



Do we need USPs?

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Australia is lacking the vital data relating to current practices needed to perform a meaningful evaluation of the quality of care in general practice. This article proposes that unannounced standardised patients (USPs) represent a valuable method of measuring actual performance in general practice. Constructive debate about the use of USPs may progress its acceptance as a valid tool for performance assessment and quality improvement.

What is actually occurring in general practice? How are clinical presentations such as angina or depression being managed? The unannounced standardised patient (USP) tool represents a valuable method of measuring actual performance in general practice. The USP is defined as 'a healthy subject or an actual patient who has been trained to present accurately and consistently a particular case and to report or judge the behaviour of the physician based on fixed criteria'.¹

Competence vs. performance

A recent series of articles explored issues of competence and performance of doctors and outlined various methods of measuring these constructs.^{2,3} The authors described competence as what a doctor is capable of doing, and performance as what occurs in actual practice. The Cambridge Model identifies performance as a product of competence, the influences of the individual doctor, and the influences of the system (eg. facilities, appointment times, remuneration).⁴ This model highlights that although competence is an essential prerequisite for performance, other factors need consideration

when analysing assessed performance. This is especially true in general practice.

Clearly, the quality of the performance in actual practice determines whether positive patient health outcomes are likely to occur. However, traditional assessments of the provision of care in general practice have relied on competence based assessments such as written tests and objective structured clinical examinations which do not tell us about what occurs in actual practice. Current medical education research is increasingly focussing on performance and on various performance assessment instruments. In particular, the validity, reliability, feasibility, educational impact and acceptability of performance based assessments are being investigated. The relative importance of these attributes depends on the purpose of the assessment. Where the aim is to improve individual doctors' practices, high levels of all these qualities is required.⁵

What is the USP?

The USP is usually an actor trained to portray a patient scenario in a standardised and consistent fashion. The USP presents

to a doctor for a routine consultation and assesses different aspects of performance, usually by completing a checklist.⁶ Tools to measure performance in general practice have been classified as indirect or direct methods. Indirect methods such as medical chart audits or patient interviews are often incomplete, inaccurate and unreliable.^{7,8} Direct methods include direct observation, video or audiotaping, and the USP. In a review article analysing these methods, the authors highlight that when the method involves the doctor knowing that they are being observed, an expected behavioural change may occur which may alter behaviour. Also, when observing real life consultations, the researcher cannot control which patients enter the surgery, making it difficult to compare performance between doctors. The review concludes: 'The [unannounced] standardised patient method has the advantages of the other direct methods, but can avoid the disadvantages'.¹ Furthermore, other researches have recently defined the USP as the validated, gold standard methodology to discriminate among variations in the quality of clinical practice.⁹

What is driving development of the USP methodology?

A recent systematic review of studies into the quality of care in general practice revealed that Australia lacks vital data regarding current practices.¹⁰ Such data would enable an analysis of the evidence practice gaps (the gaps between research findings and current clinical practice) that is critical for improving the quality of primary health care. Admittedly, a recent report does cite evidence for gaps existing in various areas relevant to general practice, from stroke prevention in asymptomatic atrial fibrillation, to antibiotic use for upper respiratory tract infections.¹¹ Another study demonstrates that we are only identifying and managing approximately 44% of patients with mental health problems who present to general practice.¹² Nevertheless, data of this nature is limited.

Once an evidence practice gap is identified, an effective program to close it is the next challenge. Establishment and dissemination of clinical practice guidelines and continuing medical education (CME) are attempts to move performance toward best quality health care. The limited evaluation research of these initiatives has shown that impact on actual practice, with measurable effects on patient outcomes, is variable.^{13,14} The lack of scientifically valid options to accurately measure and improve clinical practice has led to the development of innovative performance assessment tools such as the USP methodology.

Barriers to using USPs

General practice in Australia has been slow to embrace the USP tool, possibly because of legitimate fears (eg. being judged) or misconceptions resulting from a poor understanding of the tool. It is expected that the deceptive nature of the USP methodology – combined with uncertainty regarding confidentiality – would concern many doctors. Doctors may fear that the USP may have negative consequences such as identification of themselves as 'bad apples'. Insight into overcoming these barriers can be gleaned from the approaches of studies

Table 1. Potential uses of the USP tool

<p>Learning needs assessment for CME program planning</p> <p>Evaluate effect of CME lectures/programs</p> <p>Measuring uptake of clinical practice guidelines</p> <p>Comparison of care provided in different clinical settings</p> <p>Quality assurance</p> <p>Reinforce the need for health care system reform, and inform the necessary changes</p> <p>Audit and feedback to improve individual doctor's consulting skills</p>

that have successfully implemented the USP methodology. Concerns about performance assessment were addressed by clarifying that the purpose of the tool was to evaluate the medical profession as a whole, without focussing on the weaknesses of individual doctors. Issues of deception and confidentiality have been resolved with the requirement for written consent of participating GPs and use of only de-identified data in reporting performance results.

Such positive approaches have been utilised by a Victorian research group, who used announced simulated patient visits to GPs in actual practice, to evaluate the GAPP training program dealing with postnatal problems.¹⁵ The problem with this approach is that it only measured competence, rather than performance, as discussed above. Interestingly, 46% of the participating GPs rated the simulated patient as 'the most useful element of the program' and many of the GPs commented that they would have preferred the simulated patient visit to be unannounced.¹⁶ Constructive discussion about the use of USPs may allow the perceived barriers to be clarified and addressed, thereby facilitating its acceptance as a valid tool for performance assessment and quality improvement. Consultation with GPs, potentially through the use of focus groups, may assist in overcoming these barriers by helping refine a USP research protocol that addresses common concerns.

For USPs to attend GP practices undetected, they need to assume false identities requiring fake Medicare cards for identification and registration. This is achievable via consultation with the Health Insurance Commission. Furthermore, the USP will need to be a new

patient to the practice, therefore requiring the participating GP to work in a practice which has not 'closed its books' to new patients. To facilitate a new patient presentation, the USP role can be written as an interstate visitor, or with their usual GP on leave.

Limitations of the USP methodology

Longitudinal care of patients over time is a key aspect of general practice; the use of a USP presenting to a GP for only one consultation may lead to biased results. Therefore, the USP methodology would be more appropriate with clinical cases that require decisions to be made in the first consultation rather than for evaluating the decision making process in chronic conditions.¹ Alternatively, if research funds allow, the USP could visit the GP on several occasions.

The self selection of GPs and the requirement of informed consent, may lead to a skewed sample of highly motivated, reflective doctors who will not be representative of the wider GP population. Alternatively, due to the unobtrusive nature of the USP tool, it is possible that recruitment rates with USP research may be higher than alternative research tools such as clinical audits which require greater demands on GPs' time and resources.¹⁷ Further research is needed to determine the relative importance of these issues, and their effect on the validity of generalising results of studies using USPs to the broader general practice environment.

Potential value of USP methodology

The USP can be used in a number of contexts (*Table 1*). General practice research using a direct method of assessing actual practice

has potential to identify the factors that contribute to performance at levels below evidence based standards. Besides issues of competence, the USP methodology could highlight structural problems in the primary health care system such as time pressures, financial disincentives for longer consultations and a lack of access to advice and support. This may help drive reforms that are needed to improve performance.

Furthermore, GP involvement in research using USPs may be an effective way of closing evidence practice gaps and improving performance through the provision of valuable feedback to the GP. Very limited research exists on this potential use of USPs – an innovative approach to actually promote evidence based practice. A recent Canadian study showed that when medical students were faced with a USP in their general practice placement, followed by appropriate feedback, it had a dramatic effect on later performance in an examination of competence.¹⁸ This study reinforced that USPs can represent accurate portrayals of clinical cases, but the authors noted that they found no published studies looking at the use of USPs as teaching tools. They concluded that the use of USPs represents a 'potentially powerful intervention (that) could be applied to a range of clinical issues'.¹⁸

A number of Cochrane systematic reviews have explored the effects of educational visits, CME meetings, and audit and feedback on professional practice and health care outcomes. The authors concluded that 'audit and feedback can be effective in improving professional practice'.¹⁹ Similarly, the authors of the GAPP study recommended that the use of simulated patients be considered in educational programs aimed at changing GP behaviour.¹⁶ This notion of utilising assessment tools for its direct impact on learning is gaining acceptance, but scarcity of research in this area represents a challenge for implementation.²⁰

Conclusion

Once barriers to using USPs have been addressed, use of this methodology as an evaluative and clinical feedback tool may

improve clinical care in general practice. It is hoped that constructive debate about the use of USPs may help facilitate its acceptance as a valid tool for performance assessment and quality improvement. This will not only benefit the GPs involved, but also their patients through better quality of care.

Conflict of interest: none.

Acknowledgments

Thanks to Associate Professor Neil Spike, Dr Grant Blashki, Associate Professor Liz Farmer and Dr Mee Yoke Ling for their valuable feedback and support.

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