Visitatie of medical specialists: studies on its nature, scope and impact
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This thesis deals with the phenomenon of visitatie. In The Netherlands, visitatie is one of the medical professions' most recently developed and widely used quality assurance tools. Over the past decade it has acquired a firm and prominent position within Dutch medical quality policy making. As described in chapter 1, no other country knows a visitatie model that is as extensive (covering all medical specialties) and as well embedded in national health care policy making as the Dutch visitatie program. The visitatie model has also acquired international interest in the context of ‘revalidation’ of medical doctors and in the ongoing discussion on external peer review models used for the evaluation of (European) health services.

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

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 intervention ‘Quality Consultation’ increase the implementation of visitatie recommendations?

Visitatie is not merely a technical exercise. As was explored in this thesis, it has implications for the professionalism of medical doctors, for their concept of quality, for the organization of their practices and for the allocation of health resources. In this thesis, visitatie of medical specialists 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’. Visitatie can be portrayed as a model for external peer assessment since peers from outside the surveyed practice (hospital) conduct the review.

Crucial to visitatie is its professional ownership. This means that the developers, as well as the managers and the clientele of the program are the medical specialists. As described in chapter 1, visitatie stresses ‘the circumstances under which clinical practice takes place’, in this thesis referred to as ‘practice management’ or ‘practice organization’.

In 1989, the Dutch specialty society of surgeons carried out the first visitatie of a non-teaching practice. Today, several hundred visitaties are conducted yearly by all the specialty societies combined. Chapter 2 examines the introduction and dissemination of visitatie amongst Dutch medical specialists in the period 1985-2000. It describes how visitatie has been used in the political process between medical specialists and the state, serving as a strategy in protecting the professional 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 and the introduction of the market oriented policies, 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 profession. Once the first visitatie experiences were being communicated by the specialty society of surgeons, other societies soon followed in developing and implementing their own visitatie programs. The introduction was fuelled by factors such as health care’s interest in quality management in general, the availability of a quality assurance infrastructure within the specialty societies, the loss of the dominant position of the National Specialist Association (LSV) as the ‘voice of the medical specialistic community’ and the familiarity with and design of visitatie as a professional quality assurance instrument. For many stakeholders, visitatie was perceived to offer a conclusive reaction to the quest for self-regulation. Visitatie seems to reconfirm the public’s trust in the self-regulating mechanism of the profession.

Chapter 3 explores the legal context and aspects of visitatie. Legally, Dutch professionals base their actions on various health laws, such as the Care Institutions Quality Act (Kwaliteitswet Zorginstellingen), the Individual Health Care Professions Act (Wet BIG) and the Medical Treatment Contracts Act (WGBO). These laws prescribe health care providers to ensure the quality of patient care. Characteristic of visitatie is that it functions within the frame and context of self-regulation: 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. 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. Before individual sanctions can be applied it must be established that shortcomings can be unambiguously ascribed to the individual professional. Principally, one might duck out of the self-regulating regime by leaving the society, which shows the weakness of self-regulation. However, this ‘escape’ has been superseded by a higher legal institution: the Central College for licensure and registration of medical specialists requires specialists, under penalty of exclusion of the register of specialists, to participate in the visitatie program of one’s specialty society. This makes the reliability of the visitaties, the possibility for an appeal and the (public) disclosure of visitatie results relevant issues, which have been discussed in chapter 3.

Chapter 4 illustrates how the results of the visitatie program of the Dutch Society of Obstetrics and Gynaecology (NVOG) may contribute to the improvement of the quality of obstetrical and gynecological care. The argument of this chapter is that in order to realize actual breakthroughs in the enhancement of quality, new approaches, based on new knowledge, is necessary. The potential of the application of improvement knowledge has been demonstrated, using the quantitative data of eighteen visitaties conducted by the NVOG. Comparison of the visitatie results show great variation in practice management. For example, the proportion of abdominal versus vaginal hysterectomies varied greatly: at one clinic, 33%, whereas at another, 99% of all hysterectomies were carried out abdominally. The differences may be partly explained by differences in the composition of the patient population, but it is more likely that the cause is a different practice management. Policy differences offer partnerships opportunities for reflection and perhaps also starting points for improvement. Does the indication perhaps need to be revised? Are
all members of the specialist group sufficiently trained in both techniques? Are the necessary facilities available and how important is the gynaecologist's preference in the policy choice between performing abdominal or vaginal hysterectomies? What is said about hysterectomies is also applicable to other data that were collected within the framework of the NVOG visitatie program. Comparisons among practices may be able to chart the current differences in cooperation and, possibly, voids within Dutch gynaecology partnerships. After analysis of the possible special causes, the comparisons may lead to less undesired variation in practice management.

Chapter 5 presents an analysis of the visitatie recommendations, as the measurable outcome of the visitatie process, as well as the attitude of medical specialists towards visitatie and towards the practice-specific recommendations.

To analyse the recommendations for improvement, we constructed a comprehensive Professional Medical Practice scheme which describes the various components of a professional medical practice in five main categories and 32 aspects. Then, 464 recommendations, drawn from 50 visitatie reports of surgery (15), gynaecology (16) and pediatric (19) specialist groups, were classified according to this scheme by three reviewers (Cohen's kappa > 0.8). The results show that the current bottlenecks in medical practice management lie in the 'functioning of the specialist group' (33% of all recommendations), in 'management of care processes' (30%), in the hospital context (25%) and in specific quality assurance/improvement issues (8%).

For measuring the attitudes of medical specialists towards visitatie and towards the practice-specific recommendations, two attitudinal scales have been developed. Both scales were validated and found to be reliable. Medical specialists' attitudes were measured by postal survey. We invited 52 specialist groups of gynaecologists, pediatricians and surgeons. All but two agreed to participate. All these groups had been mandatorily surveyed by their respective specialty societies in the period September 1998 to November 1999. In the period March 1999 to September 2000 a total of 205 questionnaires was sent to the participating medical specialists. The overall response rate was 82%. Respondents express a very positive attitude towards the existence of visitatie as a quality management activity, they are positive about the way their speciality society is organizing and executing the visitaties, and, although generally positive, they show less welcoming attitudes towards the expected added value of visitatie for their own practice or the profession. No significant difference was observed between the three specialties. With regards to the recommendations for improvement, 86% of the medical specialists understands the practice-specific recommendation, 68% recognizes it and 61% also agrees with the recommendation. A majority of the respondents says to be willing (82%) and motivated (80%) to implement the recommendation, and 70% has the explicit intention to do so. Time, resources, lack of 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 to visitatie correlated modestly with a more positive attitude to the recommendations. Medical specialists' positive attitudes towards visitatie hold promise for the implementation of the recommendations for improvement. In order to achieve improvements tailor made implementation strategies need to be offered.
Although positive implementation results have been reported by specialty societies, implementation of the visitatie recommendations is not self-evident. Therefore the specialty societies of surgeons, gynaecologists and pediatricians developed an intervention strategy to improve implementation of these recommendations. Chapter 6 offers a descriptive evaluation of this intervention, called Quality Consultation (QC). QC is a site-specific multifaceted implementation approach. To support implementation of one or more visitatie recommendations, 31 specialist groups of surgeons (12), gynaecologists (9) and pediatricians (10) were offered approximately twenty hours of management consulting. All recommendations were eligible for support. The QC toolkit consisted of various management and quality improvement support methods. Which interventions were applied depended on the recommendations to be implemented and was determined by the specialist group and the consultant. Participation in the QC project was voluntary and without cost for the specialist groups. The main measures of the process evaluation of the QC strategy were the choice of recommendations supported; the type of interventions offered; the degree of implementation; the appreciation of implementation result and process; and the impact of management consultants as assessed by participants. Data were collected through participatory observation, telephone interviews, and a postal survey. The results show a high level of participation (25 out of 31 specialist groups) and a positive evaluation of the consultants and the impact of their support. Most implementation projects were related to strategic issues or the functioning of the specialist group. Every specialist group was offered multiple interventions, both participatory and non-participatory. The degree of implementation was rated 4.0 on a 5-point scale; the scores for the implementation result and process were 6.6 on a 10-point scale.

Chapter 7 evaluates the effect of the QC intervention in terms of the implementation of visitatie recommendations and explores the factors obstructing implementation. Of all the specialist groups of surgeons, gynaecologists and pediatricians who were mandatorily surveyed by their respective specialty societies in the period September 1998 to November 1999, the first 58 were invited to participate in the study. The specialist groups were randomly allocated to an intervention and a non-intervention group. The intervention group was formed by 31 specialist groups who were offered the QC intervention. 25 specialist groups (10 pediatric, 8 ob/gyn and 7 surgery) agreed to participate. The other 27 specialist groups are referred to as the non-intervention group. All but two of these specialist groups (one surgery, one pediatric) were willing to participate. To determine the implementation results a postal survey was undertaken. In the period February 2000 to June 2001 a total of 205 questionnaires were sent to the participating medical specialists. The overall response rate was 54%; 60% for the respondents in the intervention group and 47% for the non-intervention group. The self-reported results show that the specialist groups supported by the management consultants were significantly (t-test p=0.0002) more successful in partially or fully implementing the visitatie recommendations than their colleagues working in non-supported practices; 66.1% versus 53.8%. This positive effect on the implementation degree has been reported by surgery and pediatric specialist groups. The implementation result and process were rated significantly higher for all the supported groups.

A set of fourteen factors obstructing implementation of visitatie recommendations was identified, including factors such as support, time and resources available; implementation
skills and knowledge; personal views and past implementation experiences; self-efficacy; and, opinions on the practice-specific recommendations. The supported groups report to experience significantly less (p<0.005) barriers in implementation. The experienced obstructing factors are strongly related with the degree of implementation, the assessment of the implementation results and the process. The impact of QC on the implementation of visitatie recommendations may be partly explained through its moderating effect on the set of obstructing factors. 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’.

Given the study design, no final conclusions can be drawn on the effectiveness of management consultancy for implementation tasks. However, this study suggests that QC is a powerful strategy in implementing visitatie recommendations. The exact workings of the integrated approach remain unclear. Future 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.