

UEMO 2000/174

UEMO WORKING GROUP ON QUALITY ASSURANCE

9.30-11.00, 13 October 2000

Zurich Marriott Hotel, Zurich, Switzerland

CHAIRMAN: Dr. Mateja Bulc (Slovenia)

RAPPORTEUR: Dr. John Chisholm (U.K.)

MINUTES

Present: Mateja Bulc (chairman, Slovenia), John Chisholm (rapporteur, United Kingdom), Carla Archini (Italy), Michael Braun (Austria), Isabel Chaves (Portugal), Ben Duncan (United Kingdom), Alix Fiorletta (France), Lynda Hamilton (Ireland), Tony Hynes (Ireland), Steinunn Jonsdottir (Iceland), Antoon Malfliet (Belgium), Raffaella Michieli, (Italy), Fatima Oliveira (Portugal), Hartmut Seifert (Switzerland), Ole Svendsen (Denmark)

1 Minutes of last meeting, 25 May 2000 (agenda item 1)

Received: Minutes of Quality Assurance Working Group, 25.5.2000 (UEMO 00/089)

The minutes of the last meeting were received. There were no matters arising not otherwise considered on the agenda. John Chisholm gave a brief summary of the last meeting. Six responses to the diabetes questionnaire had been received. There had been an extensive discussion about the nature of quality assurance. It had been agreed that a new UEMO statement on quality assurance should be prepared, either prior to or at the Zurich meeting, to replace that adopted in Helsinki in May 1994.

2 New definition of quality in general practice: proposal for the a new UEMO document (agenda item 2)

Received: The UEMO statement on quality issue in General Practice (UEMO 2000/147)

Introduction

The document prepared by Mateja Bulc (Slovenia) was circulated to those members of the Working Group who had not received it in advance of the meeting.

Mateja Bulc (Slovenia) said that a new statement was needed in response to the new perspectives in European general practice. She suggested a new definition of quality in general practice: good medical practice nowadays means efficient use of effective health care procedures in individual patients in specific situations. She believed that in order to be efficient and effective, GPs had to base their decisions and actions on the best available evidence. Practising evidence-based medicine required the integration of individual clinical expertise with the best available external clinical evidence from systematic research.

She identified a number of ways to achieve good general practice. Solid basic medical education had to be followed by mandatory specific training, planned by general practitioners, more than half of which should be delivered in a general practice setting, and by continuing medical education. Quality assurance instruments and the establishment of groups in general practice, research, teaching, the sensible distribution of health care resources and incentives for good practice were all required.

General discussion

Antoon Malfliet (Belgium) said that GPs gave medicine a human face and approach. There was a risk that GPs would in future be replaced by computers. Evidence-based medicine also had dangers. The conduct of research was skewed by the availability of funding. Mateja Bulc (Slovenia) said that it was important that GPs knew how to assess evidence.

Raffaella Michieli (Italy) saw value in having a document about quality assurance that each country could follow. Italy was not the only European country where communal quality assurance activity was lacking. Lynda Hamilton (Ireland) saw value in incentives for quality assurance, but also dangers if the wrong incentives were used. Tony Hynes (Ireland) did not wish to see standards set that could be used to disadvantage GPs, who might be called to account or even sued by solicitors for their failure to achieve standards through no fault of their own.

Isabel Chaves (Portugal) said that in Portugal, a recent external evaluation of the primary care service had revealed wide variations in standards. She said that some doctors defined their own standards and quality and evaluated the service they provided, and she saw value in general guidelines and standards. However, the state had already set some standards, and state access to data carried some dangers.

Antoon Malfliet (Belgium) said that there were incentives for continuing medical education and for peer review in Belgium. Doctors would no longer be able to practise if they saw less than five patients a day, whatever the quality of the service they delivered. He emphasised that the best judge of a doctor's quality was the patient. Free choice of doctor was vital. Michael Braun (Austria) said that Austrian GPs had been given an award by a consumer organisation for the quality of their

excellent, consumer-friendly services. He surmised that GPs in other countries might be held in similarly high regard by consumer organisations. Steinunn Jonsdottir (Iceland) said that in her country, however, a survey of patient satisfaction in Reykjavik had revealed greater dissatisfaction with access than had been the case five years ago. She wondered whether this had resulted from the change three years ago from an item-of-service payment system to a fixed salary for GPs. She believed that primary care needed more doctors and more resources.

Raffaella Michieli (Italy) said that patients were more and more demanding. Doctors no longer had the time to eat or to go home during the day. Satisfying patient demand was a real problem. Patients often made misguided assessments of the quality of doctors. Lynda Hamilton (Ireland) said that Irish women perceived breast cancer as their biggest health problem, whereas in reality they were more at risk from lung cancer and cardiovascular disease. Michael Braun (Austria) also warned against patient satisfaction as the sole measure of quality.

Hartmut Seifert (Switzerland) felt that both patients' views and peer review were important. Ole Svendsen (Denmark) said that quality assurance reflected a number of perspectives. Doctors valued high quality basic, specific and continuing training, good practice and attitudes to patients. Politicians concentrated on resource use and on the identification of underperforming doctors. Patients had their own perspectives on quality. Decisions were required about the aspects of quality that would feature in a UEMO statement.

Michael Braun (Austria) linked protocols to audit, and Raffaella Michieli (Italy) saw virtue in evidence-based guidelines. However, Michael Braun (Austria) felt that guidelines were often specific to the health care system of particular countries. UEMO statements had to be usable in all European countries. Antoon Malfliet (Belgium) felt that guidelines were dubious, dangerous, and often defined by remote committees. Tony Hynes (Ireland) believed that whilst guidelines might be necessary or advisable, they should not be compulsory.

Steinunn Jonsdottir (Iceland) described the Icelandic development of locally appropriate but evidence-based guidelines by joint working between a GP medical director and groups of GPs and specialists.

Antoon Malfliet (Belgium) wished to see any UEMO statement incorporating moral standards, as these differentiated GPs from computers.

Lynda Hamilton (Ireland) said that quality of care was influenced by GPs' investment in buildings, staff and staff training. Inevitably, small rural practices were disadvantaged. John Chisholm (United Kingdom) agreed that performance could be adversely affected by factors outside a doctor's control – environment, resources and the level of investment in practice infrastructure. Doctors should not be wrongly and inappropriately blamed for poor performance in those circumstances.

The way forward

Ole Svendsen (Denmark) said that UEMO should join with the European Society of General Practice/Family Medicine in making a joint statement on quality assurance. Mateja Bulc replied that she had been trying to work on a joint paper with Frede Olesen and Chris van Weel since the joint conference in Florence.

John Chisholm (United Kingdom) felt that Mateja Bulc's excellent paper provided a justification for the need to revise the 1994 UEMO statement on quality assurance. He agreed with Ole Svendsen (Denmark) that UEMO should work with the ESGP/FM. He suggested that Mateja Bulc, Frede Olesen and Chris van Weel should produce a first draft of a new statement, possibly in liaison with Philip Evans also, which should be circulated to the Working Group by e-mail, revised in further drafts, and presented to the next meeting of the Working Group prior to its approval by the next Plenum.

John Chisholm (United Kingdom) also saw a new UEMO statement as having a primarily political purpose. It was to be used at a European level and in member states to argue for service developments and resources. It should not be too clinical or specific.

Mateja Bulc (Slovenia) agreed to contact the academic general practice bodies in Europe, to draft a statement and to circulate it for prompt comment. She hoped that it would be possible for the Plenum to adopt a new statement at the next UEMO meeting.

**3 Any other business
(agenda item 3)**

There was no other business.

John Chisholm
14.10.2000