Visitatie of medical specialists: studies on its nature, scope and impact
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Chapter 8

General discussion
GENERAL DISCUSSION

In this thesis the phenomenon of visitatie of medical specialists in Dutch health care has been explored from different perspectives and using various research methods. The visitatie studies answered the four main research questions, as were introduced in chapter 1:

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?

This concluding chapter presents the results, discusses the limitations and qualities of the visitatie studies and formulates the policy and research implications.

1 Main study results

The main results of the visitatie studies are:

1. Visitatie has been successfully exploited by the medical profession as a means to defend professionalism, and (thus) the self-regulatory privileges which have to be constantly negotiated and renegotiated between the medical profession and the public. (chapters 2 and 3)

2. Visitatie is based on a systems approach to quality assurance. Visitatie results in practice-specific recommendations for improvement. The average number of recommendations varies per specialty. Recommendations deal with the ‘functioning of the specialist group’ (33% of all recommendations), the ‘management of care processes’ (30%), the hospital context (25%) and specific quality assurance/improvement issues (8%). These numbers vary per specialty. (chapter 4 and 5)

3. Medical specialists show welcoming attitudes towards visitatie, measured by a postal survey. No significant difference was observed between surgeons, gynaecologists, and pediatricians. Specialists seem more critical when visitatie is discussed in an interview setting. (chapter 5 and 6) Medical specialists also express positive attitudes towards the recommendations for improvement, when measured shortly after receiving their practice-specific visitatie reports. At that time, lack of resources, time, knowledge and/or skills and the assessed self-efficacy are perceived as the main barriers for implementing the recommendations for improvement. A more positive attitude towards visitatie correlates modestly with a more positive attitude to the recommendations for improvement, holding good promises for implementation. (chapter 5)

4. Quality Consultation (QC) was designed and delivered as a multifaceted site-specific implementation intervention. Support mostly addressed managerial and organizational issues. Each specialist group was offered a unique mix of interventions. QC was positively received and evaluated by participants. (chapter 6)

5. QC seems a powerful intervention in implementing visitatie recommendations. Specialist groups who benefited from the support of a management consultant reported to be more successful in implementing visitatie recommendations than their colleagues.
in non-supported specialist groups. The implementation result and process were also rated significantly higher for the supported groups. (chapter 6 and 7) A set of 14 factors obstructing the implementation of visitatie recommendation has been identified. The supported specialist groups reported significantly less obstructing factors, suggesting that QC has a moderating effect on them. The experienced obstructing factors are strongly related with the degree of implementation, the assessment of the implementation results and process.

The main results will be subsequently discussed.

1.1 Visitatie and professionalism

The rise and spread of visitatie has been explained in the context of protecting medical professionalism. In chapter 2 it was explored how visitatie has been used in the political process between the medical community and society at large. The self-regulating rights of the profession, one of the distinctive characteristics of professionalism, were at stake in these negotiations. It was substantiated that a number of factors both internal as well as external to the medical profession all together determined the introduction and acceptance of visitatie as a credible instrument in assuring quality patient care. Although the technical argument was emphasized in the analysis, this should not be taken as if self-regulation, and professionalism in general, can be reduced to a ‘deal’ between society and medical doctors. Professionalism demands putting patients’ interests first, setting and maintaining ethical standards and serving society on health matters. (1,2) Great responsibilities are involved, as was adstructed in chapter 3. However, the claim for self-regulation is built on the assumption that the enablers for the delivery of quality patient care lie within the realm of the medical doctor himself - through his knowledge, training and compliance to ethical standards - and that mechanisms within the profession itself, such as visitatie, will assure high levels of quality. Despite the current public’s trust in visitatie as a means of professional quality assurance, the question is if this model of professional accountability can stand the test of time. There are reasons for concern. The first is of a moral nature. Most western countries have their own examples of failing professionalism, such as the extensively discussed Bristol cases in the UK and the recent Utrecht incidents in our own country. In both cases babies unnecessarily died. Clearly, the public can not be blamed for losing trust in professionalism if these practices reflect the profession’s values and conscience. It increases the pressure put on the profession to act upon individual misconduct and to seriously consider disclosure of quality assurance data.

The second reason that challenges the professional model is that mounting evidence is strongly suggesting that factors beyond the direct reach of doctors affect quality, such as organizational characteristics. (3) The increasing complexity of health care organizations and the relative roles of its players need to be acknowledged. (4) In addition, doctors today are confronted by an explosion of changes in health care. Medical specialists are still the main component of the health care system, but in their capacity as doctors they no longer direct the play at all times. (5) Obviously, one can not be hold accountable for factors that one can not control or at least influence.

Society will further increase the pressure on the medical profession to be responsive to the needs of the patients it serves. Doctors are experiencing frustration as changes threaten the
nature and values of medical professionalism. The international medical community has responded to this call for a renewed sense of professionalism. After publication of chapter 2 (December 2001), dealing with the start and spread of visitatie as a means to protect professionalism, a document was published in two leading medical journals [The Lancet and the Annals of Internal Medicine] revisiting professionalism to encompass its profiles within the new world order. The document, titled ‘Medical professionalism in the new millennium: a physicians’ charter’, confirms that professionalism is the basis of medicine’s contract with society, requiring public trust in doctors. (1) It formulates a set of ten professional responsibilities, including commitment to professional competence, to improving quality of care and to professional responsibilities. The charter explicitly states that medical doctors “both individually and through their professional associations, must take responsibility for assisting in the creation and implementation of mechanisms designed to encourage continuous improvement in the quality of care.”, “…obligations include engaging in internal assessment and accepting external scrutiny of all aspects of their performance.”, “…must strive to see that all their members are competent and must ensure that appropriate mechanisms are available for physicians to accomplish this goal.”.

Thus, the traditional professional accountability model will most likely be replaced. If not already. 15 Months after its publication the charter has engendered a high level of interest and activity, i.e. citations in several hundred newspapers, over 65,000 requested reprints, 70,000 hits on related web sites and translations in six languages and another four planned. (6) Although the charter changes the concrete format of professionalism, it stays true to the value that professionalism is the basis of the contract which the medical community has with society. Likewise, it is reasonable to assume that visitatie in its current format will only be valid temporarily. Holding on to its professional dominance, new negotiations will indeed follow, i.e. requiring more openness, more patient involvement and more individual appraisal. To be true to the claims of the new professionalism, visitatie must be demanding even while being supportive. In the context of the new professionalism this need not be threatening to the medical profession; instead it will strengthen professionalism.

1.2 Visitatie results: recommendations for improvement

In the introductory chapter of this thesis visitatie 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’. That ‘the circumstances’ are crucial for the delivery of quality patient care has long been acknowledged. The final part of Hippocrates’ first aphorism states that ‘it is not enough for the physician to do what is necessary, but the patient and the attendant must do their part as well and the circumstances must be favourable’. (7)

What these circumstances encompass in the context of visitatie, has been explored in chapter 5. As stated in chapter 1, the ‘circumstances’ refer to a set of aspects that are conditional for delivering quality patient care. Based on the analysis of 464 visitatie recommendations, it was possible to define the domain of the ‘circumstances’ of a medical practice. They can be described in 5 main categories and a total of 32 aspects. Recommendations deal with 1. the ‘functioning of the specialist group’ (33% of all recommendations), 2. the ‘management of care processes’ (30%), 3. the hospital context
4. specific quality assurance/improvement issues (8%) and 5. some miscellaneous issues (4%). The numbers vary per specialty. Comparable data are hard to find. One recent study (2001) was found reporting on the results of 87 visitations of gynaecology practices. Lips et al (8) classified a total of 844 recommendations. Although a different classification scheme was used, the general picture is similar to the results found in this study. In addition, De Boer et al (2000) reported the results of 90 pediatric visitations. In general terms they describe that most recommendations deal with the practice organization. (9) Finally, the results of the American ‘visitatie program’ run by the American College of Obstetricians and Gynecologists (ACOG - see chapter 1) report on the results of the first 100 surveys. The College found departmental and systemic deficiencies, i.e. departmental structure, collaborative practice, policies and procedures and documentation, to be the most common problems. (10)

The choice to focus visitatie on the circumstances of a medical practice was based on the adoption of the industry based systems approach to quality as the underlying philosophy of visitatie. Dutch specialty societies will admit that its non-threatening character facilitated the choice; the systems approach implies that most quality problems do not arise from individual error but rather from failures in the processes and systems of care. Today, this type of thinking, as exhibited in chapter 4, has been widely accepted and most modern quality assurance efforts embrace and confirm its principles. It may narrow the variance in the quality of care and enable a specialist group to achieve a better overall result for the patient population.

Despite the fundamental choice for the systems approach, the specialty societies are presented with the question of the evaluation of individual performance of doctors. In particular, when faced with cases of below standard performance. Under the current regime of self-regulation the possibilities of imposing corrective measures are limited (chapter 3). Thus, while acknowledging that doctors’ work is characterised by multiple complex interactions, involving different kinds of teams and embedded within the overall processes and systems of care, which methods can be applied for judging the good from the less performing doctor. Specialty societies will have to come up with an answer to this question. Options include methods for individual appraisal and assessment (11-13), multisource feedback (14,15), case-based orals (16) and direct or video observation of an individual’s practice. (17) Within the Dutch surgical community appraisal and assessment enjoy a high profile, although it has not been applied in the context of visitatie. Direct observation is resource-intensive; nevertheless, in the UK and Australia the method has been tested and does form part of performance review procedures. (16,17) Video observation has gained increasing interest for the assessment of more technical aspects of patient care such as surgical skills and resuscitation. (18-22) Clearly, every method has its pros and cons and a combination of methods might be most appropriate.

Finally, reflecting on the visitatie results, the question remains whether they are representative of the actual shortcomings of medical practice or rather reveal the focus of the visitatie team and/or visitatie program developers. Specialty societies have a great responsibility in selecting the circumstances to evaluate. Assuming that medical specialists will reflect on what they know their peers are going to inspect, the aspects to be evaluated in a visitatie process should be selected in the light of their relative importance to the delivery of quality care. (23) Preferably, those aspects are proven to contribute substantially to the enhancement of the quality of patient care.
1.3 Attitudes towards visitatie and the resulting recommendations

Medical specialists showed, measured by questionnaire survey (chapter 5 and 7), most welcoming attitudes towards visitatie as a professional quality assurance activity as well as towards the way their specialty society is organizing and executing the visitaties. In addition, their opinion of the expected added value of visitatie for their own practice or the profession was less welcoming, although still generally positive. Medical specialists were most cautious about the potential misuse of the visitatie report i.e. by the inspectorate or health care insurers. When specialists were asked about their visitatie experiences in an interview setting, attitudes overall seemed more critical. (chapter 6) Upon request, statements were made about the perceived meaning of visitatie as a quality assurance instrument, the process of visitatie, the atmosphere during the visitatie, the approach and focus of the survey team, and the results and impact of the visitatie. Reactions included favourable as well as critical attitudes towards all aspects of the visitatie.

The doubts expressed with respect to the added value of visitatie in improving quality of care and the validity of the instrument are reason for concern. Most specialty societies are still using the visitatie format as outlined in 1995 by the Organization of Medical Specialists (than called LSV). (24) The visitatie model seems in need of modernization. Therefore, late 2001, the specialty societies joined together in an effort to redesign the visitatie model to include key developments within professional quality assurance and performance measurement. This project is executed by the Organization of Medical Specialists and the Dutch Institute for Health care Improvement CBO. The visitatie procedures, focus, scope, assessment methods and reporting mechanisms are all passing in review. A once every 5 year indirect assessment of practice organization alone seems no longer sufficient. Including the evaluation of patient perspectives, team functioning and the processes and outcomes of care, are being considered. Information communication technology will support the operation of future visitatie programs. This will require consensus about the type of data to be collected as well as the establishment of uniform reporting standards. In order to prevent that obtaining and processing data will become too time consuming for doctors and/or support personnel, constructive partnerships between the specialty societies and hospitals will be necessary. Furthermore, the integration of the two currently existing visitaties models (the ‘quality model’ and the ‘teaching model’, see chapters 1 and 2) is high on the priority list. Finally, the implementation of visitatie recommendations requires attention, although specialty societies can not perform both roles of assessors and advisors/facilitators. Pilot visitaties ‘new style’ are planned for the end of 2003. The results of the visitatie modernization project are expected early 2004.

As was expected (chapter 5), a positive attitude towards visitatie correlates modestly with a more positive attitude towards the practice-specific recommendations for improvement. Shortly after receiving their visitatie reports, medical specialist were asked to express their opinion about the recommendations. The opinions were to reflect the intended actions of respondents to actually implement the recommendations. Although medical specialists were generally positive about the recommendations, the results may encourage the specialty societies to critically review their assessment methods and feedback and reporting mechanisms. From an implementation point of view, chances of following up on
recommendations are decreasing when they are not understood (14% of all recommendations, see chapter 5), recognized (32%) and/or agreed upon (39%). It stresses the importance of a rigorous evaluation and of clear oral (the closing session at the end of the visitatie day) and written (the visitatie report) communication of the visitatie findings. In addition, the results suggest hospitals may have a role in facilitating implementation of recommendations. Medical specialists perceive a lack of organizational competence and management may help them overcome these barriers. In general, strategies should be designed to overcome barriers and enhance implementation.

1.4 The QC intervention

Implementation of the visitatie recommendations can not be forced upon specialist groups (chapter 3) and is not self-evident. Given the range of variables that impinge upon the implementation process, implementation of visitatie recommendations is complex. To encourage the implementation of visitatie recommendations, the Quality Consultation intervention was developed as a site-specific multifaceted strategy. (Chapter 6) 25 specialist groups of surgeons, gynaecologists and pediatricians were supported by two management consultants, who took on a facilitative non-policing approach. Specialist groups positively evaluated the consultants and the impact of their support. The support was felt to be a facilitating factor in the implementation of the recommendations. Managerial and organizational topics were mostly addressed. All specialist groups were offered a unique mix of participatory and non-participatory interventions. Routine application of specific management tools or interventions was not deemed suitable by the consultants; it seems there is no room for standardized management consultancy practice.

The role of external management consultants in implementing change in health care settings is little researched and evidence is controversial. (25,26) Comparable studies combining external management consultancy and a multifaceted approach are even harder to find. One study in primary care was found. In a Canadian study a multifaceted approach was developed in an attempt to better preventive services. (27) Trained nurse facilitators supported primary care practices (1 to 6 doctors). The approach consisted of 7 ‘evidence based’ interventions to change practice. Preventive care performance significantly improved. The importance of the relationship between the facilitator and the practice should be recognised. (28)

When broadening the scope to include other ‘change agents’ next to external management consultants more studies become available. Harvey et al (29,30) presented a concept analysis of facilitation in relation to successful implementation of change. Their findings suggest that the presence of a facilitator, defined as ‘individuals with the appropriate roles, skills and knowledge to help individuals, teams and organizations apply evidence into practice’, who provides face-to-face communication and uses a range of enabling techniques has some impact on changing clinical and organizational practice. However, the effect size is variable and it is difficult to isolate which aspects of the process of facilitation or the facilitator role are more or less effective in influencing change. Facilitation is conceptualized and applied in diverse ways, making it difficult to draw meaningful conclusions about the efficacy of a facilitator intervention. In general, the process of reviewing the effectiveness across studies is highly complex due to the ‘immaturity’ of the
concept of facilitation, meaning it is not well understood, developed nor explained. More research is needed to clarify the concept and study its effectiveness. It is striking that in the choice of implementation subjects the vast majority of the specialist groups requested support in dealing with managerial and organizational issues. In chapter 6 it was suggested that the managerial and organizational problems specialist groups are facing today, may be dominant to such a degree that they hinder improvement of other, more clinical issues. This impacts medical specialists’ functioning on three levels. Firstly, it stresses the challenge medical specialists are facing in learning new, more corporate-based skills. Secondly, medical specialists will have to invest in the development of effective specialist groups as the basis for coordinating daily operations, patient care and professional interaction. Thirdly, the problems specialists are facing, bring to light the gap between clinical and managerial culture and the ongoing control battle between doctors and managers. The latter seems independent of health system characteristics; most health systems in the developed world are dealing with the same issue. Although no objective evidence is yet available linking good relationships between doctors and managers with better quality care for patients, serious service failures have been associated with poor relationships. (31) Dialogue, convergence of cultures, joint leadership, training of doctors in management and re-engineering of work processes (32) are just a few of the proposed solutions to the paradox, as profoundly discussed in a recent theme issue of the British Medical Journal (2003, March 22) However, actual alignment still has to be achieved. Ironically, although medical specialists may resist (further) managerial and/or organizational involvement, visitatie and QC as professional quality assurance strategies, have encouraged just that.

1.5 QC enhances implementation efforts

This study suggests that QC is a powerful strategy in implementing visitatie recommendations. Specialist groups who were supported by a management consultant were more successful in implementing visitatie recommendations than their peers in non-supported specialist groups. A relative difference of over 22% between the implementation rates of the intervention and non-intervention group was reported. The implementation result and process were also rated significantly higher for the supported groups. The supported groups reported significantly less (p < 0.005) obstructing factors. The experienced obstructing factors are strongly related with the degree of implementation, the assessment of the implementation results and the process. Systematic reviews of rigorous studies provide the best evidence on the effectiveness of different strategies to promote implementation. Although the current evidence base is incomplete, reviews have identified a number of consistent themes. (33) Passive approaches (e.g. dissemination of information) were generally ineffective in achieving change; however, the approach may be useful for raising awareness. Audit and feedback, the use of local opinion leaders, local consensus processes and patient mediated interventions showed variable effectiveness. Interactive educational meetings, reminders, educational outreach and multifaceted interventions, were consistently effective.
The results of the visitatie study seem to confirm the successfulness of combined implementation strategies. However, the exact workings of the integrated approach offered to specialist groups remain unclear. Given the substantial heterogeneity of the QC projects it will be extremely difficult to reveal QC's 'black box'. The 11 participatory and non-participatory interventions were intertwined and delivered in a different mix to each of the participating specialist groups. Few studies have been able to analyse the relative contribution of each intervention in a multifaceted approach. Thomson et al found little evidence of a measurable effect of adding a complementary intervention. (34) Wensing et al mentioned that interventions, once combined, may reinforce the impact of the separately applied interventions. (35) In the Canadian study mentioned in the previous section, it was suggested that audit and feedback, consensus building, and reminder system components were the main components for creating change. (36) Further research is needed to unravel which combination of interventions is effective and complementary as well as which components of the multifaceted strategy are effective under different settings. (33) Contrary to our expectations, medical specialists' attitudes towards visitatie were not correlated with the implementation results. Apparently, factors other than the acceptance of the visitatie model determine the implementation success. Others have suggested that the effectiveness of multifaceted interventions may be ascribed to the fact that more barriers to change are addressed. (37) Supported specialist groups consistently report to experience less barriers in implementing the visitatie recommendations. The impact of QC on the implementation of visitatie recommendations may be partly explained through its moderating effect on a set of fourteen selected obstructing factors, explaining a great deal (~32% of the variance) of the (lack of) implementation results. The mitigating effect seems largest for the barriers lack of implementation knowledge/skills and support, assessed self-efficacy and expected (limited) gains/advantages of implementation efforts. Following these findings, it is advisable that in supporting the implementation of visitatie recommendations, interventions should (also) be targeted at this set of obstructing factors. Research is needed to explore in depth the factors hampering and facilitating implementation.

2 Limitations and qualities of the studies

This study is a first attempt to address visitatie as a professional quality assurance method and the implementation of its resulting recommendations for improvement. Obviously, many questions remain, but, it is believed that the results of the studies do contribute to the greater body of knowledge on external peer review, professional quality assurance and implementing change in clinical practice. Various research methods, both quantitative and qualitative in nature, were used to answer the questions posed in chapter 1. The choices made in the design of the studies into the nature, scope and impact of visitatie created limitations as well as qualities.
and objective measures would have been applied to determine the results, and measurements would have been repeated after time. Obtaining these additional data was not possible in the context of this project. Clearly, this study was not designed as a trial. Given the non-experimental character of this study, the limited number of specialist groups involved, and the great number of variables relevant to implementation of the recommendations, no causative relations can therefore be established between Quality Consultation and the implementation of visitatie recommendations. Although the results suggest Quality Consultation to be a powerful intervention for implementation, no general conclusions can be drawn on the effectiveness of management consultancy for implementation tasks.

3 Study implications

In this final section the (potential) policy implications of the visitatie studies will be shortly discussed. The four main stakeholders will be addressed: medical specialists, specialty societies, hospital management and health services researchers.

3.1 Medical specialists

Changing clinical practice can be difficult to reach. Although medical specialists may be a motivated group, effecting change can be difficult because it often involves altering long-established practice and patterns. To some it may also be threatening. However, involvement of medical specialists in change efforts and a positive attitude towards implementation of changes seem crucial. Furthermore, specialist groups might benefit from some training in the field of implementing change. Investing in management capacities may lead to improved implementation of visitatie recommendations.

3.2 Specialty societies

The recent discussions on the new visitatie model, seem to spur the emergence of a model integrating various professional quality assurance activities. This offers a window of opportunity. In evaluating, updating and redesigning the visitatie model, the added value for medical specialist should be the primary concern of specialty societies. Addressing actual practice and contents of care seem to be a prerequisite in this. It is recommendable that preceding the development of a new visitatie model, first an assessment framework is designed. Defining the content to be assessed as well as the purpose of the assessment are the first two steps to be taken. There seems to be consensus on the visitatie content: assessment should be based on performance, rather than competence. Next, the exact components of doctors' performance need to be defined. In the international literature some attempts in this area have been described. Once this has been achieved, the purpose of visitatie should be formulated, ranging form encouraging doctors to improve to weeding out potentially poor performers. Following on from this, the use of new assessment methods within the visitatie context can be considered. It should be realized that sound
assessment methods are reliable, valid, feasible, acceptable and have an educational impact. No single method however possesses all qualities and not all are equally important in all situations. Depending on the purpose of visitatie one or a combination of assessment methods could be selected.

Specialty societies need to consider how implementation of the visitatie recommendations can be encouraged. Obviously, the roles of assessors and advisors/facilitators should remain divided. Referring specialist groups to external management consultants is one option. Given the costs involved, offering this service to specialist groups as a standard follow up of a visitatie might not be attainable nor necessary. Implementing recommendations remains primarily the responsibility for specialist groups and hospital management together. Turning to independent management consultants might remain useful however, in particular situations and for specific problems, for example when mediation skills are required or when strategic interests are at stake. Obviously, other stakeholders are also concerned about the (non)quality of delivered care. It can be expected that the self-regulatory privileges will have to be constantly renegotiated with society. The pressure on the medical profession to open its serried ranks, to publicly disclose data and to act upon professional misconduct will increase. In terms of the new professionalism, specialty societies will (have to) embrace this responsibility.

3.3 Hospital management

Hospitals are no longer simply a platform providing technical and hotel services, but are now required to be managerially responsible for clinical services. In The Netherlands, hospital management and medical specialists (legally) share the responsibility of delivering quality patient care. Against this background, hospitals should support medical specialists in their quality assurance activities, including the implementation of visitatie recommendations. This is preferably done by facilitating specialist groups in terms of time, staff and other resources. (39)

The importance of well functioning specialist groups has been undisputed: specialist groups have been referred to as the hospitals' spine. (40) Effective specialist groups are needed to make sure that the division of specialist work is anchored, knowledge and experience are exchanged, innovations are realized and continuity of care is guaranteed. The development of effective specialist groups may be a prerequisite to the realization of organizational goals. The classic management - doctor divide may be hampering in achieving this, and therefore needs to be solved. In this thesis, in addition to many other studies, one serious effort of medical specialists to show the public, and others, their accountability for the quality of patient care, was demonstrated. The profession-led introduction of visitatie and the collaboration of medical specialists in the development and execution of Quality Consultation, without doubt influenced the operations of hospital organizations. Maybe it is time that these efforts of medical specialists are answered by contra endeavours of hospital administrators showing their accountability to the medical community.
3.4 Health service researchers

Clearly, the research agenda is large. Throughout this thesis, the need for further research in the various areas of professional quality assurance, self-regulation and achieving change in clinical practice has been stipulated. In summary, future research should focus on:

- the effectiveness of a large scale quality assurance program such as visitatie on the actual quality improvement of health care practice (41), including, ultimately, patient outcomes.
- the legal consequences of visitatie for specialist groups and individuals. The (public) disclosure of the visitatie results and the sanctions imposed to medical specialists require special attention.
- the effectiveness of multifaceted interventions. Research would need to include efforts to unravel which combination of interventions is effective and complementary as well as which components of a multifaceted strategy are effective under the various settings.
- the factors hampering and encouraging the implementation of visitatie recommendations.
- the role of facilitation in general, and external management consultants in particular, in implementing change in health care settings. As discussed, the concept of facilitation is in need of delineation and comparison, which necessarily involves more research.
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