

10. Quality in Family Practice

Rajakumar MK. Quality in family practice. Asia Pacific Family Medicine. 2002;1(2&3):74-8.

Opening Keynote Address. 12th WONCA Asia Pacific Regional Conference, Monday, 1 April 2002, Kuala Lumpur

Abstract

Quality programs are difficult to implement where social support for healthcare costs are inadequate and there is no institutional support for quality programs to guide and assist the doctor in practice. 'Quality' is not the good intention to do better, but the process of measurement of behavioral change against set targets. For the majority of the doctors of this region who practice under great constraints, this article outlines some quality activities that are entirely within their personal initiative and responsibility, but should make a real difference to the quality of care provided.

Key words: family practice, guidelines, professionalism, quality.

Our region encompasses over one-half of the world's population. We have representatives from countries where impoverished doctors in rural practice in poor communities have no access to continuing medical education or to medical journals, who are even short of writing paper and paracetamol. Doctors from developed countries and cities of developing countries in the region however can use the latest drugs and equipment in their practices. The gap in quality assurance in healthcare is even wider.

There are many obstacles to organizing quality assurance although we have been very fortunate with Malaysia as it is moving rapidly towards computerization in all fields. Our health services, which are rigidly divided into public and private

sectors, have ongoing programs in the Ministry of Health for paperless health centers and hospitals. This means that electronic monitoring of performance data becomes possible. Unfortunately, the situation in general practice is bleak, with general practitioners struggling to survive in a highly commercialized environment that is dominated by for-profit hospitals.

The Idea of Quality

Our profession has an ancient commitment to quality, meaning we pledged to do our best for our patients. We require of ourselves to make our patient's interests paramount. In this sense, the pursuit of quality is a virtue and part of our ethical commitment to professionalism.

Our traditional commitment to quality is shown in our struggle to preserve standards of entry into our profession, in our scrutiny of the appropriateness of training for a specialty, and in our obsession with continuing education. These have been our collective preoccupations, expressed through the leadership of our specialty societies. In this traditional expression of concern with standards, the medical profession has been a model for other professions and an example to society.

Our newer concerns with quality are related to measuring performance, and driven by the example of industry. In recent decades, industry has come to see 'quality' as good for business. Industry provides examples that range from strict conformity to specifications of manufactured goods, to the concept of 'zero error' in the cockpit of an airplane. In medical practice, it still comes down to fulfilling our ancient ethical commitment to provide the best possible care to our patients, but we also have to satisfy the community that we can demonstrate by measurements that we are doing well. Donabedian, who pioneered thinking about quality¹:

1 Structure, in the context of health, refers to the characteristics of the healthcare setting. For most of us, there are serious economic and political constraints to making changes in the structure of practice. In developed economics with established third party payers for the provision of healthcare services, compensation for professional services incorporate an element for the maintenance

of a certain quality of structures. However, most of this region is at, what I call the pre-National Health Service (NHS UK) state of practice.

2 Process is what we actually do for patients. It is mainly the personal responsibility of the providers of healthcare. At the center of the processes of caring is the doctor–nurse dyad, and their close collaboration with the whole team is the key to improving quality in the processes of care.

3 Outcomes are the ultimate justification for the efforts and resources expended on quality. We promise better outcomes in the form of delayed death and less disability, as well as greater patient satisfaction and improved quality of life. Objective evaluation of improvements in the incidence of death and disability are research projects that are underpinned by exacting statistical tests. Research is therefore not merely desirable, but essential for making choices in healthcare. In normal practice, we have to be content with surrogate measures or intermediate outcomes that are related to ultimate health outcomes, such as exercise, the use of seat belts, ideal weights, alcohol and tobacco consumption, lipids, HbA_{1c}, and so on.

The Four Aspects of Quality

The four aspects of quality of performance in healthcare that lend to measurement and objective evaluation that all stakeholders subscribe to albeit with conflicting priorities are:

- **Effectiveness** is whether an intervention works in practice, improving outcomes, or providing relief, in a measurable way.
- **Efficiency** refers to the use of resources, or the most economical way to achieve better outcomes, or the best practical option to achieve the best outcomes for a fixed investment.
- **Patient satisfaction** is essentially subjective, but we do know what elements of care are the most important causes of unhappiness, and can attend to these areas in measurable ways, for example, communication, and waiting time. Individually and collectively, people want kindness and competence, fairness and equity.
- **Community interests** cover not only public satisfaction with the health services, but also the choices in health policy and health investment that favor the wishes of the community for equity and responsiveness to needs. These are political decisions, and the doctor as a citizen has a role and

obligation to influence public opinion, and to help shape health policy. There is tension between efficiency, effectiveness, and patient satisfaction, and the doctor must not stand apart from the debate to make difficult choices.

Quality in Practice

The stakeholders in healthcare – the individual patient, the doctor, the agency of the State to fund healthcare and the community – have different perspectives and different agendas about what constitute improvements in quality. The patient and family want the best possible care delivered swiftly to their satisfaction, by competent and compassionate carers. The doctor has a legitimate interest in personal income, but the doctor also feels passionately regarding professional autonomy to provide the most effective treatment to a particular patient in need of care, irrespective of costs to the health system as a whole. The third party payer, as with the NHS of the UK, wants to ensure that limited funds are used efficiently to achieve best outcomes and community satisfaction. The voice of the community in a democracy is articulated by their elected representatives, but also through the media where the loudest sectional interests may prevail.

For the commercial stakeholders, the paramount obligation is to the shareholder. Managers are under intense pressure to maximize profits out of the business of healthcare, through reductions in the ‘loss ratio’ – the amount spent on care, that is, drugs and services – within the limits of contractual obligations and legal liability. I do not believe that there is enough money in healthcare funding to pay dividends and business managers, without affecting the quality of care.

These are difficult and dangerous waters for the doctor to negotiate, more so if leadership and initiative in quality passes to the hands of bureaucrats or businessmen. This is already happening in most countries, and that is our own fault failure of leadership in our profession. We have to demonstrate to the community that we are totally committed to providing the best quality of care; that our position on the hard choices we have to make in healthcare will invariably be in their best interests, not just ours, and that we are their partners in winning resources for better and more equitable healthcare.

The practicing doctor must take moral ownership of the movement for better quality. We must regard quality in practice as inherent in our professionalism. Quality must be internalized into normal practice, not externally imposed by yet another group of watchdogs. Our specialty societies should be the ones to establish agencies to institute quality assurance, and to evaluate and monitor the quality of care that is delivered to our patients. We have to be tough on ourselves. Our Colleges and Academies have to win the confidence of the community and of government. I am aware that in many developed countries this role has been foreclosed by new agencies, because of the slowness of the medical leadership to respond positively to changing circumstances. The backwardness in development of some parts of this region could be an advantage as policies are not yet set in stone, and the profession still has a chance to show that the task of ensuring quality in care is best delegated to the professions of medicine. There is a vast difference between a personal quest for quality, and the mechanical filling in of forms to meet the requirements of some nuisance agency.

I must reiterate that when we speak of quality, we are measuring our performance, individually and collectively, to see how far we have met targets that are already set. It is never ending. The aim of our endeavors is to provide better care for our patients, and only secondarily to meet the requirement of some bureaucrat or businessmen. We seek to find ways to improve our work, not primarily to find fault, or to identify underperformers, or 'bad apples'.

A personal Commitment to Quality

They say in industry that quality comes free, meaning that investment in quality is more than returned by the profits and savings from having a superior product. There is truth in that, but I know that many general practitioners struggling on low incomes will grudge any diversion of their time or income. How do we make a beginning?

There are several ways of implementing performance assessment for quality:

- **Review** your own practice, by yourself
- **Practice review** by colleagues and staff of a practice
- **Peer review** by trusted and respected colleagues
- **Institutional review** organized by your College/Academy
- **Agency review** required by contract

I should like to reserve the word ‘audit’ for the mechanisms of investigation when something goes seriously wrong, thus it is not used here.

Think in terms of the ‘triple components of medical quality’ in a never ending cycle:

- **Objectives** in quality
- **Targets** for improvements
- **Evaluating** results

I propose a very limited personal program to improve the quality of the care we provide. This approach, I hope, would be relevant to most doctors in our region, who have little resources to spare, and no access to institutional help to guide and assist them, and to monitor their progress.

Making a Beginning

I propose you make a beginning in just four areas. This is an exercise in raising awareness. In each area, I propose an objective, and just two targets for performance towards achieving that objective. The targets, to which you will have to set numerical values, must be seen as an integral part of the definition of the objective:

- Medical records
- Reception and communication
- Prevention
- Management of health problems

Medical Records

Objective: To have a common database for all patients and a problem list for every patient.

Targets: To be able to analyze your practice population by age, sex, and age groups. To know the total numbers for a specific diagnosis in your practice, for example, upper respiratory tract infection (URTI), asthma, hypertension, diabetes, ischemic heart disease.

Comment: If your practice is mostly URTI, then is it because your patients do not believe you are the appropriate doctor for more serious problems, or because

of costs. Another possibility is that you send most patients with chronic diseases to the hospital because you do not feel competent to manage them?

Bear in mind that sooner or later, whoever is paying your fees or salary will want to consider if URTI and some aspects of chronic care could be managed by less expensively trained staff. Therefore, do you need to learn to be more expert in managing more serious diseases?

Objective: To have a disease-specific database for major chronic illness, for example, asthma, hypertension, diabetes, ischemic heart disease.

Targets: To know the relevant history and risk factors that will determine your management plans. To be able to review treatment of co-morbidities in the light of estimated risks of complications.

Comment: These diseases are the principal causes of disability and death. Good medical care can make a vital difference, so consider, how much difference does your practice makes to outcomes in these health problems? Co-morbidities multiply risk of complications; do your records allow you to be aware of multiple risk factors in each patient?

Reception and Communication

Objectives: To ensure that the patient and accompanying persons leave your practice pleased and contented that they have received courteous and attentive service, and all questions in their mind have been answered.

Comment: To shorten waiting time before the consultation and to increase speaking time for the patient.

Thought: Do you know how long the wait to see you, and is it a source of irritation or distress? How much of consultation time is taken up by your talking? When you conclude the consultation, does the patient still have unanswered questions? Have you asked?

Prevention

Objective: To emphasize the preventive approach in your practice, and turn every consultation into an opportunity to practice prevention.

Targets: To identify in their problem lists, those patients with high-risk behavior, such as excess alcohol and tobacco consumption, drug abuse, overeating and inactivity.

Comment: Have you an approach to diagnosing alcoholism? How would you counsel a patient about tobacco cessation? Do you know the national guidelines on immunization? What proportion of women above 45 years age in your practice have you counseled about Papanicolaou smears and breast cancer?

Management of Health Problems

Objective: To plan treatment based on the best scientific evidence, and be able to assess if treatment is producing results.

Targets: To follow guidelines for the management of asthma, hypertension, diabetes, and coronary heart disease. To share with your patient knowledge of the benefits you expect from treatment, and together assess progress at each consultation.

Comment: Are you able to evaluate the evidence for the ‘best’ treatment for a disease, or do you know how to choose between guidelines? How would you diagnose diabetes or hypertension, and what measurements would you make at each consultation? What do you tell your patients about how they can improve their health prospects?

As I said, this is an exercise in creating awareness. When you become aware, then you can set numerical targets against which you can measure performance. At the end of each year, you are able to measure your progress. Find like-minded colleagues to share your experience and exchange ideas, and form a study group. Your group can lead your College or Academy in the pursuit of quality in care. I admit that having to say all this shows how far most of us have to travel to make a beginning in measuring quality.

A Word about Guidelines

Evaluating scientific evidence requires statistical skills, but there are countless guidelines that have gone through that process that you can choose from (see recommended websites for guidelines). Beware of guidelines where the ‘experts’ do not reveal conflicts of interest, or are actually funded by the manufacturers of a particular drug. If you trust the source of the guidelines, or they have been endorsed by one of our Colleges or Academies then you should be safe. You still have to adapt general recommendations to the specific needs of your patient.

There are no ‘gold standards’ in medical treatment, no fixed set of specifications to apply to a particular diagnosis. Each patient is unique, for age and sex, personal habits and cultural practices, by environment and by genetic inheritance. Take the example of simple diagnosis of obesity, and consider the effect of co-morbidities on management options, by no means uncommon presentations in practice:

- Obesity
- Obesity with mild hypertension
- Obesity with moderate or severe hypertension
- Obesity with hypertension and diabetes
- Obesity with hypertension, diabetes and osteoarthritis
- Obesity with hypertension, diabetes, osteoarthritis and asthma

You can see that we are dealing with complexity that borders on chaos.

A Word to Colleges and Academies Yet to Make a Beginning

Quality is inseparable from training, and is the most important justification for the existence of Colleges and Academies. No third party payer will give money without knowing what they are getting for their money, so we might as well be prepared. I offer an approach we have used in the Malaysian Academy, where we too are struggling to make a beginning. We offered a negotiated ‘Learning Contract’ to members, comprising two linked parts:

1. **A continuing education program**, to help you update and improve your knowledge and skills
2. **A quality assurance program**, to help you apply your knowledge and skills to achieve better outcomes and greater patient satisfaction.

I believe that this friendly, helpful and unthreatening approach is a good way to make a start.

Conclusion

I would like to conclude with a note on how to have contented patients. Patient satisfaction is the outcome of good quality in practice. There are countless events

and images that impinge on the patient's consciousness in an encounter, but it ultimately comes down to trust and confidence. The patient and family must feel that they can trust you to do your very best, and they need to have *confidence in your ability to do so*, in your professional competence to provide the best care.

Commitment to quality, obviously demonstrated by your practice, goes a long way towards winning trust and confidence.

References

1. Donabedian A. Evaluating the quality of medical care. *Milbank Memorial Fund Q.* 1996;**44**:166-06.