Canadian quality assessment program for dental practices

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Healthcare practitioners may look back with nostalgia to the time when their decisions for treatment were based on individual skills and founded on training, experience and integrity. Today, we see erosion of this tradition by intrusion from agencies that claim to safeguard the best interest of both the individual patient and the general public. We may rail against these incursions and passively accept them as inevitable expressions of contemporary social responsibility. Alternatively, we have the opportunity to take an active role in selecting, shaping or rejecting recommendations or regulations that do not fulfill their intended goal.

As stated by the Royal College of Dental Surgeons of Ontario (RCDSO) in a Special Newsletter, the oral health of the citizens of Ontario is arguably among the best in the world.

It has become so, not by massive government fiscal support or by legislative dictum, but by the effective dental public health measures promoted by the profession and the care provided within the framework of the fee for service, private practice relationship. That is not to say that the entire population is well served within this framework.

The Ministry of Health, through the Regulated Health Profession Act (RHPA) has mandated the RCDSO to implement a Quality Assurance Program (QAP) that alleges to improve the standard of dental care of those patients currently being treated by dentists.

Although Quality Assurance requirements must include a practice review component, the ministry has left it to each college to define the details of its program, recognizing that each profession has unique concerns.

According to the director of the Professional Relations Branch, as stated in the RCDSO Dispatch, this must include a program component "to review the practice and/or the skills, knowledge and judgment of members".

However, the ministry has not provided a template for the process. Our college provided an overview of its QAP in a special newsletter to all dentists.

The centerpiece of this new system is a Quality Assessment (QA) component that features peer review. The standard of care was to be based on compliance with the practice guidelines developed by the college.

Another element of the QAP is a Mandatory Continuing Education program.

The college stated that the QAP "marks significant change in how the RCDSO will promote quality practice... and a different way to approach self-regulation".

The existing system, characterized as "reactive and punitive", was to be replaced by one that allowed the members to participate in a collaborative process with the aim of producing a "proactive preventive mechanism".

In this paper it will be discussed and analyzed the quality assurance process chosen by the college, giving particular attention to the use of clinical practice guidelines (CPGs) as standards of care in the proposed inspection program.

Clinical practice guidelines

The college stated in the special Quality Assurance Newsletter that "we have been working with members to review and develop updated practice guidelines/ standards of clinical care which establish minimal standards for the profession".

These guidelines will play a significant role in the proposed QA component as the college will be asking peer review assessors "... to look at how practice guidelines are being implemented at the clinical level and where required, proactively identify those areas where improvements are needed to meet the standards established by the college".

Since these guidelines are clearly intended to be used as standards, which will judge a dentist's competency, these documents must meet the highest standards themselves.

They should be produced in a manner, that conforms to rigorous development criteria in order to be accepted as valid by the professional community. There is a considerable body of literature on the attributes of high quality clinical guidelines for medicine, and to a lesser extent, for dentistry.

Although over 1,200 guidelines on a wide variety of topics have been published, it seems that they had limited impact on practice.

There is evidence that the RCDSO has reassessed its protocol for CPG development.

The Workshop for Guideline Preparation facilitated by the college in 1996 and its participation in the CPG Workshop sponsored by the Canadian Dental Association in 1997, are positive indicators that the approach that QAC will take in the future is more likely to conform to accepted standards for guideline development.

In contrast to the RCDSO approach to the development of guidelines, the College of Physicians and Surgeons of Ontario CPSO, acts as a facilitator to groups in the medical profession who have identified topics where guidelines could be useful educational aids.

To aid in development, they offer their considerable expertise, guidance and facilities to assure that an acceptable and truly collaborative process is followed. Further, the CPSO does not describe these CPGs as standards of practice.

RCDSO Quality Assessment Program

The centerpiece of the Quality Assurance Program is the Quality Assessment process that is surveying many aspects of practice and assesses how practice guidelines are being implemented.

The proposed process consists of three phases: a peer review or practice audit (Dental Practice Review); a more intensive evaluation of the dentist's skill, knowledge and performance for those identified with problems by the peer review (Dentist Evaluation) and a remedial education phase (Dentist Enhancement).

This multimeasure program is similar to that currently in use by the CPSO.

To audit by inspection between 400 and 450 physicians each year, including all doctors over 70 years of age, the peer review phase employed 90 assessors and cost the CPSO approximately $ 1 million annually.

A significant factor in the expense of the process is the use of teams of physicians as assessors. As a consequence, the CPSO invited the Faculty of Health Sciences of McMaster University to develop and test a multimeasure pilot program that was introduced in 1989. In 1993, after a three-year trial period, the results were published. The practice audit phase revealed that about 10 per cent of random sample showed evidence of potentially serious difficulties. Of these, about half had self-correctable deficiencies, mostly record keeping. Thus only 5 per cent of the original sample proceeded to the second phase, an intensive one or two days evaluation intended to disclose specific deficiencies in clinical knowledge. After this evaluation, 1.5 per cent of the sample was directed to the remedial education phase. At this point, some of the physicians retired from practice rather than continue process while the remainder completed their remedial courses.

The McMaster developers concluded that although the multimeasure was an improvement over the single stage peer review, "some serious problems remain". The question of cost-effectiveness was raised since only 15 in every 1000 physicians required remedial education.

As the developers stated, "if incompetence was a disease, such a low prevalence could not justify the cost unless this is treated as an important societal commitment".

They recommended its replacement with an economical screening process such as developed by the College of Physicians and Surgeons of Alberta.

This does not require visits by assessors, is estimated to cost about $25 per practice and is intended to be universal screening by mailed questionnaire.

The Federation of Medical Licensing Authorities of Canada is recommending it for a national pilot program.

The RCDSO proposed to audit 300 practices per year or approximately five per cent of the members.

At this frequency to review every dentist would require at least 20 years.

In addition the CPSO now requires peer review of all members over 68 years of age, as this is the group that shows the highest level of deficiency.

The experience of CPSO suggests an annual cost to the dental profession of between half and three-quarters of a million dollars for the peer review component alone. The registrar of the CPSO noted in his annual report of 1996 "... the logical complexity and cost associated with monitoring the performance of practitioners in different practice settings will challenge even the larger, established colleges and will likely completely overwhelm the smaller ones".

These numbers represent less that one percent of the practicing physicians, a token sampling which is less than the annual influx of new physicians.

In medicine the only effect this process has on quality assurance is directly related to the patients the few physicians identified in the random sample each year who will have remedial education.

For the 99 per cent of physicians not assessed, there is no effect whatsoever on the quality of practice.

Even if the RCDSO peer review could with confidence identify about five per cent of each sample that will require further evaluation and remedial education, this cannot be translated into a claim of maintaining quality among the members who are not evaluated.

Continuing education

Although it may never be possible to quantify the effectiveness of the Mandatory Continuing Dental Education (MCDE) program, there would be few in the profession who would reject the proposition that every dentist has an ongoing responsibility to keep abreast of advancements in his professional knowledge.

The mandatory program as cruelty organized, however, has marginal value for the vast majority of dentists who quite easily exceed the goal set by the college. As well, it presents only a minimal challenge for exposure to some scientific material. The enormous range of topics and the variable quality of material offered surely presents a challenge to the QAC in the awarding of points.

These mandatory subjects would include material, which is directly within the domain of the college such as ethics, informed consent, record keeping, interactions with third party insurers, infection control, referral and consultation.

The mandatory courses would constitute only a portion of the required points, leaving members to obtain their remaining points in topics elected on the basis of individual need and interest. Even though the evidence that continuing education can influence practice patterns and outcomes are limited, the logic of education as a prime instrument of quality assurance is far more compelling than the concept of random inspection.

In medicine, both in the United States and Europe, a number of innovative methods of improving the delivery and efficacy of continuing education have been tested.

Interestingly, in these countries there is a universal rejection of the belief that auditing of treatment practices can insure quality.

Practice evaluation

It would serve the public interest to know that a mechanism exist to inspect dental offices for things such as infection control, record and drug storage, and safety issues.

To assure that such an assessment would be non-punitive, the administration of the practice review should be at arm's length from the college. The protocol and procedures would be developed in collaboration with the Ontario Dental Association (ODA), dental specialties and the Faculties of Dentistry. As an alternative to the slow, expensive peer review that can only audit a small sample of practitioners, the mail questionnaire system of auditing seems an attractive and inexpensive alternative.

Since the major component of the RCDSO Dental Practice Review is essentially a facility assessment, a mailed questionnaire could be an effective means of gathering the desired information.

The sanctions for misinformation would be clear and, to ensure accurate compliance, would include a small number of random site audits.

Summary results would be useful to determine where additional effort should be placed in continuing education or information distribution. A program such of this would help reinforce the college's stated goal of a review that is non-punitive, educational and developed in a collaborative manner.

The ODA can be proud of the many initiatives and actions taken on behalf of dentistry in Ontario and, without question, the profession and the public have been well served by these efforts. It is not difficult to imagine that, without the presence of ODA, agencies of government would have imposed regulation and control devoid of significant input from dentists.

Some view the ODA primarily as a counterweight to safeguard interest of the profession from regulation purporting to protect the public interest.

The ODA Task Force on Quality Assurance has responded vigorously to a variety of issues arising from the college's attempts to develop a QA program and has achieved a certain measure of success.

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