The College and 'clinical effectiveness'

Robert Kendell

'Clinical effectiveness' is a slogan. It was introduced by the UK Health Departments three or four years ago, and like many slogans it is a convenient shorthand for a rather complex set of ideas and aspirations.

It is obviously important that all clinical interventions (i.e. the treatments given to individual patients and the preventive strategies adopted for individuals and populations) should be as effective, and as cost-effective, as circumstances allow. A wide range of activities, institutions and facilities have a bearing on the overall efficacy and cost-effectiveness of any healthcare system, including:

(a) the calibre of recruits to the medical profession and to all the other healthcare professions, and indeed to healthcare management;
(b) the quality of the undergraduate and postgraduate training that doctors and other health professionals receive, and the quality and quantity of the continuing professional education they receive after qualifying;
(c) the economic framework of the healthcare system, in particular whether it provides perverse incentives to doctors and others to provide relatively ineffective clinical interventions;
(d) the quality and scale of health services research (health technology assessment, in contemporary jargon), locally and internationally, generating information about relative efficacy and cost-effectiveness;
(e) the availability of information about the relative efficacy and relative costs and cost-effectiveness of clinical interventions. This involves such issues as the availability of libraries and library software, of review articles, of specialised journals, and of specialised agencies like the Cochrane Collaboration and the Centre for Reviews and Dissemination;
(f) the availability of local information about the effectiveness and cost-effectiveness of local service delivery; this includes such things as the quality and scale of clinical audit and the availability of information about the comparative performance of different clinical services, hospitals and health districts.

The term 'clinical effectiveness' tends to be focused on those elements in this long and incomplete list which are relatively new, and which are being actively promoted by the Health Departments and other bodies. The most important of these at present are:

(a) health technology assessment;
(b) clinical audit;
(c) measures to cope with the increasing volume of relevant clinical information ("the information explosion"), including the Cochrane Collaboration, new journals like *Evidence Based Medicine*, and the Clinical Effectiveness Bulletins produced by the Centre for Reviews and Dissemination;
(d) the production of evidence-based clinical guidelines. These are not, as is sometimes assumed, a device for instructing doctors how to treat their patients; a medical equivalent of painting by numbers. They are simply a means of providing healthcare professionals (and in some circumstances patients as well) with pre-digested information, drawn from all available primary sources, but particularly from random-allocation clinical trials, about the efficacy and relative efficacy of all the therapies and clinical policies available for the condition in question;
(e) the development of clinical outcome indices for measuring outcome after a wide range of clinical interventions, followed by comparison of the performance of different clinical services, hospitals and health districts on these indices.

It is important to appreciate that this is not simply a UK initiative. Similar campaigns are being mounted throughout the Western industrial world in response to a common set of problems and circumstances. The three most important elements are the steadily rising cost of medical treatment, which is forcing governments and other funding agencies to question those

https://doi.org/10.1192/pb.21.7.385 Published online by Cambridge University Press

costs and to try to control them; the rise of consumerism and the increasing reluctance of increasingly well-educated patients to accept medical advice uncritically; and the mounting evidence of widespread variations in clinical practice which are not attributable to differences in patients. This variation is particularly embarrassing to the medical profession because there are only two ways of explaining it. Either there is no evidence in many situations about the relative efficacy of different interventions, which implies that clinical medicine is still fundamentally unscientific; or alternatively the evidence exists but many doctors are either unaware of it or are ignoring it.

It is important to appreciate, too, that although the contemporary slogan 'clinical effectiveness' may change, the need, and the pressure, to maximise the efficacy and cost-effectiveness of all clinical interventions will not. Indeed, it is bound to intensify.

What are the implications of all this for psychiatry and for our College? Firstly, it is at least as relevant for psychiatry as for any other branch of medicine. Many of the clinical interventions on which we rely are expensive and have rarely been evaluated: long stays in hospital for a wide range of disorders, many forms of psychotherapy, including supportive psychotherapy, and many rehabilitation strategies, for example. In other areas, thanks to the initiative of our predecessors, we have substantial evidence about efficacy. We have good evidence for the efficacy of neuroleptics, antidepressants, lithium and electroconvulsive therapy (ECT), about the settings in which these therapies are effective, and about the relative efficacy of different neuroleptics and antidepressants. We have similar evidence for the efficacy of cognitive and behavioural psychotherapies and of various forms of family therapy for schizophrenia. Unfortunately, much contemporary practice ignores, or is ignorant of, this evidence.

The *raison d'être* of our College, like that of the other medical Royal Colleges, is to achieve and maintain the highest possible standards of care, in our case of care for people suffering from psychiatric disorders. The campaign to improve 'clinical effectiveness' has, therefore, to be our campaign as well, and the College already has some substantial achievements to its credit. We demonstrated our commitment to clinical audit several years before the Health Departments started to promote audit as part of the Government's NHS reforms, with our national survey of ECT, published in 1981, and we have mounted two further audits of ECT since that time. The establishment of the College Research Unit (CRU) in October 1989 was itself a clear indication of the College's commitment to raising standards of clinical care, and since then the CRU has, with Department of Health funds, developed the Health of the Nation Outcome Scales (HoNOS) – a powerful tool for measuring outcome across the whole range of psychiatric disorders – and embarked upon the production of what will eventually be a series of evidence-based clinical guidelines. The most important tasks for the College, though, are not simply to help its Research Unit to develop outcome indicators, to produce clinical guidelines and to mount further audits. It is to convince all its members and fellows, in every branch of psychiatry, that improving 'clinical effectiveness' in psychiatry needs to become a basic professional commitment for every one of us. Ultimately, attitudes are at least as important as instruments. Indeed, the attitudes of ordinary clinicians will determine whether or not the instruments are properly used.

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https://doi.org/10.1192/pb.21.7.385 Published online by Cambridge University Press