Quality improvement by quality assessment in General Practice

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aiming to promote general practice
as a discipline by learning and teaching
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INTRODUCTION

The New Leeuwenhorst Group is a European working party whose aim is to promote general practice as a discipline by learning and teaching. The New Group considers itself fortunate to be able to build on the foundations laid by the Original Leeuwenhorst Group. Their definition of the work of a general practitioner and their statements on education and general practice influenced the developments in learning and teaching in general practice which have taken place in Europe in the last decade. This booklet is the second to be produced by the New Group. The first describes the present state of learning and teaching general practice in Europe.*

This publication looks at quality assessment as a way of improving the quality of care provided by general practitioners. The New Group gave quality assessment the highest priority in its consideration of the educational aspects of general practice because members of the Group see quality assessment as being at the centre of all educational activities in general practice.

This document will be supplemented by a further publication which will give examples of the practical methods of quality assessment already taking place in general practice in the different countries of Europe.

Summary
Quality assessment is not an end in itself but a means of improving the quality of health care with the aim of improving the health of the population. It is an essential part of medical education and important not only in continuing education but also in vocational and undergraduate education.

Medical competence has traditionally been tested by means of formal examinations. Such examinations have little relevance to the standard of health care provided by the individual doctor.

Quality assessment begins when a doctor, a group or a health care system no longer assumes that the work is being carried out in the best possible way. In seeking to define what the health care system is attempting to achieve, quality assessment forms the central core of continuing education for general practitioners.

Population needs, concepts of health care, medical knowledge and economic resources are rapidly changing and it is no longer sensible to rely on qualifying diplomas as guarantees that doctors will be competent practitioners throughout their professional careers.
Participation in quality assessment activities as part of continuing education by all health professionals is essential if high standards or care are to be achieved.

Quality assessment is not an activity for health professionals in isolation. Patients should be encouraged to participate in the planning and implementation of health care. The extent of patient involvement in health care systems may be an indicator of the quality of the service.

The statement discusses the characteristics of quality assessment applicable in general practice. Quality assessment does not imply only a numerical approach to the evaluation of care. Standards and criteria of care require to be agreed but are not fixed. Similarly, quality is not an absolute concept but is made up from subjective selections and priorities. Although quality assessment may support and legitimise existing practice, in essence it aims to create change.

In starting to carry out quality assessment in general practice, the most fundamental requirement is positive motivation. Small discussion groups of colleagues are powerful ways of stimulating interest in quality assessment. Increasingly such peer groups are becoming the chosen format for continuing medical education.

The practical steps required to carry out quality assessment are
1) selection of subject for study, 2) examination of existing practice, 3) formulation of desired standards of care, 4) plan of changes required to improve care, 5) re-evaluation to see if changes have been implemented and selection of new subject for study.

Introduction
Quality assessment is an extremely important aspect of general practice. It is not an end in itself but is a means to improving the quality of health care provided with the aim of improving the health of the population. It is an essential part of medical education, and important not only in continuing education but also in vocational and undergraduate education.

What is quality assessment In general practice?
Quality assessment has for too long been understood only in the narrow sense of the formal examination of professional knowledge. The examinations have been derived from hospital based experience and used as regulatory instruments by government and professional bodies. Whilst examinations are crucial to the individual doctor in determining his progress in the profession, they have little relevance to the standard of health care provided by that individual.
Quality assessment in general practice is much broader in its scope and its aims. It forms the central core of continuing education for general practitioners. Quality assessment begins when a doctor, a group or a health care system no longer assumes that the work is being carried out in the best possible way and seeks to define what the health care system is attempting to achieve. Defining specific objectives and criteria of good practice implies collaboration and discussion with colleagues. The comparison of existing practice with the agreed criteria identifies opportunities for improving the quality of care provided. By this process quality assessment seeks to have a positive effect on the physical, social and mental well-being of patients.

Why Is quality assessment necessary?
Population needs, concepts of health care, medical knowledge and techniques, and economic resources are rapidly changing and it is no longer sensible to rely on qualifying diplomas as guarantees that doctors will be competent practitioners throughout their professional careers. All health professionals have an obligation to maintain high standards of care and participation in quality assessment activities is essential if high standards are to be achieved.

At the present time, every European country requires to recognize the limits to the resources available for health services. Medical intervention must not only be of proven value in scientific terms, it should also be efficient. The measurement of efficiency implies the measurement of cost. In the context of health, cost should not be restricted to a financial interpretation. Health, sickness and treatment have personal and community costs in addition to financial ones.

Seen from general practice the present small proportion of total health care funds spent on services outside hospital seems absurdly small. As well as providing information against which an individual doctor can gauge his performance, quality assessment aims to provide information which will enable a more rational distribution of resources between hospital and community than the present ad hoc arrangements.

What are the basic aspects of quality In general practice?
The World Health Organization has formulated policies in its aim to provide health for all by the year 2000 through primary health care. The principles defined in the Alma Ata Declaration are important and provide opportunities for quality assessment: a) health care should be related to the needs of the population; b) consumers should participate, individually and collectively, in the planning and implementation of health care; c) the fullest use must be made of available resources; and d) primary health care is not an isolated approach but is the most local part of a comprehensive health system.

Access to health care if therefore one major aspect of quality. It should be considered in social and psychological ways as well as in terms of geography and organization. A health care system should be acceptable to the population served, not only because this is desirable in itself, but also because it is likely to lead to greater compliance with treatment and so more effective care.

Encouraging patients to participate in the planning and implementation of health care is one aspect of the overall aim of encouraging individuals to take responsibility for their own health. This is of particular importance at a time when health workers are developing their own exclusive professional groups with the consequent risk that patients may feel unqualified in health matters and so avoid taking responsibility for their own health. The extent of patient involvement in health care systems at all levels may be a good indicator of the quality of the service.

In the first part of the paper we wish to clarify the characteristics of quality assessment which are applicable in general practice and primary health care. The second part seeks to highlight ways in which quality assessment in general practice might start, and the third part draws attention to the close link between quality improvement and continuing education.

Characteristics of quality assessment applicable in general practice
(a) Quality assessment does not mean only a numerical approach to the evaluation of care. it is too easy to give priority to aspects of care which are measurable. The creation of fixed criteria of health care can cause attention to be focussed more on the criteria themselves than on the needs of the patient. Probably the most important aspect of improving the quality of care in general practice is that every general practitioner should be committed to assessing his own performance.

(b) In order to assess the quality of care, it is necessary to establish agreed objectives. Such objectives should attempt to reflect the desired standards of care provided. These standards are not fixed. Social and geographical factors, as well as scientific and medical ones, will influence standards, which should also be expected to change with time. Quality assessment itself will generate new standards.

Traditional medicine has generated certain standards and through quality assessment general practitioners have the opportunity to modify and build on these standards.

Quality is not an absolute concept but is made up from subjective selections and priorities. Quality assessment is necessarily a selective activity. It will never be possible to measure all aspects of care. It is likely that there will always be a tension between the aspects of care considered important by the individual general practitioner and those considered important by external agencies.

(d) Although quality assessment may support and legitimize existing practice, in essence it aims to create change. It is thus best carried out by those whose behaviour has to change. When it evokes negative attitudes, it loses what is most important, the positive enthusiasm for improving one's own level of performance.

(e) The outcome of health care might seem to be the only important aspect of quality. Theoretically, it should be like that. Moreover, external organizations, such as governments, are often only interested in the outcome of care and this often only in financial terms. However, it is very difficult to measure health outcomes. When it is possible, it is difficult to identify the aspects of the structure and process of health care which are of relevance in determining the outcome. A study of the outcome of health care may therefore not lead to any change in the provision of services.

Whilst assessments of the processes of health care may be less secure scientifically than outcome assessments, it is much more likely to lead to changes in the way in which care is provided. We have to recognize that in many aspects of health it is possible for us only to evaluate the structure and process of care in the hope that we may be able to improve outcome.

Starting quality assessment in general practice

(a) The most fundamental requirement is motivation, the willingness to ask questions of oneself and to change one's behaviour. Hitherto, general practitioners have tried to learn to change their clinical practice by attending postgraduate lectures and by reading textbooks and journals. Quality assessment can be carried out by individuals and programmes which enable systematic self-evaluation of practice are now available.[3]

Alternatively, small discussion groups of colleagues are an excellent format for continuing education provided that the members of the group feel both safe and enthusiastic. The quality assessments carried out by such peer groups may be more effective than self-evaluation in that the individual doctor is encouraged to compare his performance and attitudes with those of his colleagues. The doctor may become aware of weaknesses in his performance which he did not previously recognize as a problem.

Some national medical organizations have worked out methods which can help such groups; for example, mutual visits to the practices of group members can be used to evaluate the more accessible aspects of quality.[4] Small group learning, as organized in the Dutch 'project group programme' starts by the examination of clinical practice as a key element in continuing medical education.[5] This is a step on the way to full quality assessment.

Until now there has been little experience in mufti-disciplinary quality assessment for the primary health care team and even less experience exists of patient participation in the evaluation process. This is dangerous because concepts of health may become dominated by the views of doctors. If patients do not become involved in quality assessment from the beginning, they will have no influence on the selection of indicators of quality or priorities in the setting of standards. Indeed, quality assessment may become another mechanism for excluding public criticism of medical care.

National associations and colleges can support quality assessment in many different ways. They should plan and implement strategies to increase the motivation of their members for active involvement. National colleges in some countries will soon require, as a condition of membership, an active commitment to some form of quality assessment as an obligation for all general practitioners, not merely an option. Active commitment to performance review by general practitioners is likely to have a more far-reaching effect on the quality of health care than any externally imposed quality control programme.

Government should consider quality assessment at different levels as an essential component of the health care system and should promote and support its implementation by individuals and teams.

The reviews and assessments carried out at the different levels in a health care system should complement each other. Collaboration between general practitioners, specialists and administrators can lead to the co-ordinated action which is necessary for significantly improving the health of a community.

Traditional medical education always influenced the attitudes of students but did not seek to do so in a positive or systematic manner.

Education for quality assessment

The education of a general practitioner should produce a doctor who is doing his lob well and is competent to practice. Competence to practice means the ability to realize a therapeutic strategy: it is based on sound medical knowledge, is feasible and acceptable to the patient, and is adapted to his personal and environmental situation. Medical education needs to use methods and examination procedures which consider clinical performance in addition to knowledge.

Personal motivation in learning is the crucial central point. It is an intrinsic attitude. We must assume that within every doctor there is a desire to improve and so become more effective in improving the health of patients.

If this were not true, quality assessment would be impossible. Attitudes are not immutable, they can be encouraged or discouraged by outside influences. Education is one of them. Basic, as well as vocational, medical education should aim to produce doctors who will wish to assess the quality of care that they are providing. This implies an acceptance that no knowledge remains useful forever, that change is inherent in science and is a continuing process. It also implies a willingness to being observed and to observing colleagues, to giving and receiving feedback. Educational methods which involve active participation can increase motivation to change. Small group learning, with interactive teaching procedures, allows and encourages participation. Positive attitudes to continuing learning can be demonstrated in a stimulating way when teachers themselves evaluate their own educational methods.

It may be easier for a group practice or primary health care team to provide the structure for quality assessment programmes than it is for an isolated general practitioner. However, the key requirement is a positive attitude rather than a good organization.

Collaboration with colleagues in hospital practice is essential in assessing the care of patients with serious chronic problems such as diabetes and hypertension.[5] Although sophisticated information systems may assist in data collection, again the key requirement is a positive attitude. A willingness to talk to colleagues and share information with them will not only enable quality assessment to be carried out, it will also improve future communication between the doctors in the different settings.

Government action can stimulate quality assessment directly to some extent. However, there are limitations:

information about prescribing can easily become control of prescribing; financial rewards for active participation in quality assessment could become rigid bureaucratic systems for encouraging rigid and eventually inappropriate standards of care. In general, governments and, in a broader sense, all health insurance systems, should create the favourable environment needed for primary health care teams to carry out their own quality assessment activities.

Some present characteristics of general practice are disincentives to quality assessment. Inadequate and ill-structured medical records preclude quality assessment. In contrast, good medical records may add information about decision points and the rationale of recommended therapies to the traditional function of records as aide memoires. In this context too, small group learning is important. It can encourage doctors to formulate and record their way of thinking and acting, with every doctor having something valuable to bring to his colleagues. Small discussion groups help to overcome the traditional isolation of general practitioners and may be the means of creating a new scientific tradition in general practice.

ADDENDUM: STEPWISE STRATEGY TO QUALITY ASSESSMENT

First step: choose an area to focus on

It is not possible for a doctor to assess all aspects of his practice. One area has to be chosen. The interest of the. doctor in a certain area will be stimulated in several ways: as part of a general concern in medicine and society, e.g. prescribing of minor tranquilizers, by seeing the possibility of improvement in health care by technological advances in medicine, e.g. measurement of Hb A_1 in patients with diabetes, by having possible subjects for study identified by others, e.g. a specialist colleague aware of deaths in patients with asthma may invite the doctor and other general practitioners to collaborate in assessing the quality of care given to this group of patients.

Making the choice of subject for assessment within a peer group or a primary health care team can be very difficult. Discussion is more likely to be fruitful if it is structured. The group can agree to use the prevalence of serious chronic disorders as a means of establishing a priority list of subjects for assessment. Alternatively the group can present random case histories until a problem is revealed which all group members consider important enough to assess. The precise method employed is not important but having a structure is.

Second step: discover what is actually done now

It seems best to start with facts and reality. Counting populations, morbidity, age-sex distributions, outcome figures and analysing practice activity can be done for the whole practice or for selected groups. Medical records play a vital role. Video consultations or mutual practice visits can be valuable. Organized peer group discussion and structured project work can produce the protocols required for data collection.

Third step: formulate standards of care

The facts established by the collection of data may differ from the preconceived ideas of the doctor. His clinical behaviour may be different from what he imagined it to be. The behaviour of patients may also be shown to differ from what had previously been thought to occur.

Formulating realistic standards of care is a complex process. Standards have to represent what is feasible within the near future. They should attempt to take into account the views of the practitioner and his colleagues, the patient's expectations, as well as information from the literature, from peer groups and from consultant experts. Standards are not static nor universal. The experience of working towards a standard can challenge the validity of it and can generate a new one.

This phase of quality assessment is firmly linked with continuing medical education. The examination of clinical practice must be the key element in continuing medical education, which otherwise becomes an intellectual or scientific game without clear consequence.

Fourth step: plan changes to improve care

The planned changes should be feasible and acceptable to the participants. It is best to define the time within which changes should occur.

Fifth step: start again by the first step

Quality improvement is a continuous process. It can appear as a circle but if it is well done it will be a spiral leading upward to improved quality.

REFERENCES

- Hannu Vuori, 1. Quality Assurance in Europe - Concepts and Methodology. WHO Regional Office for Europe (1982).
- The principles of quality assurance. EURO Reports and Studies 94. WHO Regional Office for Europe (1983).
- Qualitative and Quantitative Evaluation of the Practice of General Medicine. UEMO Interim Report *2(1984).*
- Quality in General Practice. Policy Statement 2. Royal College of General Practitioners, 14 Princes Gate, London (1985).
- The CASE Programme. Centre for Medical Education, The University of Dundee, 2 Rose Angle. Dundee, Scotland, DD1 4LR.
- What Sort of Doctor? Royal College of General Practitioners, 14 Princes Gate, London (1985).
- Gids voor Huisartsen Projectgroepen. The Netherlands College of General Practitioners, Utrecht (1982).
- Grol, R. & Mesker, P.: Huisarts en Toetsing. Nilmeegs Universitair Huisartsen lnstituut, Nilmegen (1984).
- Van der Rydt-Van de Ven AH,l., Tou, An., Groot, J.B.: Onderiinge toesting in de huisartsgeneeskunde. Eindverslag van de experimentele fase. Stichting Q&O, Utrecht (1983).
- Kwaliteitsverbetering in de eerste lijn. Projekt Eersteiijnsgezondheidzorg deel 2, Ministerie Wetenschapsbeleid, Brussel (1978).
- Riou, F.: Concept d'evaluation de la qualite des soins en medecine de primiere ligne en cabinet de medecine de premiere ligne en cabinet de medecine generale. Ministere de la Sante France (1980).
- Armangaud & Bros: Consensus sur la demarche diagnostic et therapeutique des maladies infectieuses en ville. Medecine et Maladies lnfectieuses 10 (1980).
- Matoth, Y. Quality assurance. An Israeli point of view. Quality Review Bulletin 79 (1981).
- Grinblat, J. & De Vries, A. Implementing the Medical Quality Control Program. Israeli Family Physician 176, (1976).
- Rutle, D. & Wiump. Quality Control in General Practice Self Control and Future Development. Tidsskr. Norwegian Laegeforen 292 (1980).
- Borchgrevinck, C.F.: Instruction for small groups in General Practice. Longitudinal studies of groups of G.P. Tidsskr. Norwegian Laegeforen 512 (1984).
- Rokkones, T.: Home visiting and Hospital admission Rates. Tidsskr. Norwegian Laegeforen 371(1985).
- Rokkones, T.: The General Practitioner Service and Hospital admission Rate. Tidsskr. Norwegian Laegeforen 369 (1985).
- Schoelmerich, P.: Zur Bewertung der therapeutischen Effizienz. Die Medizinische Welt 36 (1985).
- Kekki, P.: Assessment of Medical Certificates with a Diagnostic Outcome method. Scand. J. Prim. Health Care 2,175 (1984).