Maintaining professional standards

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Providing quality care to patients is not easy. Times change and patient management changes. The best treatment for a patient today is usually not the same as the best treatment was 10 years ago. New drugs are developed, old treatments are found to cause more harm than good when combined with newer medicines, and lifestyle changes become more important in the overall management of the patient. What are the implications of these rapid changes for the practitioner working directly with the patient in the community, and what is the responsibility of the individual physician, the professional bodies and the government in the maintenance of quality care?

Many organisations and countries have worked to ensure standards and quality of care to patients. I am not knowledgeable about the details of all these efforts so will base my initial remarks on some of the activities in Ontario in Canada, a system I know quite well. My comments should be relevant to many other systems and places, and each reader can substitute their own experience.

In the modern era in North America, the earliest auditing of medical care occurred in Boston in the early 1900s. These early programmes were very controversial and were not extensive. Over the past several decades, in many parts of the world, efforts have been made to make the maintenance of standards of care more formalised.

Professor Earl Dunn graduated from McGill University in 1960. He then did a general practice residency in the USA. After that he spent five years in a rural practice in Canada before spending 28 years full-time at the University of Toronto. He joined the FMHS in 1995. One of his research interests has been in CME and changing physicians' practice. He was involved with the Physician Enhancement Programme in Ontario (a programme for assessing physicians and remediation) for a number of years.

In Canada, several provinces have introduced programmes for physician assessment and enhancement.[1]

The system in Ontario

In Ontario the requirement of a specific number of hours of study credits per year for general/family physicians has been an expectation for more than 40 years. More recently the Ontario system has become quite extensive and comprehensive. Currently there are several overlapping programmes. All physicians (except for grand-fathered physicians) must be certified by either the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada. These organisations have specific requirements for maintaining membership that include study credits, practice self-audits and other activities. Programmes for study credits are monitored for quality and relevance. In addition, the College of Physicians and Surgeons of Ontario, the registration and licensing body, has a programme of peer assessment which is mostly based on audits of randomly selected practices, although elderly practising physicians are routinely selected for audit (on a non-random basis). This assessment includes the physician response to a questionnaire and an in-office assessment by a peer evaluator. Physicians are graded as to their quality of care and receive feedback as to their practice compared to peers. A very small number of physicians who are rated very low on the peer assessment programme or who are identified by other mechanisms, such as complaints, are required to undergo a planned programme to upgrade their skills and they are then reassessed.

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What have been some of the results of the Ontario peer assessment programme?

First, more than 90% of physicians are performing at an adequate level to provide acceptable and safe care to their patients with only minimal changes in their practices or skills. A number of factors were found to

be related to quality care.[2] These included age, sex, certification, and practice location. Younger physicians, female physicians, certificants of the College of Family Physicians of Canada and urban physicians had, on average, higher grades. Re-assessment of physicians after more than 10 years showed that 64% declined in grade, 32% stayed the same and only 4% increased in grade.[3] The small number of physicians with the lowest grades had specific counselling and were provided with recommendations for an organised CME programme. In contrast to most physicians, more than 75% of these physicians improved[4] with performances 10 years later, better than a matched group of physicians. Nonetheless a very small group of dyscompetent physicians remain and remediation of these physicians is very difficult.[5]

What is the current range of methods used internationally for the maintenance of competency?

Most of them can be classified under one of six general areas: the measurement of minimal standards of competency and safety for registration; required CME activities of varying types and amount; self-audits; voluntary external audits, mandatory external audits and recertification.[6] Each of these contributes to a different aspect of the problem and they are not mutually exclusive. For example, in Ontario, all of these modalities are used in different circumstances.

Let me consider each one of these in turn and give my opinion of their benefits and their problems.

Registration

Registration with a licensing body is essential for new practitioners to any medical jurisdiction. When done properly this helps to ensure the minimal quality and safety of the new physician and can aid in appropriate allocation and use of resources. It is not perfect but most jurisdictions have a reasonable system which works most of the time. Remember, registration usually only ensures minimal standards and safety and not ideal care.

Required CME

There has been a great deal of experience with required CME in many parts of the world. There are several problems with this as a sole method to maintain competence. First, physicians have a tendency to attend CME activities in areas they are already competent in and to shy away from those areas where they need more knowledge and skills. Second, there has been no good evidence that CME by itself changes physician practices in any way. Traditional CME can increase knowledge but appears to have less effect on practice and little or no effect on patient outcomes.[7]

Self-audits

Self audits are used frequently in maintenance of competence programmes. These can be voluntary or mandatory. They have the advantage that the physician usually chooses his own topic to audit and thus will have more interest to complete the cycle and make changes. This method has the disadvantages that many topics are not conducive to audit and that the physician can ignore, either consciously or unconsciously, his own areas of weakness. As one component of a programme to maintain knowledge and skills, self audits can be a very useful method for the physician or practice to look at the practice and to find better ways to do things for the benefit of the patients.

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External audits

External audits, both voluntary and mandatory, are useful. They give a broader picture of the practice and activities in the practice and, combined with appropriate feedback, can be a good tool to help maintain quality care over time. It has a major problem in that practice audits are very expensive and there can be concerns as to who bears the costs and how this is done. In addition, many physicians have concerns in allowing their peers to have access to their practice and their patient records so this can be accomplished. Once the audit has been completed there is no easy way to turn the results of the audit into an educational prescription so that the physician can deal with the specific areas of need that have been identified.

Recertification

Recertification has now become more popular as a method of ensuring competent and safe practice. This can and is being done in many different ways. Frequently the methods are driven more by financial considerations rather than good educational and quality assurance principles. Recertification, like registration, is usually more concerned with minimal standards and safety than with quality care.

Working towards better quality care

Recently, many jurisdictions have extended the CME requirements to include varied formats. As yet there is no evidence this makes much difference, although there is some evidence that interactive CME with participants actively involved can effect changes in practice and, on occasion, can effect health care outcomes.[8] Bennett et al[9] have described, for a North American audience, a staged action plan to enhance and improve the effectiveness of CME activities within organisations associated with the AAMC (Association of American Medical Colleges). Most of their seven steps in their suggested action plan can be adapted and applied in other environments.

After being engaged in this process for more than 30 years as a researcher, as an assessor and as one who has volunteered and who has had

to undergo varying mandatory forms of assessment, what do I think of all these various activities? First, it must be done fairly and properly – it should be an educational activity and not a punitive process. Second, to do it properly costs money, often a lot of money – is it worth the price and who pays for it? Third, although we have learned a lot, we still do not know how to effectively and efficiently maintain quality physician care over time and how to assess whether it is occurring. We must be very careful that in our desire, and sometimes obsession, to maintain standards we do not smother creativity and good practice that is not in the centre of mainstream practice. All advances in patient care start as practices outside of the mainstream of usual practice. We must not discourage a flexible and creative approach to patients and patient care.

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In spite of my many reservations, I firmly believe that, in this day of rapidly changing and expanding medical practice, we must find effective ways to maintain physician competence and safety and we must effectively and efficiently apply methods to ensure this occurs. In this context 'we' means the individual physician, the professional bodies and government agencies. All must work for better care for the population and for the individual patient. Many challenges still exist – especially those related to the effective methods to maintain practice skills and how to turn audit activities into better quality care.

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