Visitatie of medical specialists: studies on its nature, scope and impact
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Chapter 1

General introduction
This thesis deals with the phenomenon of visitatie. In The Netherlands, visitatie is one of the medical professions’ most recently developed and widely used quality assurance tools. Over the past decade it has acquired a firm and prominent position within Dutch medical quality policy making and the international quality management scene. The use of the Dutch term visitatie in the international literature may demonstrate the acceptance of the model as a serious option in addressing the issue of professional quality assurance.

Visitatie is not merely a technical exercise. As will be explored in this thesis, it has implications for the professionalism of medical doctors, for their concept of quality, for the organization of their practices and for the allocation of health resources. This makes research into the nature, scope and impact of visitatie relevant and necessary.

The visitatie studies aim to judge visitatie on its (scientific) merits in order to prevent new measures having unintended outcomes entering our health care system. Visitatie was brought into existence to, ultimately, improve the quality of patient care. In terms of quality management theories this would require that all four steps of the quality cycle (or: plan, do, check and act cycle), as once defined by W. Deming, would be systematically and periodically addressed. The visitatie model has become particularly powerful as a diagnostic tool, stressing the evaluation component of the quality cycle (step 3: check). The current design of the visitatie model has left the improvement part (step 4: act) to the medical specialists undergoing the review. Improvement is believed to come around when the specialist groups follow up on the recommendations for improvement as suggested by their peer surveyors in the practice-specific visitatie reports. So far, the effectiveness of the visitaties, in terms of the implementation of recommendations, has not been systematically evaluated. The visitatie studies are a first attempt to address visitatie as a professional quality assurance method and the implementation of its resulting recommendations for improvement.

This introduction sketches in broad outline the concept and context of visitatie. Visitatie of medical specialists will be defined (§ 1) and positioned in its national (§ 2) and international (§ 3) context. Section 1.4 presents the visitatie studies and the research questions. This introduction will be closed by delineating the following chapters of this thesis.

1 Defining visitatie

Visitatie of medical specialists, as it will be discussed in this thesis, has been defined as ‘a standards-based, on-site survey conducted by medical peers in order to assess the circumstances under which clinical practice takes place, aimed at improving the quality of patient care’. (1) In common parlance this type of visitatie is also referred to as ‘quality visitatie’ in order to set it apart from the so called ‘teaching visitaties’. As will be discussed in chapter two, the teaching visitaties, in place since 1966, later inspired the development of these quality visitaties. This thesis concerns the quality visitaties, unless stated differently. Crucial to visitatie is its professional ownership. This means that the developers, as well as the managers and the clientele of the program are the medical specialists. Given this
professional ownership it may come as a surprise to some that visitatie does not evaluate the medical aspects of patient care. Nor does it evaluate individual performance of medical specialists. Visitatie is most of all a collegial review building on the insight that quality enhancement is best achieved through teamwork and the improvement of the systems of care. (2-8) Therefore it stresses ‘the circumstances under which clinical practice takes place’. The Dutch term ‘praktijkvoering’ is most commonly used to address these ‘circumstances’. The term however is vague and difficult to define. Various attempts, as described by Van den Hombergh (9), to translate or avoid the term ‘praktijkvoering’ have been unsuccessful. He concludes that ‘the concept is concise and refers to all aspects necessary for providing good (clinical) care, to both management and organization, encompassing structural as well as process aspects’. In this thesis, for practical reasons, the terms ‘practice management’ or ‘practice organization’ will therefore be used as equivalents to the Dutch term ‘praktijkvoering’.

Hospital based specialist groups or, when self-employed, ‘partnerships’ are the focus of visitatie. (10) This is where visitatie differs from models such as accreditation or certification that focus on an organizational entity, i.e. a unit or department, and mostly extend their scope to include the whole organization. Furthermore, these models of external assessment are by definition based on a pass-or-fail judgement of the site under evaluation, meaning that an organization complies with the preset standards, and is therefore granted a certificate of achievement, or it does not. (11) Consequently, these evaluation processes must be independent (certification) or impartial (accreditation). The visitatie model has no room for a pass-or-fail approach. Its goal is education and prevention of adverse outcomes. Therefore, all surveys result in recommendations for improvement. The visitatie of health care institutions can be considered a compromise between the focus on a whole organization, the educational purpose of an assessment and the ownership of the model in the collective hands of the institutional members. This thesis does not involve the programs for visitatie of institutions.

Visitatie can be portrayed as a model for external peer assessment, since peers from outside the surveyed practice (hospital) conduct the review. Appreciating its collegial character and the systems approach to quality, the model has also been applied within the context of organizations. Several general as well as academic hospitals have adopted this modification of the visitatie model, the so called internal visitaties. (12,13) In the Academic Medical Center in Amsterdam the internal visitatie program is currently under evaluation. (14) Other modifications of the original visitatie model have occurred; shifting the scope of the evaluation. Examples are the visitatie of particular care processes, such as the quality of oncological care or renal dialysis.

2 Visitatie in the national context

2.1 Visitatie and professional quality management

At first glance, the attention paid to visitatie, together with the investments, financially and otherwise, put in its development, implementation and evaluation, may come as a surprise to some. After all, quality assurance has always been one of the core responsibilities of medical doctors and one of the primary tasks of their professional bodies. In the process of
forming and formalising the medical profession, as we know it today, many developments were explicitly initiated to assure and improve the quality of patient care. In The Netherlands, obtaining control of postgraduate medical training, introducing a system of registration of medical specialists (1930), providing a peer review system for teaching practices (1966), establishing medical audit in hospitals (1970/80) and developing national clinical guidelines (1980/90), can be considered quality assurance landmarks in the history of the medical profession. (15) Oftentimes, these activities were linked to the foundation of organizations enabling or supporting them, such as the Organization for Medical Registration (1963) and the Dutch Institute for Health care Improvement CBO (1979). (16,17) What these accomplishments share, and what sets them apart from later initiatives such as visitatie, is their underlying notion of professional quality. Traditionally, medical doctors have thought of quality merely in terms of the technical care of an individual patient. (18) However, the emergence of quality management as an academic discipline provoked the redefinition of professional quality assurance to also include the organizational and interpersonal dimensions of patient care. (19) Since the late eighties, this change of paradigm is reflected in the organization and focus of Dutch health care quality assurance. Visitatie makes a good example of this shift in focus, focussing on all aspects that promote the delivery of quality patient care.

Others have explored and described in detail the interesting history and development of quality management of Dutch medical specialists. (10,15,16,20-22) Their work will not be repeated in this thesis. Some of the major movements, however, will be addressed in chapter two. Clearly, many quality assurance mechanisms have been developed by the medical profession. The challenge now is to create synergy between all the profession owned activities. Initiatives to create these links have already been established.

Visitatie experiences in The Netherlands are not limited to medical specialists. Over the past decade most health care professions introduced a visitatie program as part of a broader quality management policy, which mostly also includes elements such as guideline development and continuing professional education. The initiatives to introduce peer review in general practice probably have the longest history, the first attempts dating back to the sixties. The current visitatie model, which is very similar to the one used by the medical specialists, is the result of ongoing improvements and multiple (re)designs ever since. The visitatie model of the general practitioners has been systematically developed, implemented and evaluated. (9,23) Closely related to the development of visitatie within the medical profession, the professions of orthodontists (24,25), maxillofacial surgeons, parodontologists (26) and general dentists (27) introduced their visitatie programs. (28) Although still very comparable to the original visitatie model introduced by the medical specialists, interesting alterations have been made, such as adding an on-site assessment of a patient treatment in case of the visitatie program of the parodontologists.

Several other professions joined together in starting a visitatie program. Collaboration was sought in order to find collective funding and professional support for the development, implementation and evaluation of the efforts. To improve the quality of paramedical care, for example, eight professional associations (i.e. physical therapists, occupational therapists, podologists, dieticians, and dental hygienists) managed to have their visitatie
undertakings funded by the College for Care Insurance (CVZ) and evaluated by an independent research institute. The visitatie program was well received by the professional associations, who are now incorporating the instrument into their professional quality policy. A similar strategy was chosen by a large group of alternative health care professions. The Ministry of Health financed the visitatie project and the Dutch Institute for Health care Improvement CBO supported its development and implementation by sharing knowledge and expertise. Positive results have been reported. In general, all professions seem to acknowledge and appreciate visitatie as a professional tool for assuring and improving quality.

2.2 Visitatie and organizational quality management

The context of the Dutch health care system has made it possible for both medical specialists and hospital management to develop their own, separate quality management activities. The so called ‘Leidschendam quality conferences’, firstly held in 1989, fuelled this separate development. Health care stakeholders met in Leidschendam to agree upon a national quality policy. Consensus was reached on the responsibilities for the delivery of quality patient care. As was later ratified by the Care Institutions Quality Act (1996), the responsibility for the quality of care provided by the hospital lies with (top) management, but medical specialists remain responsible for the delivery of quality care to individual patients. Ever since the enactment of the Quality Act, there has been an upheaval of quality initiatives both in hospitals and within the professions. On the institutional level the implementation of quality management systems is high on the priority list. A quality system is defined as the ‘organizational structure, responsibilities, procedures, processes and resources needed to assure and improve the quality of care’. For hospitals its implementation is relatively new and must be considered a complex innovation. It encompasses both managerial and professional activities, but, as Wagner showed, quality assurance activities have been developed mainly by professionals. However, organizations with an integrated approach to quality more often report positive effects of the quality assurance activities than organizations with a more one-sided approach (emphasizing either profession oriented or management oriented activities). Creating synergy between profession based and hospital based quality approaches should therefore be encouraged. This requires overcoming the classic barrier of the professional - manager dichotomy. Today, the emergence of a hospital wide quality management policy, linking the professional and managerial approaches, can be observed in most Dutch hospitals. Collaboration between medical specialists (and other health professionals) and hospital management has resulted in demonstrated quality enhancements.

The visitaties have played and still play a role in bringing together professional and managerial quality activities. The focus on practice management evidently includes the evaluation of aspects of the hospital organization. Also, in the assessment process parties other than the medical specialists under survey are being invited to participate. Many specialist groups have reported to share the visitatie results voluntarily with hospital management. In addition, new contracts between hospitals and their practising medical specialists require that selected visitatie results are shared. On the national
level, the integration of the speciality based visitaties and the hospital based accreditation system, is being propagated. (39)

3 Visitatie in the international context

Visitatie of medical specialist is not a model that is widespread outside The Netherlands. Although in the literature some visitatie initiatives are reported, no other country knows a visitatie model that is as extensive (covering all medical specialties) and as well embedded in national health care policy making as the Dutch visitatie program. One exception is the UK, where the General Medical Council launched peer review of practices very similar to the Dutch visitatie program. However, the program is conducted in the context of revalidation of medical doctors; these reviews aim to assess performance of doctors who may be seriously deficient. Early experience of the peer visits has confirmed their feasibility and effectiveness. (40)

Other British visitatie-based systems are the visitatie program for renal departments, recently launched by the Royal College of Physicians of London, and the visitatie program run by the British Thoracic Society, in place since 1992. Both programs are associated with educational approaches. They seem successful and wider use has been encouraged by the participants. [41,42] In Europe, visitatie-based systems have been adopted in Sweden and Finland where programs are in various stages of development. (43) Very little has been published about the European systems.

In the United States only two national specialty societies offer visitatie-like programs. (44) The American College of Obstetricians and Gynecologists (ACOG) started its voluntary and confidential program in 1986. Since its inception until November 2002 nearly 200 visitaties have been conducted, representing approximately 6% of hospitals providing obstetric inpatient care. ACOG’s predecessor is the American Society of Anesthesiologists who established its program in 1982.

In Australia and New Zealand quality assurance is a component of most of the programs managed by the medical specialty colleges. It is not clear though if visitatie-like activities are included. (45) The Royal Australasian College of Physicians offers members a 5 yearly quality review that seems comparable to the Dutch visitaties. (46)

Despite the somewhat ‘isolated’ use of visitatie, the model has been mentioned internationally in the context of two pivotal debates. Firstly, visitatie has been mentioned in the ongoing discussion on ‘revalidation’ or ‘recertification’ of medical doctors: how can medical doctors maintain their performance throughout their working lives and demonstrate their competence convincingly to their patients? Throughout the western world, thinking about competence of medical doctors has shifted. Doctors now need skills that extend beyond updating their medical knowledge in order to practise effectively in modern health care. Such skills include communication, team building, management, collegiality and the ability to improve. (47) This shift in thinking calls for new assessment methods, which are indeed being presented. Multisource feedback (48) and appraisal and assessment (49) are two examples. It is in this context that visitatie has been mentioned. (36,50,51) Visitatie could contribute to a medical doctor’s demonstration of whether he or she is achieving acceptable standards of practice. In the UK, external peer review is considered an essential stimulus to effective performance. (52)
Secondly, visitatie has become part of the discussion on external peer review models used for the evaluation of (European) health services. Visitatie has been classified as one of the four principal models for external review. Thanks to funding by the European Union, the design and use of these models, ranging from doctors-driven visitatie, through accreditation and European Quality Awards (EFQM) to industrial certification using ISO standards, have been explored and compared. The responsibility for quality improvement as taken on by professionals is what the visitatie model is noticeably commended for. The results of this study on external peer review techniques (ExPeRT) describe that the four models have begun to converge. The study participants generally plea for the emergence of one common (European) model for evaluation of the health services. In building such an integrated model, the challenge is to embrace the strengths of each of the models. Future discussions on this topic will benefit from input from the visitatie experiences.

4 Research questions and outline of the thesis

The success of visitatie has multiple causes and significant consequences. This thesis examines both. It explores the phenomenon of visitatie from different perspectives and using diverse research methods. This thesis addresses the following four main research questions.

1. How can the rise and spread of visitatie for medical specialists in The Netherlands be explained?
2. How can visitatie be positioned in its legal context?
3. How can the visitatie results contribute to the improvement of practice management?
4. Does the implementation intervention ‘Quality Consultation’ increase the implementation of visitatie recommendations?

The above questions will be answered consecutively. In short, chapters two till four take down the nature and scope of visitatie, positioning visitatie in a political (chapter 2) and legal (chapter 3) context and exploring its role and (potential) value as a quality management tool (chapter 4). This part of the thesis gives an outline of the development and current status and power of visitatie as a professional quality assurance tool. The following specific research questions will be addressed in the chapters mentioned:

i How did the general health care policy context in The Netherlands contribute to the onset of visitatie within the medical profession? (chapter 2)

ii How did the context of quality policy in The Netherlands contribute to the rise and spread of visitatie of non-teaching departments at the end of the twentieth century? (chapter 2)

iii Which were the internal developments within the medical profession that contributed to the adoption of the visitatie model and how does the nature of the visitatie model, in terms of method and scope, fit in the ongoing process of professionalization? (chapter 2)

- How does visitatie fit in the evolution of quality assurance of medical specialists?
- How was the development of visitatie politically embedded in the medical quality policy?
- How did the tension between the specialty societies and their corporate organization effect the development of visitatie?
• Which other facilitating factors contributed to the anchoring of visitatie in Dutch medical specialistic health care?
iv What legal consequences can be ascribed to the design of visitatie as a peer review system? (chapter 3)
• What are the (potential) external effects of the functioning of an internal (self-regulatory) system?
• What role does the health care setting in which the visited peers operate legally play?
v. How does practice variation knowledge contribute to the improvement of obstetrical/gynaecological care delivery? (chapter 4)

The chapters five till seven deal with the impact of visitatie and can best be summarized as the evaluation of an implementation study in clinical practice. Previous research has shown that implementation of change in clinical practice is complex. (56) This is no different for the implementation of visitatie recommendations, given the range of variables that impinge upon the implementation process. Although some positive implementation results had been reported in the (grey) literature (37, 57) and most surveyors involved in the visitatie programs expressed to have witnessed the positive effects of the visitaties, many remained convinced that actual improvement could be and should be encouraged. This conviction turned out to be the start of a joint quality improvement and research effort: under the auspices of the Dutch specialty societies of surgeons (Nederlandse Vereniging voor Heelkunde), gynaecologists (Nederlandse Vereniging voor Obstetrie en Gynaecologie) and pediatricians (Nederlandse Vereniging voor Kindergeneeskunde) the preparations of the so-called Quality Consultation (QC) project started in 1998. The goal of the QC project was, in a nutshell, to increase the impact of the visitaties by supporting medical specialists with the implementation of visitatie recommendations. (58) The support was offered by two management consultants and financed by the Dutch Ministry of Health. In addressing the following specific research questions this study evaluates the impact of visitatie, in terms of the implementation of practice-specific recommendations for improvement:
i What is the nature of the recommendations for improvement resulting from a visitatie? (chapter 5)
ii How is visitatie perceived by the medical specialists undergoing the peer review? (chapter 5, 6 and 7)
iii How are the recommendations for improvement perceived by the medical specialists with respect to barriers for implementation? (chapter 5)
iv How was the intervention introduced and received by the specialist groups? (chapter 6)
v Which recommendations were selected for calling in professional support and why? (chapter 6)
vi What types of interventions were offered to support implementation of the chosen recommendations? (chapter 6)
vii How were these interventions looked upon by the participants? (chapter 6)
viii What is the effect of Quality Consultation in terms of the implementation of visitatie recommendations? (chapter 7)
ix Which factors are obstructing the implementation of visitatie recommendations? (chapter 7)

The following chapters of this thesis will now be introduced briefly.
The emergence of visitatie: a policy analysis
Chapter two explores the rise and spread of visitatie within the medical profession, offering an insight into the dynamics of professional self-regulation and health care policy making. The leading question in this chapter is why the specialty society of surgeons, later followed by the 26 other specialty societies, started to systematically peer review all of the approximately 100 surgical non-teaching practices by means of visitatie. The answer to this question was found in the political-sociological literature on professions. It is described how visitatie was used by the medical profession as a strategy to protect its autonomy and defend its domain. This independence is crucial since it is believed to give the profession the authority to take all actions necessary to fulfill the responsibilities for carrying out their professional work. This responsibility includes monitoring and improving the quality of the medical work, which is critical to the practice of medicine.

Visitatie in a legal perspective
Chapter three continues the exploration of visitatie by looking into the legal consequences of running a professionally owned peer review program. Not surprisingly, visitatie originated, and still operates, within the frame and context of self-regulation. By growing to its full stature, however, the societal interests in the visitatie programs of the specialty societies increased, and so legal issues arose. This chapter explores the relative power of self-regulation by dealing with the legal issues of the design of a peer review system, the external effects of the functioning of a self-regulatory system and the role of the health care setting in which the visited peers operate.

Using visitatie to improve the quality of obstetrical and gynecological practices
Although it is undisputed that quality assurance has always been an intrinsic part of delivering good medical care, the use of traditional quality assurance approaches alone seems no longer sufficient. New approaches, based on new types of knowledge, need to be embraced in order to encourage actual breakthroughs in the enhancement of quality. Batalden and Stolz (59) hereto introduced the concept of improvement knowledge. They argue that the use of improvement knowledge, in addition to medical knowledge, is necessary to realize more improvements of a different kind and at a faster pace than before. Chapter four is an illustration of how improvement knowledge, in this case exemplified by the results of the visitatie program of the Dutch Society of Obstetrics and Gynaecology (NVOG), may contribute to the improvement of the quality of obstetrical and gynaecological care. Through the comparison of data, the visitatie program has cast light on the existing variation between ob/gyn practices. Although some variation is expected in virtually all aspects of medicine, the extent of variation reflects, in part, how medical doctors practise medicine and make decisions. Knowledge of variation is helpful in flagging potential quality issues.

How doctors perceive visitatie and its resulting recommendations for improvement
Chapter five begins by describing the results of the visitaties: the practice-specific recommendations for improvement. This chapter gives an overview of the number and nature of these recommendations. Recommendations are classified and presented in a scheme that was hereto developed based on the analysis of 50 visitatie reports. In addition
the attitude of medical specialists towards the recommendations for improvement as well as towards visitatie as a professional quality assurance instrument were measured. Both are believed to be relevant from an implementation point of view, because perception has previously been found to influence actual implementation.

**Supporting implementation of visitatie recommendations: a qualitative evaluation**

Chapter six is a descriptive evaluation of the Quality Consultation project, in which 25 specialist groups of surgeons, gynaecologists and pediatricians were supported in their implementation efforts by a management consultant. Quality Consultation was developed as a multifaceted and site-specific intervention. For the effectiveness of both design features the literature offers convincing evidence. Numerous (systematic) reviews show that combined, rather than single, interventions are more likely to result in significant change. Emerging literature emphasizes the importance of taking unique, contextual factors into account when promoting change. This chapter reports in detail how QC was designed and executed to fit the implementation needs of each of the participants.

**The success of QC and the impact of visitatie**

In the seventh chapter of this thesis the effects of QC on the implementation of visitatie recommendations have been quantified. The implementation results of the 25 supported specialist groups were compared to the implementation results of an equal number of specialist groups who did not receive this support. The implementation results were specified into the degree of implementation of the recommendations and the specialist groups' assessment of the implementation results as well as the process. Chapter 7 also focusses on the experienced obstructing factors in implementing recommendations.

**General discussion**

Like any thesis, this thesis concludes with a general discussion. A reflection will be given on the main findings of the studies and potential implications for the further and future development and evaluation of visitatie as a professional quality assurance tool will be formulated.
REFERENCES


44. Gluck PA, Scarrow PK. Peer Review in Obstetrics and Gynecology by a National Medical Specialty Society. Jt Com J Qual Saf 2003;29;2;77-84.


50. Bourdillon P. Dutch system of peer review is different and effective. BMJ 1999;318;1143.


