Providing for the Providers

By Penny M. Davis, DCH, DObstRCOG

In an ideal world there would be no question that physicians in training and practice would provide perfect up-to-the-minute evidence-based health care to all patients, regardless of geography, wealth, or status. Public pressure, and the licensing body's response to public pressure in Canada and abroad, have demonstrated this is not reality in too many cases.

Providers of continuing medical education (CME) and professional development have often taken the attitude that "If you build it, they will come." Because of the traditional structure of planning committees, CME departments rely heavily on the involvement of physicians who already have commitment to lifelong practice improvement, and, as an essential prerequisite to this, to lifelong critical assessment of their own performance. As a result, a large area of physicians' needs may have been overlooked. This is the need for self-assessment tools, and the ability to compare one's own performance to accepted best practice. It would be a tremendous achievement of medical training if all graduates emerged into the light of practice with commitment to this kind of self improvement. It would be even more wonderful if all practicing physicians had the skills, time, and conviction to self-assess and self-enhance.

Since the Aylmer series of conferences began, almost all provincial jurisdictions have developed programs to assess physician performance. It is an unfortunate indictment of traditional CME programs that almost all of them originated from provincial licensing bodies, with highly variable input from other professional organizations, and from educational organizations, such as CME departments. The thrust of most of the early assessment programs was toward detection of poor physician performance before potential escalation into malpractice and significant patient harm.

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Editorial

Reports from *The Altantic Provinces Peer Review, The Alberta Physicians Achievement Review,* and *The Saskatchewan Practice Enhancement Programme* (PEP) have all provided excellent pointers to best practice, but there is still a bias against compulsory review as a catalyst of genuine practice change. Certainly, meaningful change is unlikely to take place without internalization of assessment findings, but to reject the process of peer assessment out of hand does eject the baby with the bathwater. *The Atlantic Provinces Medical Peer Review* pointed out in the '90s that physicians were more likely to be at risk for poor performance on a review if they were solo practitioners without hospital privileges, and over 50. *The Alberta Physician Achievement Review* has identified exceptionally good practice markers.[1] Examples of such markers are adherence to practice guidelines, established interventions for disease screening, and developing an area of particular interest into a focus for excellence within the practice. The Saskatchewan PEP has collated the most common areas in which improvement was advised after an on-site office assessment. These included lack of formalised monitoring of chronic conditions and inconsistent assessment/recording of patient history and risk factors (personal communication).

Although quality of care is not the only parameter assessed, it is a major part of these processes. In the day-to-day pressure cooker of healthcare provision, self assessment (like professional development) can often lose priority. No physician sets out to offer anything less than ideal care. The difficulty is often in recognizing the benchmark standard to which we should compare ourselves.

Many of the variables that determine physician performance are beyond the influence of CME; physician shortages, excessive workloads, geographical or professional isolation, or inadequate facilities are issues in which other jurisdictions must wrestle. Departments, divisions, and offices of CME, situated as they are within colleges of medicine but also acting in the community, have a powerful opportunity to influence the final product of medical schools by feedback from our teaching experiences, and to advocate for lifelong, self-critical evaluation with self-targeted lifelong learning by practicing physicians.

Because of the intricate networks which CME offices have built up with teachers and learners, they are exceptionally well-situated to assist in the development and dissemination of self-assessment tools. In the interests of providing up-to-date information to physicians where they work, and of making the best use of their available time, we offer courses on how to use technology available through computers and PDAs. We should also offer courses on effective self-assessment tools so physicians can make the most of self-directed learning opportunities which are all around them.

It is a tragedy for the patient, and a shame to the profession, if even one patient suffers from physician incompetence or neglect. It is equally tragic, and has a wider impact on patientcare (though less on media coverage) if a proportion of physicians are practicing at less than their full potential. If CME is to fulfill its basic mandate—that of improving the quality of patient care by improving physician performance—we need to be actively involved in providing physicians with tools for self-assessment. We should be providing them in an easily accessible and understandable format. CME

Reference

1. Flook, N: PAR program: Characteristics of commended physicians. CPSA newsletter The Messenger 2003; Issue 102:4-5.