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CLINICAL PRACTICE GUIDELINES, QUALITY INDICATORS, AND THE TRUE VALUES OF PRIMARY CARE

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ABSTRACT

Despite the increasing popularity of the concepts known as person-centered care and the holistic approach, their implementation in real life is far from optimal. Patients' priorities, preferences, and values are still too often neglected. The tendency to measure the outcomes of primary care just in terms of avoiding hospital admissions, reducing health care costs, and increasing adherence to treatment can cause problems and create distortion.

Guidelines are too focused on single diseases and not patient-focused. Most guidelines have a "one-size-fits-all" mentality and do not build flexibility or contextualization into their recommendations.

Quality indicators should be used with caution and wisdom, especially in primary care, as they are mainly related to a few common chronic diseases and this is not conducive to recognizing the vast range of health problems of our patients. Quality indicators can be useful as a starting point for discussions about quality in primary care but not all the data that we have in our electronic clinical records can be used to derive good quality indicators and they cannot reflect the broad scope of primary care. Some core values are difficult to measure because doctors and nurses are pushed to spend too much time on the registration and administration of the required data rather than dedicate this time to the actual care of the patient.

Person-centered health care is certainly one the visions of primary care and primary care doctors need to step up and lead the change. Rural primary care doctors, who traditionally adopt a less biomedical and more holistic approach than their urban counterparts, could become the pioneers in the implementation of this process.

KEYWORDS: clinical practice guidelines, quality indicators, core values, primary care, rural primary care

Getting impatient about person-centered care

Primary care is person-centered, not disease-focused care, over time. According to Klikmann & van Weel [1], *"Primary care doctors are those who help persons with problems over time"*: GPs deal with peoples not patients; they give advice, not orders; they cope with problems not with diagnoses, and many times, not just one at the time. Finally they are concerned with the entire episode of care and not only a single visit.

Despite the number of articles published in the last decades on the concept of person- centered care and the need fora more focused holistic approach, the situation in real life is far from optimal [2]. The elicitation of priorities, preferences and values are essential for a person-centered approach and it is a prerequisite for assessing the needs of the patients and identifying their goals [3]. The outcomes of health services need to be measured in terms of their ultimate product: health.

This is not trivial as Valderas states "considering the tendency to measure the outcomes of primary care just in terms of avoiding hospital admissions, reducing health care costs, increasing adherence to treatment or achieving some degree of control of physiological measurements" [2].

The WONCA International Classification Committee (WICC), in designing its classification for primary care (ICPC), gave significant importance to the social and personal factors which affect care, dedicating them to Chapter Z of the classification [4] and the person-related information is still an active line of research in the WICC [5, 6].

The theme of the VII European Rural and Isolated Practitioners Association (EURIPA) forum

The theme of the VII Euripa Forum which took place in November 2017 in Crete (Greece) was "Rural Renaissance". This title attempts to correspond to the demands of a challenging world that has already recognized the health inequalities among and within rural regions. Holistic health care needs assessment along with the essential four dimensions of the quality in Primary Health Care (PHC) (continuity, accessibility, comprehensiveness and coordination). The renaissance of rural health can help to rediscover the true values of our discipline. Why rural health? Because it is less biomedical and more holistic than the urban counterpart and rural doctors usually have an increased social standing [7]. The local doctor is the one who has to deal with very personal issues, and be a reliable friend who patients can count on if there is a problem [8]. PHC and General Practitioners (GPs) could become the agents for "Rural Renaissance", and rural doctors, the pioneers of this old/new approach.

Clinical practice guidelines (CPG)

In the view of many researchers, controlling risk factors in many chronic conditions is unsatisfactory and doctors need to be more proactive [9, 10]. Family doctors are the ones who are blamed the most, often accused of not following the guidelines, and being affected by some sort of clinical inertia. Is this the key issue [11]? CPG should have a role in guiding how we care for patients, but they have been largely developed for and emphasize only the single disease perspective.

Two out of three patients in primary care, over age of 50, have more than one chronic disease, yet most studies apply strict criteria to exclude those with diseases other than the condition under study, to reduce confounding variables [12]. Excluding patients with multiple, chronic diseases from studies may improve the precision but diminishes the relevance of the findings.

Besides, many current guidelines have become marketing and opinion-based pieces, delivering directive rather than assistive statements [13]. Guidelines are often too focused on single diseases and not patient-focused. Most guidelines have a "one-size-fits-all" mentality and do not build flexibility or contextualization into the recommendations. CPG are supposed to be guides, not rules, and one size certainly does not fit all patients. Recommendations should vary based on patient's comorbidities, the health care setting, and patient's values and preferences [14, 15]

Quality indicators

The most popular quality indicators are those included in the pay-for-performance scheme called Quality and Outcome Framework (QoF) [16], which was introduced in the UK National Health Service (NHS) in 2004 as part of the General Medical Services (GMS) contract for UK general practice. As Barbara Starfield argued in her article "Is patient-centered care the same as person-focused care?" [17] the payment for performance could be a good approach to encourage adherence to evidence-based processes of care, but its application could be problematic in terms of attention to people's problems. Quality indicators are mainly related to a few common chronic diseases and this is not conducive in recognizing the vast range of health problems of our patients. Unfortunately, this performance measurement has been extended to interventions that have only a small clinical benefit while many other important aspects of care are neglected.

Using multiple, single disease–focused quality indicators to judge the quality of care provided to older patients with multiple comorbidities creates another level of difficulty. In these patients, we need to balance each patient's overall health status with the burdens, risks, and benefits of complex care, and this is something that single-disease guidelines and their resultant quality indicators do not address [13].

Nowadays, there is the great underestimation of the importance for long-term relationships with patients, which is often independent of the care for specific disease episodes. Rather, the priority seems to be in the interest in individual diseases, chosen because they are costly or because they are thought to cause considerable premature mortality and disability [10]. It is important to point out that these proxy outcomes are, of course important, but along with other factors, which unfortunately are continuously neglected, these indicators met a managerial agenda rather than a clinical one [18]. Recently the QoF scheme has been abandoned in Scotland and radically reshaped in England [18]. The advisory group NHS England urged that one of the key priorities for a reformed QoF was to enable a more holistic, person-centered care approach [19].

Mid-Staffordshire scandal

What can happen when empathy and compassion are not considered priorities? One example is the scandal which happened at the Stafford Hospital in Mid-Staffordshire, England. It concerned poor care amongst patients at a UK hospital in the late 2000s. This scandal grew from a gap between resources and expectations. Mid-Staffordshire's leaders aggressively pushed clinical managers to slash spending to meet approval standards. Waiting-times and other performance targets were introduced. A government-commissioned inquiry by Sir Robert Francis revealed how these circumstances combined to create a major health care scandal [20]: "Mid Staffordshire's leaders imposed cuts without assessing risks, then intimidated the staff into suppressing their concerns. Emergency department

nurses were told to delay the start of antibiotics and pain medication, and staff who missed targets, feared being fired. This fear led to premature discharges and falsification of records. Meals were left out of reach of bedridden patients, drug doses were missed, and incontinent patients weren't cleaned." The final report was published on the 6 February 2013, making 290 recommendations to enforce openness, transparency, and candor amongst NHS staff.

As Gregg Bloche wrote in its editorial in the NEJM we should not minimize the importance of these scandals [21]: "the scandals are often a Sentinel Event of something which is going in the wrong direction. Rules and incentives often corrode intrinsic motivation to avoid shirking and self-dealing." Politicians promise and when things do not work, it's the fault of the institution's leadership. The result is a "toxic atmosphere" that "prevents those who are running the show from telling the truth" and signals doctor and nurses to keep quiet."

Western Societies live under the illusion that some core values can be achieved forever. Unfortunately, this is not always the case. What happened in the past can happen again in the future if the true values of heath care are not regarded as a priority. The problem often hides surprisingly under the guise of "optimal" appropriateness and efficiency. Wisdom, empathy, and compassion are not old-fashioned approaches to deal with our patients, and even less a luxury that we cannot afford to overlook in a period of financial crisis, but essential core values which should always guide our decisions.

Measuring quality in primary health care

Quality indicators should be used with wisdom especially in PHC. The European Society for Quality and Patient Safety in General Practice (EQuiP) recently raised this issue in its position paper "Measuring Quality in Primary Health Care" (appendix 1).

While quality indicators can be useful as starting points for discussions about quality in PHC, their generalized use might pose some issues [22]. Not all data we have in our electronic clinical records can be used to derive good quality indicators and quality indicators cannot reflect the broad scope of PHC. Some core values and characteristics such as person-centered care and continuity of care are particularly difficult to measure, moreover the indicators urge doctors and nurses to spend too much time on the registration and administration of required data rather than dedicating this time to the actual care of the patient. "Not everything that can be counted counts and not everything that counts can be counted" is a quote attributed to Albert Einstein which fits perfectly with the existing quality indicators.

WONCA definition of general practice/ family medicine and the true value of primary health care

According to the WONCA [23]: "General practitioners/family doctors care for individuals in the context of their family, their community and their culture, always respecting patient autonomy. In negotiating management plans with their patients, they integrate physical, psychological, social, cultural, and existential factors, utilizing the knowledge and trust engendered by repeated contacts."

Table 1 below highlights the cultural differences between primary and secondary care [24].

By way of conclusion, we think that primary care doctors who recognize themselves in the WONCA definition, cannot be complacent with the mere achievement of the optimal target of these quality indicators and they cannot be satisfied with the subsequent economic incentives. These indicators measure neither our wit nor our wisdom, neither our compassion nor our devotion to our profession. They measure a variety of factors, except those which perhaps make our profession really worthwhile. They can tell us some important aspects about Primary Care management except not whether we can feel proud to be family doctors.

Table 1. Cultural differences between primary and secondary care

	Secondary health care	Primary health care
Planning	Short perspective Great changes in short time	Long perspective Rest of life
Assessment	Diagnosis and treatment with advanced technology	Functional ability scales, Patient preferences and self-care
Disease	Focus on one diagnosis at the time	Many patients have more than just one chronic disease
Clinical guidelines	Strong adherence	A part the nice guidelines [24] Real guidelines for multimorbidity do not exist
Patient role	Leave to health personnel to decide what to be done	At home the patient decides Don't want to be reminded about the disease

Adapted from Anders Grimsmo, Wonca International Classification Committee (WICC) Meeting (Ravello, Italy, November 2012).

References

1. Klinkman M, Van Weel C. Prospects for person-centred diagnosis in general medicine. J Eval Clin Pract 2011; 17: 365–370.
2. Valderas JM. Getting impatient about person-centred health care. Eur J Gen Pract 2013; 19: 141–142.
3. De Sutter A, De Maeseneer J, Boeckxstaens P. Empowering patients to determine their own health goals. E Eur J Gen Pract 2013; 19:2: 75–76.
4. Colleges WOoN, Academies, Physicians AAoGPF. ICPC-2-R: International Classification of Primary Care. New York: Oxford University Press, USA: 2005.
5. Schrans D, Boeckxstaens P, De Sutter A, Willems S, Avonts D, Christiaens T, et al. Is it possible to register the ideas, concerns and expectations behind the reason for encounter as a means of classifying patient preferences with ICPC-2? Prim Health Care Res Dev 2018; 19: 1–6.
6. Schrans D, Avonts D, Christiaens T, Willems S, De Smet K, van Boven K, et al. The search for person-related information in general practice: a qualitative study. Fam Pract 2016; 33: 95–99.
7. Roberts RG, Wynn-Jones J. Research and rural; EGPRN and EURIPA-finding common ground. October 2013, Malta. Eur J Gen Pract 2015; 21: 77–81.
8. Petrazzuoli F, Ungan M. Rural medicine in the world: a focus on rural primary care in Europe. Turkiye Klinikleri Family Medicine-Special Topics 2018; 9: 256–261.
9. Kotseva K, De Bacquer D, Jennings C, Gyberg V, De Backer G, Rydén L, et al. Time trends in lifestyle, risk factor control, and use of evidence-based medications in patients with coronary heart disease in Europe: Results from 3 EUROASPIRE surveys, 1999–2013. Glob Heart 2017; 12: 315–322. e3.
10. Heuschmann PU, Kircher J, Nowe T, Dittrich R, Reiner Z, Cifkova R, et al. Control of main risk factors after ischaemic stroke across Europe: data from the stroke-specific module of the EUROASPIRE III survey. Eur J Prev Cardiol 2015; 22: 1354–1362.
11. Boeckxstaens P, Willems S, Lanssens M, Decuypere C, Brusselle G, Kühlein T, et al. A qualitative interpretation of challenges associated with helping patients with multiple chronic diseases identify their goals. JOC 2016; 6: 120–126.
12. Lionis C, Stoffers HE, Hummers-Pradier E, Griffiths F, Rotar-Pavlic D, Rethans JJ. Setting priorities and identifying barriers for general practice research in Europe. Results from an EGPRW meeting. Fam Pract 2004; 21: 587–593.
13. Shaneyfelt TM, Centor RM. Reassessment of clinical practice guidelines: go gently into that good night. JAMA 2009; 301: 868–869.
14. Boyd CM, Darer J, Boult C, Fried LP, Boult L, Wu AW. Clinical practice guidelines and quality of care for older patients with multiple comorbid diseases: implications for pay for performance. JAMA 2005; 294: 716–724.
15. Smith SM, Soubhi H, Fortin M, Hudon C, O'Dowd T. Managing patients with multimorbidity: systematic review of interventions in primary care and community settings. BMJ (Clinical research ed) 2012; 345: e5205.
16. Roland M. Linking physicians' pay to the quality of care – a major experiment in the United Kingdom. N Engl J Med 2004; 351: 1448–1454.
17. Starfield B. Is patient-centered care the same as person-focused care? Perm J 2011; 15: 63.
18. Roland M, Guthrie B. Quality and outcomes framework: what have we learnt? BMJ (Clinical research ed) 2016; 354: i4060.
19. Iacobucci G. Quality and outcomes framework faces radical reshape in England but will be retained. BMJ online 2018; 362.
20. Francis R. Report of the Mid Staffordshire NHS Foundation Trust public inquiry: executive summary. Vol. 947. London: The Stationery Office; 2013.
21. Bloche MG. Scandal as a sentinel event – recognizing hidden cost-quality trade-offs. N Engl J Med 2016; 374: 1001–1003.
22. Arvidsson E, Dijkstra R, Klemenc-Ketis Z. Measuring quality in primary healthcare - opportunities and weaknesses. Zdr Varst 2019; 58: 101–103.
23. Allen J, Gay B, Crebolder H, Heyrman J, Svab I, Ram P. The European definitions of the key features of the discipline of general practice: the role of the GP and core competencies. Br J Gen Pract 2002; 52: 526–527.
24. Kernick D, Chew-Graham CA, O'Flynn N. Clinical assessment and management of multimorbidity: NICE guideline. Br J Gen Pract 2017; 67: 235–236.

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