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We know little of what goes on behind the closed door of the GP's office. Now and again the door should be left ajar

Behind closed doors

Alone in the office with the patient, attempting to solve the problems he brings to me, I sometimes envy my colleagues at the hospital. Seen from the aspect of the one-to-one nature of general practice, hospital doctors appear to have the closest proximity to guidance, professional discussion and the work of quality improvement. For were the problems dealt with optimally? Would more experienced colleagues have done things differently? Does my practice lean in one particular direction – and if so, which? Unless I actively ask for advice, no one else participates in assessing the numerous problems of the day.

One-to-one consultations behind closed doors have clear advantages. Confidentiality, trust and personal acquaintance over time are core values in general practice. Part of the purpose of the regular GP scheme is to foster precisely these values. Patients expect to see their doctor – alone (1).

The disadvantages of this way of working are equally obvious. If professional practice takes place entirely behind closed doors, outdated knowledge may remain unchallenged and bad habits may arise and become entrenched. In many respects, variation in practice is a benefit – different doctors solve problems in different ways, and patients find the doctor who suits them best. However, pronounced variation in practice may also be a sign that the doors have been too firmly closed. A case in point is the significant variation in the prescribing of antibiotics for respiratory infections. The one-fifth of GPs who most frequently prescribe antibiotics do so around 2.5 times as often as the one-fifth who prescribe them least (2).

To compensate for the one-to-one aspect, the only specialty that requires recertification is the general practice and family medicine specialty. To maintain the specialty there is a requirement to participate in small groups with other GPs, and to attend a certain number of courses. Completing two full days of visits to a GP colleague's practice over a five-year period is also mandatory between each re-certification. This is of course a good thing, but not sufficient to eliminate the slight trace of envy felt towards colleagues who – to an outsider – appear to spend their working lives continuously visiting other practices.

The newly established Centre for quality in medical practices, owned by the Norwegian Medical Association and its subsidiary associations, is currently testing improvement tools based on a model taken from Prescription Peer Academic Detailing, a quality improvement method devised by the Department of General Practice at the University of Oslo. The fundamental principle of the method is to throw open the doors and compare one's own practice data – such as prescribing and referral practice – with those of one's colleagues, and discuss the reasons for possible variations. The method changes practice in the desired direction (3) and the doctors appear to like it (4), but if all the GP surgeries in Norway are to participate in this quality initiative, the authorities need to provide both interest and resources.

Successful quality improvement work requires the endorsement of management (5). The hierarchical structure of the specialist health service makes it easy to place responsibility. In the primary health service, this is more complicated. The GPs have an independent responsibility to «carry out their work in line with requirements adopted in legislation and regulations, updated knowledge and national professional guidelines» (6), while the municipalities, which are the contracting authority, «shall ensure that systematic work is performed on quality improvement and patient and user safety» (6). Given the 428 different contracting authorities that usually lack the resources or competence to ensure this, and rarely come together to find good shared solutions, it is far more difficult to place responsibility.

For many, the wish to work freely and independently can determine the selection of general medicine as a specialty. However, the tendency appears to be for GPs to wish for increased collaboration with colleagues. The solo practices of the past are disappearing, with nine in ten GPs now working in group practices (7). At many doctors' surgeries there are regular practice meetings in working hours, and a low threshold for requesting a second pair of eyes to take a look at a difficult problem.

Most of the conditions are in place for less professional loneliness and more quality-improvement work in general practice. It is to be hoped that those who contract the GPs also realise the necessity of this.

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