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Visitatie by medical specialists in a legal perspective

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VISITATIE BY MEDICAL SPECIALISTS IN A LEGAL PERSPECTIVE

To assure and improve the quality of patient care much is being invested by health care providers. In different parts of the world the preferred approaches vary. In the UK the focus is on the revalidation of doctors (1-3), in the USA patient safety is emphasized (4-5), in Australia clinical indicators enjoy a high profile (6) and in The Netherlands visitatie has become an important vehicle for professional quality assurance. (7,8) Visitatie is a peer assessment method focussing on the organization and delivery of individual health care by means of a standardized on-site visit. It is a doctor-led and -owned quality assurance activity, meaning that medical specialists administer and execute the visitatie programs. Visitaties are ultimately aimed at improving patient care quality.

Legally, Dutch institutions and professionals base their actions on various health laws, such as the Care Institutions Quality Act, the Individual Health Care Professions Act and the Medical Treatment Contracts Act. Although quality assurance remains to a large extent in the formal domain of national authorities, the development of legal frameworks in an international context can be expected. (9) This calls for the exchange of knowledge about nationally developed systems. This paper concerns the legal perspective of visitatie of non-teaching medical practices.

Although the Dutch dictionary Van Dale defines 'visitatie' as a 'skin-search', the peer review method is not that physical and there is no need for medical doctors to feel searched for hidden talents or deficiencies. Visitatie of non-teaching medical practices, introduced by the Dutch Society of Surgeons in the late eighties, is now a well-established professional quality assurance system in all of the 27 Dutch medical specialty societies. (10) By growing to its full stature, the societal interests in visitatie have increased. Once started as a 'peers only' QA program, visitatie has grown to become an activity involving many actors and even more stakeholders.

Studying the phenomenon of visitatie, many legal questions arise. This paper deals with the main legal aspects of:

1. The design of visitatie as a peer review system (i.e. who sets the standards, what is their legal strength, who carries out the assessment and what skills and expertise are required)
2. The (potential) external effects of the functioning of an internal system (i.e. can doctors be forced to submit themselves to a visitatie, can the visitatie results be publicly disclosed, what sanctions - collectively and individually - can be attached to the visitatie results and is there a possibility of appeal?)
3. The role of the health care setting in which the visited peers operate (i.e. how does the organization influence a doctor's position, what is the meaning/role/responsibility of a partnership in a visitatie?)

The visitatie context

Visitatie of non-teaching practices focusses on the quality of patient care. More specifically, the conditions for realizing quality patient care (practice keeping) and the systematic
assurance and improvement of that care (the quality management system) are stressed in the survey. The visitatie programs of the 27 speciality societies show considerable resemblance. (11-13) Most societies installed a Plenary Visitatie Committee, usually operating under the auspices of the Quality Improvement Committee, taking care of the development, execution and maintenance of a visitatie program as approved by the general meeting of specialist members. This committee develops all the necessary visitatie documents, proposes quality norms to the general meeting, recruits and selects (peer) surveyors and approves and ratifies the practice specific visitatie reports. For the actual on-site survey, per practice an ad hoc visitatie team of (2 to 4) peers is formed. Criteria for the selection of peer surveyors, the composition of the ad hoc survey teams and other procedures are formulated by each specialty society and documented in the visitatie regulations.

Visitatie in the format discussed here, is a method of inter collegial assessment or peer review. Depending on which perspective one chooses to study visitatie, it can be characterized as either an internal or external review system. External since peers from outside the surveyed practice (hospital) conduct the survey, but internal since the assessment takes place within the boundaries of one specialty and one professional society. However visitatie is alluded to, it is clear that both the evaluation procedures and the visitatie norms are developed by, for and within the separate specialties and that the execution of the reviews is a matter of the medical profession. Legally it is relevant to know who sets the norms, who conducts the surveys and what sanctions are available. The starting point is that peers set the norms as well as perform the assessments. Therefore, sanctions should also be determined and applied by the profession; the field of competence is limited by the boundaries of the profession.

Next to the relatively new visitatie of non-teaching practices, also referred to as the 'quality visitaties', reviews of teaching practices have been in place since the sixties. In contrast to the quality visitaties these surveys aim at the quality of the training, the trainer and the training site and are conducted to obtain or maintain a teaching status. Obviously, the quality of patient care is equally important for teaching sites. Therefore, the Dutch organization of medical specialists (Orde van Medisch Specialisten), the umbrella organization for all the specialty societies, together with the Dutch Institute for Health care Improvement CBO, are currently developing an integrated framework for the visitatie programs for teaching and non-teaching practices. This could result in a 'baseline visitatie' for all practices, comparable to the current system of quality visitaties, complemented by a 'teaching section'. Although the 'integrated' visitaties are not common property yet, several specialty societies have conducted one or more of them over the past few years.

Developing visitatie norms

Based on the visitatie experiences and aggregated quantitative visitatie data, quality norms are being developed incrementally per specialty. In the first trajectory the implicit quality perceptions of the peer surveyors are made explicit by means of formulating practice specific recommendations. These recommendations are then presented to the Plenary Visitatie Committee who determines whether the recommendation has a local meaning only
or should be extended and made valid to the whole profession. In the latter case the Committee formulates a quality norm to be presented, approved and ratified by the general meeting. The second trajectory builds on the available quantitative visitatie data. For certain aspects of medical practice organization quality norms are set based on the analysis of a number of visitatie reports. A study of the Dutch Society of Obstetrics and Gynecology exemplifies this approach. (14) The Dutch Society of Internal Medicine has conducted similar exercises. The visitatie experiences of the Dutch Society of Surgeons resulted in publication of the document Quality Norms for Surgery Practices. (15) This document was authorized by the society’s members in 1996, and has since been used for review of all surgery practices, teaching as well as non-teaching. The visitatie norms translate in concrete terms the concept of ‘responsible care’ as mentioned and meant in both the Care Institutions Quality Act and the Individual Health Care Professions Act (article 40). (16-19) Also, they give meaning and substance to the concept of ‘good care providership’ as meant in the Medical Treatment Contracts Act. Although the development, ratification and use of the visitatie norms are matters of the profession, they do have a legal dimension. The purport of ‘good care providership’ and of the rules for conscientious and careful medical practice as articulated in the various Quality Acts, is to offer footing to judges when faced with quality of care evaluations. Keeping this in mind, reliability of the visitaties and the possibility for an appeal become relevant issues. (20)

Reliability

Scientific studies researching the reliability of visitaties are not yet available. Nevertheless, measures are being taken to assure and increase the reliability. Firstly, the visitatie process is being standardized. Each specialty society uses a visitatie questionnaire that needs to be filled out by the reviewed peers before the visitatie takes place. This questionnaire is the leading document for the interview with the specialist group. For the interviews with other parties, such as the hospital administrators, the medical staff representatives and the nursing staff, interview guidelines are available. Other important documents are the pre-structured visitatie report and the available visitatie norms. Where norms are lacking surveyors hold on to the ‘golden rule’ that within the ad hoc visitatie team consensus needs to be reached on the practice-specific recommendations for improvement.

For the reliability of the visitaties, the quality of the surveyors is crucial. Many specialty societies have a so-called ‘College of surveyors’: a relatively small group of specialists who perform at least 2 or 3 visitaties per year. Within this group the required experience and expertise can be build up. Further, surveyors can be trained in gathering objective data. Lastly, a number of specialty societies collaborate with a professional facilitator who oversees the accuracy of the procedures and drafts all the visitatie reports. This is beneficial to the uniformity, the reliability and the comparability of the various visitatie programs. Despite all the measures taken, and even apart from them, surveyed peers may not agree with the conclusions as laid down by the ad hoc visitatie team and approved by the Plenary Visitatie Committee in the visitatie report. The surveyed specialist groups can than turn in a motivated plea with the Plenary Visitatie Committee. This Committee, considering the objections, will adjust and ratify the report.
Self-regulation and its external impact

Characteristic of the visitatie norms is that they originate within the frame and context of self-regulation. It concerns rules, with a binding pretence, for a certain group. In general, the power of self-regulation depends on the format chosen. In the case of visitatie the format is one of internal group regulation. The context is the specialty society, within which a majority decision is binding for its members. This is how quality norms can be laid down, and also how sanctions can be dictated, from financial or other obligations to suspension or termination of the membership. Of course, one can duck out of this regime by leaving the society. This shows the weakness of self-regulation compared to generally binding legislation: membership, of any society, cannot be forced upon people. However, some societies have a monopolistic character: to be able to use a tennis court one has to be a member of the tennis club. Also, certain legal or societal mechanisms can make membership de facto mandatory: subscription in a register can be made dependent on the membership of an organization. Through the membership of their specialty society many medical specialists submit themselves voluntarily to self-regulation.

Voluntary or mandatory participation for visitaties?

A number of specialty societies have made visitatie a mandatory activity for their members; others have chosen, as yet, for voluntary participation, hoping and expecting that by ‘peer pressure’ all colleagues will be surveyed once every five years. As argued before, specialists who are a member of a specialty society can be forced by a legally valid decision to resign themselves to visitatie. Principally, without losing their subscription in the specialist register, they could withdraw from the specialty society’s jurisdiction by terminating their membership. However, this ‘escape’ has been superseded by a higher legal institution: the Central College for licensure and registration of medical specialists, the responsible body for defining the legal criteria for the specialty training and registration of medical doctors, will soon require specialists, under penalty of exclusion of the register of specialists, to participate in the visitatie program of one’s specialty society. (21,22) This decision was preceded by discussions with the specialty societies. The initial proposal of the College, to also include the results of the visitatie surveys in the decision whether or not to re-register an individual specialist, did not (yet) pass the debate. This should not be taken as if the mandatory visitatie is the only qualitative requirement the College put forward for the individual re-registration of physicians: specialists should also have participated sufficiently in accredited continuous medical education activities. Lastly, the quantitative requirement of ‘regular practice keeping’, in power since 1991, will remain in force without abatement.

Public disclosure of the visitatie reports

Considering visitatie as a form of internal quality assurance one could defend the statement that there is no need to make visitatie results public, ergo outside the circle of professionals. Today, the survey findings are still confidential; the results are provided only to the
specialists being surveyed. However, some initiatives and incidents announce change with regard to the confidential status of the visitatie reports.

Firstly, local arrangements on voluntary disclosure of visitatie reports are common. The Dutch Society of Surgeons reported in 1993 that 78% of the reviewed surgery partnerships shared the results of the visitatie with their hospital management. (13) Given the shared responsibility and mutual dependency of doctors and hospital administrators in delivering quality patient care this is not surprising.

Secondly, in 1997, the press managed to have a visitatie report of a presumed dysfunctional practice publicly disclosed. (23,24) In this case, the Inspectorate of Health investigated the practice and used the visitatie report as drawn up by the Dutch Society of Obstetrics/Gynecology. Since the Inspectorate is a public body, operating under the direct responsibility of the Minister of health, TV-reporters claimed disclosure of the report based on the Act on Public Administration. The interest of public disclosure was weighted against other interests such as the continuous willingness of medical doctors to participate in the visitatie program and the potential harming effect of disclosure on an individual doctor. The judge ruled against the confidential status of the visitatie report; this decision was confirmed in further appeal. (25)

Lastly and most recently, confidentiality is under pressure since in the new collective agreements between hospital administration and its medical staff, on which the individual contracts with the hospital's practising independent specialists are based, the requirement to share selected visitatie results has been added: “the medical specialist must cooperate in the hospitals’ quality management policy, which implies, amongst others, participation in visitatie, ….. On request of the hospital administrative board and/or the board of the medical staff the medical specialist will to the best of his ability provide information concerning the results of the visitatie, ……..”. (26-27)

Surely, the rationale behind all these actions rests on the belief that the release of data will lead to improved quality and facilitate patients to make better informed choices. Therefore, in the context of implementing quality improvement measures, the debate on the (limited) disclosure of the visitatie results seems advisable and necessary. However, the disclosure of the visitatie results might have the unintended effect that specialists grow shy and mask or cover up shortcomings; this would set the cart before the horse.

One could wonder if disclosure of the visitatie results (of non-teaching practices) can be enforced since the enactment of the Care Institutions Quality Act in April 1996. Article 5 of this Act requires health care institutions to document their quality management efforts in a yearly report, including ‘the frequency with which quality assessment was performed, the methods used and the results achieved’. This stipulation, however, does not need to be interpreted as if the visitatie reports as such are to be published. Irrespective of this, the Inspectorate of Health, based on her supervising task as documented in the Care Institutions Quality Act, may claim access to the visitatie reports at any time.

Finally, the visitaties of teaching practices come under a different regime: since the hospital itself needs to comply with the requirements for teaching institutions as set by the Central College for licensure and registration of medical specialists, the visitatie reports are self-evidently made known to the hospital administrators.
Sanctions and the organizational context

Lastly, the question is whether sanctions can be imposed on negative visitatie results, and if so, which sanctions. For teaching practices the teaching qualification can be conditionally extended or even withdrawn. For non-teaching practices it is more complicated. Options are to force a practice to take certain measures, to develop protocols, to put the physicians through educational activities or to enforce them to arrange professional support. Potential sanctions with regards to individual doctors have been mentioned before: besides individually focussed measures such as coaching, supervision or (continuous) medical education, the most severe sanction that can be imposed is to expel a member from his or her specialty society. Individual sanctions are not always straightforward: can shortcomings be unambiguously ascribed to the individual professional, or are the specialist group and/or the health care institution also (at least in part) to blame? In other words, before an individual doctor can be punished, based on the visitatie results, it must be firmly established that he is to blame for the failure in question. Particularly the legal consequences of visitatie need to be considered fully.

Closure

It is impossible to imagine professional quality assurance today without visitatie. However, more time needs to be allowed to further develop and enhance the mechanism, in terms of setting the norms and refining the procedures. In this article a few important legal aspects of visitatie have been explored. The enactment of visitatie procedures and norms is a form of self-regulation. For their members the medical specialty societies make legally binding decisions. But non-members too are obliged by law to submit themselves to visitatie.

This judicial exploration invites one to further investigate certain visitatie aspects. Particularly interesting are the legal consequences of visitatie for practices as well as for individual professionals. The (public) disclosure of the visitatie results and the sanctions imposed to practices and individuals require special attention. As long as a mist surrounds the precise consequences of visitatie, it is our opinion that the specialty societies should be left room for further development of the visitatie system. Than, a well-balanced system of baseline visitaties for all practices completed by additional visitaties for i.e. teaching practices or practices with specific top clinical functions will be in store for medical specialists and society at large.

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