Visitatie of medical specialists: studies on its nature, scope and impact
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The introduction and dissemination of visitatie amongst medical specialists in The Netherlands in the period 1985-2000

M.J.M.H. (Kiki) Lombarts
N.S. (Niek) Klazinga

ABSTRACT

By examining the introduction and dissemination of external peer review through site-visits (visitatie) amongst Dutch medical specialists, this paper sets out to deepen our insight into the dynamics of professional self-regulation and health care policy making. We explore how visitatie has been used in the political process between medical specialists and the state, serving as a strategy in protecting the autonomy of physicians. In the late eighties and early nineties, factors both internal as well as external to the medical profession all together determined the start and spread of visitatie. The conflict between state and doctors over the specialists' income, the introduction of the market oriented policies, new visions on quality assurance, the debate on the future of medical specialistic care and a new legal framework on quality assurance, challenged the medical community to find ways to reconfirm the public's trust in the self-regulating mechanism of the profession. One answer is found in carrying out 300 to 400 visitaties yearly. During the past years, many stakeholders have perceived visitatie as a credible instrument in assuring quality patient care. The dynamics of professionalization and measurable impact of visitatie will determine whether or not it is here to stay.

1 Introduction

In 1989 the first external peer review site-visit (visitatie) of a non-teaching surgical practice took place: on behalf of the Dutch specialty society of surgeons a committee of 3 surgeons surveyed the first of the almost 100 surgical non-teaching practices in Holland. (1) Currently, all of the 27 medical specialty societies (see figure 1) in The Netherlands have a program operational for external peer review through site-visits, submitting their specialist members working in non-teaching settings to a quality survey every 3 to 5 years. On a yearly basis, an estimated 300 to 400 visitaties are now carried out nationwide. Such a rapid introduction and dissemination of a quality assurance mechanism does not know its equal in the history of Dutch medical quality assurance. Other quality assuring mechanisms typically used by doctors, such as medical audit1, took notably longer to get firmly established. Although the introduction of medical audit was well embedded in health care policy making, it is even legally anchored, the involvement of doctors has always been problematic. Therefore its spread has been slow and often ineffective. (2) The introduction of such professional activities seems always related to self-regulation on the one hand and accountability on the other.

This article sets out to deepen our insight into self-regulation and policy making by examining the (relatively rapid) rise and spread of visitatie within the medical profession. We describe and analyze the phenomenon focusing on the following three questions:

• How did the general health care policy context in The Netherlands contribute to the onset of visitatie within the medical professions?
• 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?
• 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?

1 The Dutch word is intercollegiale toetsing which can be translated as medical audit or peer review.
Table 1. Overview of the number of registered medical specialists per specialty.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Number of specialists registered by the Medical Specialist Registration Committee (31-12-1999)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiology</td>
<td>1089</td>
</tr>
<tr>
<td>Cardiology</td>
<td>662</td>
</tr>
<tr>
<td>Dermatology</td>
<td>396</td>
</tr>
<tr>
<td>Gastro-enterology</td>
<td>145</td>
</tr>
<tr>
<td>Surgery</td>
<td>1023</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>1707</td>
</tr>
<tr>
<td>Ear, Nose and Throat surgery</td>
<td>453</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>996</td>
</tr>
<tr>
<td>Clinical genetics</td>
<td>66</td>
</tr>
<tr>
<td>Pulmonology</td>
<td>388</td>
</tr>
<tr>
<td>Clinical neurophysiology</td>
<td>457</td>
</tr>
<tr>
<td>Microbiology</td>
<td>214</td>
</tr>
<tr>
<td>Neurology</td>
<td>651</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>109</td>
</tr>
<tr>
<td>Nuclear medicine</td>
<td>85</td>
</tr>
<tr>
<td>Obstetrics/gynaecology</td>
<td>817</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>627</td>
</tr>
<tr>
<td>Orthopaedic surgery</td>
<td>466</td>
</tr>
<tr>
<td>Pathology</td>
<td>335</td>
</tr>
<tr>
<td>Plastic and Reconstructive surgery</td>
<td>176</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>2072</td>
</tr>
<tr>
<td>Radiology</td>
<td>883</td>
</tr>
<tr>
<td>Radiotherapy</td>
<td>172</td>
</tr>
<tr>
<td>Reumatology</td>
<td>163</td>
</tr>
<tr>
<td>Rehabilitation medicine</td>
<td>297</td>
</tr>
<tr>
<td>Thoracal surgery</td>
<td>106</td>
</tr>
<tr>
<td>Urology</td>
<td>315</td>
</tr>
</tbody>
</table>

These three questions are answered respectively in this paper. In addressing the first two questions we will not discuss the Dutch political context in detail. We will refer to others who analyzed and described the Dutch situation, in this journal and elsewhere, and limit ourselves to the policy occurrences relevant to the analysis of the phenomenon under study. Most attention is therefore paid to the third question, the analysis of the internal developments within the medical profession. We focus on the following questions:

- 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?

\(^2\) At present the Dutch health care system counts 27 acknowledged specialty societies, each linked to one specific specialty. In Dutch they are called medisch wetenschappelijke verenigingen which literally translates as medical scientific associations.
How did the tension between the specialty societies and their corporate organisation effect the development of visitatie?

Which other facilitating factors contributed to the anchoring of visitatie in Dutch medical specialistic health care?

We end this paper with conclusions and discussion.

2 Methods

The answers to the research questions listed above are based on the literature on health care policy and quality policy, on document analysis, on interviews with stakeholders and on observations made by the authors as privileged observers.

In this paper visitatie is studied from the perspective of professionalization of medical specialists. The theoretical basis of our analysis is found in the political-sociological literature on professions. In studying the concept of professions, the sociologist Freidson concludes that it is impossible to define a profession in general, absolute terms. In his view, what a profession is, is defined by various groups in society at a certain time and in a certain historic context. Despite this contextual and dynamic approach of the concept of professions, by Freidson referred to as the ‘folkloristic approach’, the essential elements of professionalism are left unaffected, as well as the dynamics which are inherent to professionalization: maintaining autonomy, high prestige and public trust. (3-6) Fundamental to the medical profession is its primacy of medical knowledge expressed through its members’ claim to the responsibility for their professional work, and thus, for the quality of that work. This responsibility implies that the medical profession, whose status as a profession has been undisputed, needs to monitor and, if necessary, improve quality. Accountability takes it one step further and asks responsible professionals to also explain or answer for their actions. (7) The ultimate consequence is that the medical profession, being accountable for the quality of care they deliver, needs to develop mechanisms that will in the eyes of the ‘interested parties’ justify the way medicine is practiced. It is only by the grace of these interested parties that the medical profession can or can not keep control over her own work, ergo, set her own standards, train her own people and determine who can join the profession. Losing a party’s favor implies that others will take over one or all of these assets. Who the interested parties are and what they require from professionals in order to reconfirm their given support and confidence in the self-regulating mechanism of the profession, might change over time. In many countries, the increasing demands to make the results of medical interventions transparent to the greater public has triggered the medical community to try to influence the conditions for quality assurance. Both the Swedish and British endeavors make an example of the success with which doctors succeeded in retaining a large degree of autonomy in the initiative and design of medical quality assurance. In describing the Swedish and British case histories respectively, Garpenby and

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As a staff member of the Dutch Quality Institute in Health Care CBO (1992-1997), MJMH Lombarts was involved in the development and implementation of visitatie programs for non-teaching practices. She worked with many specialty societies and conducted over 100 visitaties as a professional assistant to the survey teams.

NS Klazinga was as a staffmember of CBO (1985-1999) and as boardmember of the Royal Dutch Medical Association (1989-1994) involved in the policies related to visitatie.
Dent show the mutually ambivalent relationship between the medical profession and the state. (8, 9) They illustrate that the institutional power and status enjoyed by doctors is largely the consequence of the (constitutional) commitment of governments to the provision of quality care to the general public, and that at the same time, these governments are dependent on the medical community to ensure such a delivery of care.

This is not to be taken as if medical professionalism can be reduced to a technical ‘deal’ negotiated with society. There is a need for professionalism since professional self-regulation also serves social functions, although medical professionals can and do misuse their power. (10) In this paper the technical argument is emphasized since in medical matters neither health care consumers nor government regulators are capable of assessing every health care product or service.

Thus, it is against the background of the relationship between the state and the medical professions that visitatie will be explored in this paper, since quality assurance is one of the strategies of the medical profession to protect its autonomy and defend its domain. This independence is crucial since it is believed to give individual doctors clinical freedom and the profession collectively the authority to decide about standards of professional practice and education, the organization of medical work and discipline. (11) Before starting the analysis of the Dutch situation, we will shortly outline the Dutch health care system and the visitatie model.

2.1 The context of the Dutch health care system

The Dutch health care system is based on a public and private insurance scheme that offers wide coverage of all health care costs. Only 10% of all health care costs are financed directly by the government out of tax money. Hospital care and care delivered by medical specialists make up for 27.5% respectively 3.7% of the total health care bill (1994). (12) Most hospitals are private, not-for-profit institutions. The Dutch system is defined by highly organized health providers, institutions as well as professionals, patient organizations, and many consultative structures on health policy, organization, planning and finance. (13) The practice of (the 14,779) medical specialists is usually limited to one hospital exclusively and the access to their services is ‘controlled’ by (7345) general practitioners who serve as ‘gate keepers’ (1997). (14) The majority (approximately 70%) of the medical specialists are independent entrepreneurs, per specialty organized in ‘partnerships’, who are paid through a fee-for-service system. (15) On the hospital level, specialists are organized in a medical staff through which they participate in hospital management.

2.2 Introducing visitatie

A visitatie program (the Dutch word ‘visitatie’ means ‘visit’) consists of systematic site-visits conducted by peers and is aimed at improving the quality of patient care. It is a doctor-led and -owned quality assurance activity, meaning that physicians set the standards, conduct the surveys, formulate the recommendations for improvement and decide upon sanctions or corrective actions. (16) The collegial surveys, usually lasting one day, take place under the
auspices of the specialty societies. The functioning of a group of specialists in a partnership is taken as the starting point of the survey. (17) The performance of individual physicians is not the primary focus of the evaluation. Instead, the collegial surveyors focus on the circumstances under which clinical practice takes place, such as medical record keeping, process management, the use of guidelines, intra- and interdisciplinary collaboration and evaluation of patient satisfaction and treatment outcomes. (18, 19) This systems approach to improving quality of care is believed to be more effective than the person approach. (20, 21) Every survey results in recommendations for improvement, based on explicit quality standards and the surveyors' experience. The survey findings are confidential and are provided only to the specialists being surveyed. Implementation of the recommendations is also left to them.

3 Health care policy in The Netherlands; self-regulation under cost constraints

The first research question focuses on the contribution of the general health care policy context in The Netherlands to the onset of visitatie within the medical profession. In general terms it is important to note that Dutch policy making is characterized by a massive neo-corporatist bureaucracy and an emphasis on consensus building. Bringing together all the parties in the decision making process has internationally become known under the Dutch term as the 'polder model'. (22)

With regards to government involvement in health care, the Dutch system can be positioned, on an international scale, somewhere between countries with a national health care system, such as the United Kingdom, and countries where the market approach in organizing and financing health care is dominant, as is the case in the USA. Compared to the USA, the Dutch health care system can be characterized as highly regulated, but Dutch government has considerably less power and influence than its British counterpart. (23) Whatever its relative position nowadays, clearly the role of Dutch government has changed over the past 25 years.

From 1974 to 1987 the answer to the growing health care costs was sought, and only partly found, in detailed planning and regulation. In this period numerous attempts to call a halt to the increasing health care costs were undertaken. At first, actions were directed at reducing the number of hospital beds, planning facilities, setting hospital rates, introducing basic health insurance and a system of hospital budgeting. The central role of government in these days did not leave the medical profession unaffected and self-regulation was put on the stand by society. Not coincidentally, medical audit among medical specialists, in the context of medical staffs, was launched and formalized in this period. (2)

3.1 Visitatie is put on the agenda of the specialty societies

When government's central interventions turned out not to be sufficient in reducing health care expenditures, the government directed her policy plans to control volume and specialists income. (24, 25) The interference with the income of specialists caused a series of serious conflicts between the government and the medical specialists. These conflicts did
not just disappear. Ultimately, the government was willing to change her plans under the condition that the health care parties (the organizations of medical specialists, hospitals and insurance companies) would come up with acceptable measures for reducing the costs and improving the efficiency and quality of medical care. In 1989 this resulted in the so-called Five Parties Agreement.

Although the medical profession managed (again) to avert drastic interventions from the central government, the question of (economic) autonomy and accountability was asked and needed to be answered. In this political climate, visitatie of non-teaching practices was put on the agenda of medical specialists as a means to assure public trust and maintain autonomy. Early 1986, the society of surgeons announced the installation of a Committee which was to explore possibilities for visitatie of non-teaching surgical departments. In the societies’ Newsletter of August 1987, the start of the collegial peer review program was announced by arguing that ‘quality assurance should at any costs remain in the hands of the profession to prevent administrative interference, who lack insight in these matters’. The willingness to participate in the visitatie program was high amongst the colleagues in non-teaching practices. (26) The initiative is followed shortly (February 1987) by the society of anesthesiologists, whose Board emphasizes the potential great value of visitatie ‘...also in contacts with the Inspectorate of Health’. (27) Also for some other specialty societies visitatie becomes a discussion topic in the late eighties.

The withdrawal of the central government in seeking a solution for the conflictuous relation with the specialists, leaving the problem solving to the executing parties in the health care sector, was indicative for the new political wind that was blowing by that time. This new period in health care policy was ushered in by the publication of the report of the Dekker committee in 1987, named after its chairman and former captain of industry dr. W. Dekker. After a phase of centralization, regulation and detailed planning, the government was in need of new ideas on how to control volume, restructure the health insurance schemes and deregulate. (28) Dekker’s report Willingness to Change proposed some major reforms pleading for deregulation, introducing the market approach in health care and emphasizing self-regulation by health care providers and purchasers. Dekker’s plans were ratified by the ruling government as laid down in the policy document Change assured (1988). Later policy proposals also confirmed the chosen course by building onto the committees’ work, such as the 1990 report on the introduction of a basic health insurance (by secretary of state for health Simons) and the 1991 report Critical choices in health care (also known as the Dunning report) on the extent of its coverage. Despite the warm reception of Dekker’s reforms, they were never fully implemented. However, they did bring some deregulation and decentralization and fed the discussion on a more market based health care. Dekker redefined the health care sector in industrial terminology, speaking of an ‘industry’ in which doctors and patients are referred to as ‘providers’ and ‘consumers’ of health care services. (29) More substantially, the roles and responsibilities of the stakeholders in the health care arena have been re-arranged since 1987. By abolishing a number of detailed legal regulations (23) the government put herself on a distance in favor of the providers and financiers of health care, who are now to negotiate on costs, volume and quality of patient care.
4 Quality policy in Dutch health care; a shift in accountability

In analyzing visitatie, we now refer to the question of how the context of quality policy contributed to the rise and spread of visitatie of non-teaching practices. Here too, the Dekker report marks the start of a new era in Dutch quality policy. In line with the centralization and regulation philosophy of the seventies and early eighties, legal regulations were for a long time considered the main instrument in assuring the quality of patient care. (30) Dekker broke through this world of thought by outlining a health care system in which the quality of patient care is a result of the collaboration and negotiations of the key partners in the health care field. Thus, bringing the quality of care within the sphere of self-regulation. This shift in roles and responsibilities was discussed among the representatives of 40 relevant parties during two national conferences in 1989 and 1990. As a result the organizations of health care providers (institutions as well as professionals) financiers and patients/consumers reached agreement on a coherent, joint policy on the quality of care. (31)

4.1 The rise of visitatie

Ever since these so-called ‘Leidschendam conferences’ the notion of quality assurance caught fire quickly. ‘Quality’ was put high on the agenda of professionals, health care institutions, consumer organizations and insurance companies. Although the insurers were made accountable for contracting quality care, the setting of quality standards was left to the health care providers on the condition that they would be open to evaluation of the implementation of the standards. This is when external models for quality assurance were brought into the discussions on establishing a trustworthy health care system. For health care institutions quality assurance through certification or accreditation seemed to be the obvious means. Nowadays, their existence in the Dutch health care system is undisputable. Health care professionals were to develop their own quality assurance mechanisms in contributing to a transparent health system. For the medical profession this development took for a great part place within the framework of the specialty societies. (32) The expansion of external peer review through visitatie of non-teaching practices, was one of the ways in which professionals expressed their responsibility for the quality of patient care. In the late eighties and early nineties approximately 20 of the 29 professional societies started surveying their members working in non-teaching practices, i.e. the societies of orthopaedic surgeons (1989), internists (1991), ear-nose- and throat specialists (1991), neurologists (1991), gynaecologists (1992), pediatricians (1992), urologists (1992) and dermatologists (1993). (18) In the execution of the visitaties the government financially supported the specialty societies. (33)

The government has been supportive of all the initiatives taken by the field parties and developed a new policy on the quality of care which reinforced the position of the different actors. In her 1991 policy document Quality of Care it is stated that ‘the quality of care can be better promoted by strengthening opportunities for self-regulation than by means of direct control by central government’. (34) The following years the government acts upon
this pronouncement by introducing a new, general legislative framework which created room for self-regulation and, at the same time, gave expression to the government's constitutional responsibility for the quality of provided care. In only a few years time, five new laws on the quality of professionals (1994, 1995), on patient rights (1995, 1996) and on the quality of health care institutions (1996) were completed. For the development of visitatie the Individual Health Care Professions Act (Wet BIG) has been most important. This law provides legal protection of registered specialist titles and mentions the need for a system of re-registration to be set up by the medical profession.

Clearly, in the early nineties the modernization of the health care system has also found its translation in new visions on maintaining the quality of patient care. The energy with which these were propagated and implemented elicited a referral to the post-Dekker decade as the ‘golden era in Dutch quality assurance’. (35) It should be noted here, that the changing views of quality assurance in health care can not be totally ascribed to the new administrative approach to organizing the health system. Other developments contributed equally in assigning quality assurance a prominent place in the health system’s debate, such as changes in science and technology, the increasing bureaucracy in and complexity of organizations, sub specialization, several incidents concerning dysfunctioning specialists and the growing number of health care related professions. (33,36)

5 Internal developments; empowerment of the specialty societies?

In many European countries, external pressure caused by the reforms in health policy and quality assurance contributed to the development of new models for control. (17) The first part of this paper sketches how the political and societal changes over the past 25 years in The Netherlands created a context in which medical specialists, as well as all the other health care parties, were pressured to come up with mechanisms to assure the quality of their work in a way that would strengthen public trust in the medical profession. In the winter of the planning age this led to the onset of visitatie programs for medical specialists. And when the market approach took over, making self-governance the dominant administrative view, the first visitatie experiences were cautiously expanded. However, external incentives alone can not explain the development of the visitatie programs. In the second part of this article we will focus on the developments within the medical professions, analyzing how those internal developments triggered and determined the course of visitatie events. The questions formulated in the introduction of this paper will be leading in this section.

5.1 How does visitatie fit in the quality policy of medical specialists

Previously, specialists were ‘only’ accountable to their patients and their colleagues. Nowadays, in the more market oriented and political health care arena, they are hold accountable on diverse matters (costs, volume and quality) and to diverse parties (i.e. central government, patients/consumers, health care institutions). (37) This shift in
accountability is closely related to physicians' perception of quality. Their natural tendency to define quality merely in terms of technical quality (38) now needs to be replaced by a quality concept that also embraces organizational and relational aspects of quality patient care. In The Netherlands, the definition of the quality of professional practice, as phrased by the National Council of Health Care in 1986, entails all three of these elements. (39) This definition is now widely used and accepted by health care professionals, including medical specialists. (40) In the UK a similar shift in terms and concepts with regards to the (accountability of the) quality of medical doctors can be seen. In 1999, the Academy of Royal Colleges endorsed the colleges to also be responsible for skills that extend beyond the acquisition of medical knowledge, such as management, information technology, communication, team building and audit. The term continuous professional development was introduced to replace the more limited term continuous medical education. (41,42)

The change of paradigm is also reflected in the history of Dutch medical quality assurance. The initiative to and the timing of the development of a particular quality assurance mechanism depends on the maturity of a profession and its position in the health care system. In ‘growing up’, a profession will first focus on claiming the ownership of the education of its members and acquiring acknowledgement for its unique knowledge, skills and activities. Only if these are established, the attention might shift to developing internal and external quality assurance systems. For the Dutch medical community, quality assurance has developed itself following this ‘blueprint’: organizing and controlling postgraduate medical training, introducing a system of registration of medical specialists (1930), providing a visitatie program for teaching practices (1966), establishing medical audit in hospitals (1970/80), developing national guidelines (1980/1990) and implementing visitatie programs for non-teaching practices (1990). (29) In analyzing this developmental process other shifts become visible, such as the shift from individual quality assurance (i.e. training and registration) to quality assurance based on the joint responsibility of care (i.e. medical audit), the shift in focus from structure (again training and registration) to process oriented quality assurance (i.e. guideline development), the shift from evaluating competence (training, ‘teaching visitaties’) to evaluating the conditions under which practising takes place (‘quality visitaties’) and, lastly, the shift from ‘doctors only’ (training, registration, medical audit) to doctors ‘in collaboration with’ (guideline development, quality visitaties).

The quality assurance activities mentioned here, will not be discussed in this paper. Others have done this extensively in the Dutch and international literature. (for example 2,35,40,43) Two issues, however, must be mentioned here since they bear relevance to the (course of the) development of the visitatie programs for non-teaching practices: the visitatie model for teaching hospitals and the foundation of CBO.

The specialty training has always been in the hands of the medical community. Since 1966, a visitatie program is operational for teaching practices under the auspices of the speciality societies aimed at the quality of the training. As is the case in many western countries, medical and surgical practices are being assessed on a regular basis in order to obtain or maintain their teaching status. The assessors focus on three aspects: the educator, the curriculum and the hospital setting. Only compliance with all the requirements, as determined through a collegial visitatie, will grant or prolong this status. This visitatie model
later inspired the development of the Dutch visitatie programs for non-teaching departments. In common parlance the two models are also referred to as the ‘teaching visitaties’ and the ‘quality visitaties’.

CBO (literally: the Central Support Organization) was created in 1979 as an organization to help clinicians in their self-imposed task of medical audit. (44) It was one of the gains of the negotiation process that took place between the government and the medical specialists over the introduction of medical audit in the context of hospital medical staffs. Ever since the inception of CBO, its functions have broadened and its staff has increased. For medical specialists CBO’s support activities have expanded to also include the areas of guideline development (since 1982) and visitatie of non-teaching practices (since 1992).

From a quality assurance perspective, developing visitatie for non-teaching practices was the next logical step to make by the medical specialists. It introduces an external quality assurance model (interhospital surveys) and cautiously breaks through the peer character of earlier quality models. In involving the nursing staff, referring general practitioners, hospital managers and others in the survey, non-doctors also are granted a role in monitoring the quality of care medical specialists deliver.

5.2 How was the development of visitatie politically embedded in medical quality policy?

In 1988 the Central Board of the Dutch Specialists Organization (LSV), the umbrella organization for all the specialty societies, published the policy document Tomorrow’s Specialist in which she sketches the future of medical specialist health care. (45) The document is a reaction to the government’s ad hoc measures and cost reductions that are, in the eyes of the Board, merely sham solutions to the real problems in health care, with potentially very negative consequences for the quality of patient care. The Board pleads for a collaborative strategy, involving care givers, consumers and the government, in seeking optimum solutions for the problems in the health sector. With regards to the quality of medical specialist health care the Board suggests “to implement a visitatie system for non-teaching departments in order to assess the functioning of departments or operational units within the hospital. Attention should also be paid to the performance of individual specialists”.

The policy document is discussed at a LSV organized conference later that year. Among the presenters are the secretary of state for health, Mr. Simons, and the chairman of the LSV Quality Committee. In the light of the announced new legal framework on quality, the former explicitly approves of the visitatie model as a professional quality assuring mechanism. The latter, Dr. Brinkhorst, elaborates on the work of the Quality Committee, which was installed in 1988 ‘to develop an external review system through visitatie, in conformity with the visitatie program for teaching sites’. (46) The committee proposes to implement two different visitatie systems: the medical staff based (or: integral) visitatie system and the specialty based visitatie system. The specialty based visitaties would have to be administered and executed by the specialty societies focusing on the typical methodical-technical aspects of that specialty. The integral visitatie system on the other hand, would have to direct its efforts to the more general aspects concerning the medical staff,
evaluating the quality systems as developed by the medical staffs. These surveys are to be conducted by a specialists' delegation under the auspices of the LSV.

The essential elements for both types of visitatie programs were defined by the quality committee. They can be summarized as follows: participation in a visitatie program should be voluntary, the program should be consultative in nature and be developed incrementally, uniform quality criteria are to be developed and the program must be complementary with internal quality assurance activities. Naturally, overlap between the two programs needed to be prevented. The realization of (both types of) the visitatie programs required close collaboration between the LSV and the speciality societies.

The LSV took the lead in the integral visitatie program and adopted a stimulating, coordinating and facilitating role in the specialty based visitaties. The development of the two programs has taken different routes over the past decade: the integral visitaties never really took off, the specialty based visitaties however are now well established in medical quality policy. In the next section both will be discussed.

5.3 How did the tension between the specialty societies and their corporate organization effect the development of visitatie?

In 1989, the LSV Quality Committee conducted seven integral pilot visitaties in general hospitals in order to evaluate the developed survey method and to assess the motivation and perceived added value of the survey. Obviously, the pilot surveys had landed on fertile grounds, because the Quality Committee was invited early 1991 to further develop the visitatie model in a second series of (10) pilot visitaties. Even before publication of the results of this second episode, the importance of visitatie was stressed once more in the LSV policy document Quality and Efficiency: “visitatie promotes the quality of medical professional collaboration and guarantees society the commitment of the medical profession to quality assurance”. (47) The results of the second phase of the pilot project were reported by the Quality Committee shortly after release of this policy document: the survey method and the supporting documents were developed and the first draft of the quality norms for medical staffs were formulated. Based on her experiences, the Committee recommended to continue the visitatie program “since surveying and being surveyed seems to have a quality improving effect”. (48) The pilot visitaties however were never followed up. Despite all the pleads for introducing integral visitaties and specialty based visitaties simultaneously, LSV leadership seemed unable to convince its membership of the merits of the integral visitatie. The multi-specialistic approach, the general character of these visitaties and the unfamiliarity with them, might explain the termination of the program. At a LSV organized meeting on visitatie policy, with representatives of all specialty societies present, one of the participants stated it as follows: “in contrast to the specialty based visitaties, with which doctors are familiar, it is hard to form a picture of the integral visitaties”. (49)

Besides these possible explanations, it is likely that the ending of the program was at least partly caused by the loss of LSV’s dominant position as ‘the voice of the medical specialistic community’. The reason for this decline dates back to 1990, when the LSV, as one of the participants in the Five Parties Agreement, agreed to collaborate on reshuffling the incomes of the various specialities. Consequently, the tariffs of the better paid specialities, i.e.
cardiopulmonary surgery, were cut back in favor of the lower paid specialties, such as pediatrics. Many specialists thought these cuts to be unjustified and therefore left the LSV to start up their own representative body; others left because they found the economic issues being overemphasized in LSV’s policy making. (24) In loosing her leading role as the defender of the Dutch specialists’ (material] interests, the gap between the LSV and the specialty societies widened. (50) The separate specialty societies became more prominent in making and defending their own specialty oriented policies. The split facilitated that administrative power was shifted into the hands of the specialty societies. The societies picked up the administrative gauntlet that was thrown at them, and so also claimed the administration of a solid quality assurance policy. The decreasing solidarity between the specialty societies made it more difficult for a collaborative effort such as the development of the integral visitatie program to succeed.

It needs to be said, that although the integral visitaties left the stage early, the LSV did play an important role in stimulating and coordinating the specialty based visitaties as well as medical quality assurance in general. In the LSV’s publication Quality assurance of Medical Specialists 1995 much attention is paid to the visitatie programs and on an operational level it contains regulations for a society's visitatie program, a basic questionnaire to be used in the surveys, draft quality standards and a standardized report form. (40) This standardizing work has been helpful in pulling together the various programs, who initially diverged in methodology, goal and scope.

5.4 The rise and shine of specialty based visitaties

Dutch medical specialists are organized in partnerships. Besides being an economic unit (for approximately 70% of the specialists) these partnerships are the most important operational unit for professional interaction. (35) Specialists therefore strongly identify with their group of partners. (51) The specialty based visitaties correspond well with doctors’ perception of medical practice because they take these partnerships as a starting point. Also, most specialists are familiar with the specialty based surveys from the teaching setting in which they all spent many years of training. This surely facilitated the rapid spread of the visitatie program since no outsiders were needed per se to translate the teaching model into a model for non-teaching practices. This should not be taken to mean as if the two models only differ with regards to their target market. In essence, the purpose of the programs is different. The survey team in charge of evaluating a teaching practice is led by the question whether or not the site is ‘equipped’ for specialty training. Strict (minimum) quality standards are available to make this judgement. However, the survey team conducting a visitatie in a non-teaching practice is focusing on the question whether or not it is reasonable to expect that the circumstances under which a professional group practices medicine will result in delivering high quality care. (52) Other major differences between the two programs relate to the confidentiality of the survey findings and the sanctions attached to a visitatie. In short, the results of a teaching visitatie are fed back to the colleagues being surveyed and to senior hospital management. The teaching status is at stake in this survey and so it can be, ultimately, withdrawn. A practice either passes or fails the test. The quality survey, on the other hand, is not built around a pass/fail system. Every report contains suggestions for improvement, but so far there are no formal sanctions for
the non-teaching visitaties. Results are only reported back to the surveyed ones. These conceptual differences between the two visitatie programs can best be summarized by classifying the teaching visitaties as ‘inspection’ and the quality visitatie as ‘education’. Needless to say, in reality this distinction is not absolute: an educational approach also needs standards and a normative approach also has educational value.

In December 1986, the scientific council of the quality supporting institute CBO proposes that all the societies install a quality committee. The proposal, previously approved by the LSV, argues that in order to be able to stimulate and support systematic quality improving activities, which is the responsibility of a professional society, “...a recognizable structure and continuity are needed”. (53) In 1989, 14 out of the 32 (35) and in 1993 all of the recognized societies, did have such a committee operational. (54) The discussion on the role of the specialty societies in assuring the quality of its members, and the installation of quality committees, prepared the soil for real actions. The availability of a quality assurance infrastructure, likely facilitated the start of the visitatie programs. It were these committees who initially worked on the elaboration of the visitatie programs. When the programs matured, and consequently became more time consuming, separate Visitatie Committees were launched that could dedicate all their efforts to the execution of the visitaties.

Not surprisingly, the society of surgeons was the first one to report on her visitatie experiences. Not only did the program know a positive reception by its participants, it also demonstrated quality improvement effects. (55) In the nineties, specialty based visitatie showed up in many other publications, in the press and even in an inaugural speech. (56) The societies of pediatrics and gynaecologists report their visitatie results on several occasions, giving insight in the nature and frequency of recommendations as formulated for the various surveyed professional groups. (57,58) The latter also presents her results in the context of practice variation and benchmarking pleading for more systematic quality improvement based on outcome analysis. (59) Most other specialty specific publications in the nineties are mainly descriptive in nature; they emphasize the progress in refining the survey methodology, the importance of initially forming a picture of ‘the average practice’ or the efforts to define a ‘golden standard’. In a special edition of the Dutch Journal of Dermatology and Venereology, devoted to the 100th anniversary of the society of dermatologists, an article on visitatie is inserted, as one of the 10 contributions. The title a historic milestone is illustrative of the perceived importance of the program. (60)

Several contributions from the staff of the quality supporting institute CBO, who are involved in the development and implementation of the visitatie programs of about a dozen medical specialties in the mid-nineties, offer an overview of the (differences between the) various programs and discuss actual themes. Furthermore, in many specialty linked journals, newsletters and policy documents, contributions on visitatie appear, making specialists aware of this newly introduced quality assuring activity. The press too is interested in the specialists’ quality initiative as headlines such as Surgeons commit to quality label show. (NRC, 18 December 1993).

All these publications and a series of articles on medical quality assurance in the popular Dutch journal Medisch Contact in 1996, illustrate clearly that visitatie of non-teaching practices gained a prominent place in the quality assurance policy of many scientific societies.
5.5 Which other facilitating factors contributed to the anchoring of visitatie in Dutch medical specialistic health care?

In painting a complete picture of the rise and spread of visitatie of non-teaching hospitals, a last facilitating factor needs to be added at this point: the discussions that took place on the legalization of visitatie in the context of re-registration of individual medical specialists. The discussions were fuelled by the report *Quality assurance by re-registration of medical professionals* that was conceived by the Quality Committee of the Royal Dutch Medical Association, the umbrella organization for all medical doctors (including general practitioners and physicians in social medicine), in preparation of the national quality ('Leidschendam') conferences. (61) This report suggests visitatie as one of the elements of the re-registration model. The requirements for re-registration are rooted in the Individual Health Care Professions Act (Act BIG), one of the five pillars of the legal framework that supports quality assurance and self-governance of the health care parties. (62) The Central College for licensure and registration of medical specialists is the responsible body for defining the legal criteria for the specialty training and registration of medical doctors. Triggered by the Royal Dutch Medical Association's report, this College started looking for ways to assess and approve the actual level of performance of individual specialists, in continuation of the quantitative requirements for re-registration, in force since 1991. Given the complexity of this assignment, the College took several years (1991 thru 1993) to make an extensive inventory of the existing medical quality assuring mechanisms as they were used by the specialty societies. Based on this inventory the first draft of the qualitative requirements for re-registration was presented at the end of 1994. Visitatie was given a prominent place in the proposals, next to the standards set for continuing medical education. Initially, the College proposed to include the results of the visitatie surveys in the decision whether or not to re-register an individual specialist. This, however, seemed one step too far in the eyes of the specialty societies, as well as in the opinion of CBO. Their resistance was partly based on the immaturity of the visitatie programs at that time. More fundamentally, the proposal was criticized because quality improvement, requiring an open and self-critical attitude, and external regulation, based on a pass-or-fail approach, were perceived incompatible. Furthermore, the essential incompatibility of the group focus of visitatie and the individual approach of registration was ground not to embed visitatie in the framework of re-registration. Interestingly enough, in discussing the level of performance of specialists, it was put forward by several specialty societies that quality audits directed to the specialty groups were deemed more useful than individual quality assessments. (63,64) After debate and consultation, the College adapted her proposal and reformulated it in requiring specialists to participate in the visitatie program of one’s specialty society. (65) With this decision, visitatie is no longer a voluntary, but a mandatory activity for specialty societies to organize and for specialists to undergo. Although the discussion on the status of visitatie in the qualitative requirements was settled relatively quickly, the formulation of the criteria on continuing medical education keep the final approval of the entire proposal waiting. However, it is expected that the qualitative requirements will take effect shortly. In the meantime, most specialty societies carry out their visitatie programs as if the College's proposal was already in force.
6 Discussion

The professional autonomy of doctors is something that has been constantly negotiated and renegotiated between the state and the medical profession. Since the former is constitutionally involved in the delivery of health care, doctors' performance is explicitly questioned at times. To safeguard their professionalism, doctors must substantively respond to the challenges thrown at their feet by society. In this light we have discussed the introduction and dissemination of visitatie of non-teaching practices by answering the three research questions. Our personal involvement in the development of visitatie allowed us to access certain relevant resources (documents and stakeholders) that otherwise might have stayed undisclosed for research. We believe it also enabled us to interpret the collected data with a sense of nuance, being familiar with the political context, the parties involved and the interests at stake. Undoubtedly, our professional involvement challenges the scientific endeavour of objectivity. In answer to this we painted a detailed portrait of events in order to give insight in the (way) sources (were) used. Other descriptive research on the topic of introducing (both nationally and internationally) quality assuring mechanisms within the medical profession, confirmed our work methods and is in line with our analysis. (66)

The results of this descriptive research, the strategy found most suitable in answering the research questions, are not meant to and can not be generalized to other health care systems. We believe however that the results do contribute to the greater body of knowledge on external peer review, on quality assurance and on professionalization. Recently much attention is being paid to these issues in the international context, proving the actuality of the debate. A clear example of this is the 3 year research project on external peer review techniques (ExPeRT), funded by the European Commission; a project to which the International Journal for Quality in Health Care devoted a special issue last year. (67) It identified visitatie as one of the four principal models of external quality improvement in health care and acknowledges that it is gaining popularity outside The Netherlands. (68-70) Although the delivery (and thus quality) of health services in EU countries remains the unique responsibility of individual states, the convergence of the various models into a more powerful and comprehensive model, is being discussed. (69,71) Clear insight into (the rise and spread of) each of the models is therefore necessary.

In short, we discussed that concentrated in the late eighties and early nineties, several occasions took place that all together determined the start and spread of visitatie. (see figure 2: explanatory factors to the rise and spread of visitatie) Internal and external incentives to initiate and elaborate the visitatie programs succeeded and reinforced each other. The conflict between state and doctors over the specialists' income and the introduction of the market approach in the second half of the eighties provoked the medical community to internally discuss the future and governance of modern medical specialistic care: this is when visitatie of non-teaching practices was mentioned for the first time by the medical profession. When the first visitatie experiences were being communicated by the surgical society, the instrument turned out to be the answer to many questions asked by many different stakeholders. Visitatie entered the political stage as if it had been sent for, offering a conclusive reaction to the quest of self-regulation, the national agreements on quality assurance and the continuing search for ways to reduce health care costs.
Figure 2 Explanatory factors to the rise and spread of visitatie

<table>
<thead>
<tr>
<th>External factors contributing to the rise and spread of visitatie</th>
<th>Factors within the medical profession contributing to the rise and spread of visitatie</th>
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<tbody>
<tr>
<td>1. government's threat to interfere with the income of specialists in the late eighties</td>
<td>1. the development of quality policy in health care in general and of medical quality assurance in particular, in which visitatie was the logical next step</td>
</tr>
<tr>
<td>2. introduction of the market approach in health care, deregulation and decentralization, marked by the publication of the Dekker report in 1987 and confirmed and followed up by several government policy documents</td>
<td>2. the debate on the future of medical specialistic health care, in which the LSV took the lead. Two LSV policy documents were most relevant: Tomorrow's Specialist in 1988, and Quality and Efficiency in 1992. In both these documents the development of visitatie is encouraged</td>
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<tr>
<td>3. the national quality conferences (the ‘Leidschendam conferences’), assigning the responsibility for the quality of care to the health care providers in 1989 and 1990</td>
<td>3. several proposals of the LSV Quality Committee on the development of visitatie (1989 - 1992)</td>
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<tr>
<td>4. a new legal framework on the quality of professionals, of health care institutions and patient rights. Crucial to visitatie was the Individual Health Care Professions Act (BIG).</td>
<td>4. the empowerment of the specialty societies to develop their own (quality) policy by the loss of LSV’s dominant position as ‘the voice of the specialistic community’ in the nineties</td>
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<tr>
<td>5. other developments in health care: changes in science and technology, increasing bureaucracy and complexity of organizations, sub specialization, increase in number of health care related professions, several incidents concerning dysfunctioning specialists</td>
<td>5. the method, scope and the mono-disciplinary character of the visitatie instrument</td>
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<tr>
<td>6. the availability of a quality assurance infrastructure within specialty societies as stimulated and supported by CBO in the late eighties</td>
<td>6. the availability of a quality assurance infrastructure within specialty societies as stimulated and supported by CBO in the late eighties</td>
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<td>7. the familiarity with visitatie as a quality assurance mechanism for teaching sites</td>
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<td>8. the debate on legalization of visitatie in the context of re-registration of medical specialists, fuelled by the Dutch Medical Association in preparation of the ‘Leidschendam conferences’ in 1990</td>
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The Dutch medical profession seems to have succeeded in maintaining its professional autonomy. During the past years, the visitatie programs have been perceived by many stakeholders as credible instruments for assuring the quality of patient care and with that, the position of the medical profession as a reliable partner in delivering health care has been re-established. Interestingly enough, this has been achieved while maintaining the visitatie results confidential. Up till now, there has been minimal exchange of information.
about clinical practice and outcomes. So, while it remains unknown to the public what the 
actual quality of the delivered care in the various practices is, and whether or not visitatie 
has a positive impact on that quality, visitatie as a means of quality assurance has gained 
the public trust. As long as there are no signs of serious dysfunctional practices, it is easy to 
take self-regulation for granted. The public might want to believe that good clinical practice 
is also a result of the fact that a system of preventive professional visitaties is in place. It is 
very likely that this positive attitude will change when cases of unacceptably poor practice 
are being identified. There is one situation to underpin this. In 1997, the press started a 
process to make the visitatie report of a presumed dysfunctional practice public; ultimately, 
disclosure was forced by the Dutch Council of State (the body supervising the legislative 
processes).

Not surprisingly, medical doctors are very reserved in sharing visitatie results. Their 
williness to participate in the visitatie programs of their speciality societies has a lot to 
do with the confidential status of the results, the lack of formal sanctions and the fact that 
the visitaties are aimed at ‘getting better’ in stead of ‘eliminating the negative outliers’. If 
the occurrence of incidents of dysfunctional doctors or practices had been the main 
incentive for the development of visitatie, it might not have been so successful. We would 
have seen a more defensive attitude and a similar visitatie model. Quality improvement 
requires a positive environment to grow and bloom. Nevertheless, in line with the current 
spirit of the age, more transparency is expected with regards to the visitatie results. (72,73)

The rise of the visitaties in the late eighties, the shine of the programs in the mid and late 
nineties and the foreseen formal anchoring of the instrument in the near future, prove that 
the medical specialistic community takes her accountability for the quality of patient care 
seriously. In other words, for the collectivity of medical specialists, visitatie has come and 
gained the victory. However, although the key players, the representatives of the organized 
specialists and the government, are aware of these positive results of this political struggle, 
the practising physician might be less conscious of its benefits. To him, reality is that he is 
faced with another ‘bureaucratic’ demand which keeps him from caring for his patients. 
Since the collaboration of practising doctors is needed in preventing that visitatie will leave 
the stage as quickly as it entered it, its added value on a individual and group level is 
crucial. In stead of spending too much time to perfection the structures and supporting 
documents already in place, new directions are necessary. Initiatives taken by some 
speciality societies are a cause for optimism, such as the more process oriented approach 
that the dermatology society is experimenting with, and the pathologists’ initiative to 
inegrate the professional based visitatie program with the organization based certification 
model for laboratories. The latter is indicative for a more general development in the Dutch 
health system: in tune with the movement of involving doctors in hospital management, the 
integration of the doctors’ based visitatie model with the hospital based accreditation and 
certification models is propagated. (74) Furthermore, in discussing new directions, it is 
likely that the perceived value of the visitaties will increase if the survey focus is shifted from 
the circumstances under which clinical practice takes place, to clinical care itself. The time 
seems ripe for this challenge. Deriving feasible measures of outcome that can be used in 
evaluating the effectiveness and efficiency of services seems difficult, but is not impossible, 
as is shown by a recent study on quality assurance in obstetrics. In this study population 
adjusted obstetric interventions and mortality rates are used to compare obstetric practices
and raise the quality of care. (75) In general it is foreseen that with the further development of specific databases on specialty specific topics (i.e. registries for surgical complications, obstetrics, total hip replacement) specialty specific indicators will become available that can be integrated in the visitatie process. Lastly, to increase the merits of the visitaties more attention needs to be paid to the implementation of the recommendations. Currently, three specialty societies are experimenting with professionally supporting the implementation of recommendations. To improve and encourage the implementation of recommendations, several practices are offered a limited number of hours of help by management consultants. The support, that is offered under the name Quality Consultation, is subsidized by the ministry of Health. It is expected that the impact of the visitaties in terms of complying with standards and following up recommendations will be much greater for those practices and specialists participating in the project. Evaluative research will have to show this. (76) In conclusion, visitatie has proven itself a sufficient vehicle in the professionalization of medical specialists. To also maintain its value as a quality assuring instrument for the professionals undergoing the surveys, continuous improvement and embedding in the totality of quality improving activities is requested.

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