateful for constructive comments from R J S Bryant, N R Gray, J Hamilton and J T Leeming. The views expressed are, however, solely their own.

References

- ¹McLachlan, G (1976) (ed), *A Question of Quality*, Nuffield Provincial Hospitals Trust, London.
- ²Lewis, C F (1974), *Medical Care* **XII**/10, 799–806.
- ³Doll, R (1974), *To Measure NHS Progress*, Occasional Paper 8 (Fabian Society),
- ⁴Doll, R (1974), Surveillance and monitoring, *International Journal of Epidemiology*, vol. 3, no. 4,
- ⁵British Geriatric Society and Royal College of Nursing in the UK, (1975), *Improving Geriatric Care in Hospital*, Royal College of Nursing, London.
- ⁶Jeffereys, M (1971), The Contribution of Health Services to Social Welfare, in *Evaluation in the Health Service*, ed. W A Lang, Office of Health Economics, London.
- ⁷Miller, E J & Cwynne, C V (1974), *A Life Apart: A Pilot Study of Residential Institutions for the Physically Handicapped and the Young Chronic Sick*, Tavistock, London.
- ⁸Donabedian, A (1968), *Medical Care* May June **VI**/3.
- ⁹Baldock, P (1975), *Gerontologia Clinica* **17**, 13–22
- ¹⁰Hospital Advisory Service, (1975) *Annual Report 1974*, London.
- ¹¹Henderson, V (1969), *Basic Principles of Nursing Care*, Carger (for International Council for Nurses Basle, rev. ed.
- ¹²Rudd, T N (1974), *Nursing Mirror* 53–54.
- ¹³Cuming, M W (1978), *Personnel Management in the NHS*, Heinemann.
- ¹⁴Klein, R and Hall, P (1974), *Caring for Quality in the Caring Services*, Bedford Square Press for Centre for Studies in Social Policy, London.