The Journal of Laryngology & Otology
December 2000, Vol. **114,** pp. 910–914

The Future of ORL-HNS and Associated Specialties Series

Quality issues in otorhinolaryngology: part II

M. J. Burton, G. G. Browning

Key words: Otolaryngology; Quality Indicators; Health Care

Last month we discussed quality issues in training and continuing professional development (CPD) – we now turn to service provision. Many parts of the British National Health Service are already characterized by their high quality. But the currently fashionable political imperative is for quality standards to be transparent, for them to be uniform across the country and for all members of the healthcare team to be seen to be both complying with current minimal standards and to be striving to improve standards.

In this article quality issues in service provision will be considered, again trying to identify current quality standards, the systems which monitor them and their strengths and weaknesses.

Quality issues in service delivery

Setting in which care is delivered

Much of the practice of otolaryngology takes place in the out-patient department. By their nature, otolaryngology out-patient consultations are often multidisciplinary in nature. When they take place in training or teaching institutions they have additional important components. There are several factors which influence quality including time, equipment, surroundings and the availability of ancillary staff. Time is almost certainly one of the most important commodites or resources in the out-patient setting.

Time. The time for patient consultations is becoming an increasingly important issue. The current 'quality standards' may not be immediately apparent, but in fact they are very clear. They are more clearly set out, by a statutory body – the General Medical Council, than most other quality standards. Our professional body, the British Association of Otolaryngologists – Head and Neck Surgeons, has produced guidelines for out-patient clinics. They suggest minimum time slots for consultations in general otolaryngological practice of 15 minutes. It is self-evident that in those centres involved in post-graduate training, student teaching and multi-disciplinary practice at a tertiary-level, the time requirements will be greater. There are clear distinctions between a low quality and high quality out-patient consultation. The elements of a high quality consultation are set out in Table I. To many, the contents of Table I may seem unreasonably altruistic. Yet many of the elements listed (those marked†) are *mandatory* requirements set out by the General Medical Council. All too often these are sacrificed on the altar of 'not enough time'. Yet it is absolutely clear who is responsible for ensuring that adequate time is available for all of these. It is the professional person delivering the service. If an individual doctor (or other health professional) fails to conduct a satisfactory out-patient consultation, they, and not the hospital management, will be brought to task. A patient must be given the time they require for a high quality consultation.[1]

There seem to be few, if any, existing systems designed to monitor this component of out-patient consultations. When clinics are over booked and more patients are rushed through than can reasonably by seen something has to give. All too often quantity triumphs over quality. But perhaps the issue is more than simply one of quality. If a purchaser pays for a 15 minute 'new patient' consultation, and the patient receives a brief, five minutes, who is defrauding whom?

Another time issue relates to the time between referral and consultation. There are clear quality standards set out by Government for cancer referrals. Since cancer (along with cardiovascular disease and mental health) is so clearly at the top of the Government agenda, this is not surprising. Significant extra resources have been invested in implementing the administrative components of the two-week rule, even if the appropriate clinical resources to cope with this implementation have not been forthcoming. Long waiting times for non-cancer out-patient consultations are currently under scrutiny. By affording each patient more time in a consultation (in line with GMC recommendations) it is likely that the number of out-patients seen in any one Department will be reduced. The waiting time for an appointment is bound to increase (pending the

TABLE I
ELEMENTS OF HIGH QUALITY CONSULTANT–OUT-PATIENT/PATIENT INTERACTION IN A TEACHING AND/OR TRAINING CENTRE

Greeting patient, introducing self and all others present
Comprehensive history
Comprehensive examination
Application of local anaesthetic as necessary and instrumental examination as necessary
Performing diagnostic tests in clinic if necessary
Explanation of nature and effect of investigations, ascertaining potential contraindications
Providing details of the diagnosis and prognosis, and the likely prognosis if the condition is left untreated†
Clarifying uncertainties about the diagnosis including options for further investigation prior to treatment†
Outlining options for treatment or management of the condition, including the option not to treat†
Explaining the purpose of a proposed investigation or treatment; details of the procedures or therapies involved, including subsidiary treatment such as methods of pain relief; how the patient should prepare for the procedure; and details of what the patient might experience during or after the procedure including common and serious side effects†
For each option, providing explanations of the likely benefits and the probabilities of success; and discussion of any serious or frequently occurring risks, and of any lifestyle changes which may be caused by, or necessitated by, the treatment†
Giving advice about whether a proposed treatment is experimental†
Explaining how and when the patient's condition and side effects will be monitored or re-assessed†
Giving the name of the doctor who will have overall responsibility for the treatment and, where appropriate, names of the senior members of his or her team†
Giving a reminder that the patient can change their minds about a decision at any time†
Giving a reminder that the patient has a right to seek a second opinion†
Obtaining full information about the patient's 'beliefs, culture, occupation and other factors' because these may have a bearing on the information they need†
Answer any questions the patient raises†
Providing 'accurate data' of possibility of success/failure†
Informing patients of counselling services and patient support groups†
When students present:
Explanation of history, examination findings and treatment
Supervision of students taking history and examining patient
When trainees present:
Triaging all patient notes and allocating appropriate cases to them
Reviewing patients when trainees have seen them
Providing feedback on trainees' patient management suggestions
Seeing those patients who trainees cannot manage
Filling in diagnosis/audit data according to local requirements
Filling in next appointment or discharge data
Farewell salutations, etc

†GMC requirements

appointment of more consultants). This raises another issue related to timing – when does a patient become a patient? Who is responsible for the person on a 12-month waiting list for an out-patient appointment? It is mandatory that high quality care is provided to those patients we actually see in out-patients. For this reason our 'old' patients who have been seen in the past and are still under our care must take priority over 'new' patients. Pragmatism dictates that although adequate time and resources must be available to see new patients with *urgent* problems, there will be a group of 'new' patients with routine conditions, who may need to wait a considerable time for out-patient treatment. There are only three options for these patients – (i) to wait, (ii) to be seen locally in a unit provided with increased resources (usually, but not always, consultant time and its appropriate back-up), or (iii) to be referred elsewhere, where adequate resources are already available but are not being used.

Some have suggested that as soon as a patient is referred for an opinion, responsibility has been passed from the general practitioner to the specialist. But surely, if adequate provision has not been made for all those referred for secondary level otolaryngological care to receive it, those individuals delivering care cannot be responsible for it. Only when we meet a patient for the first time can responsibility be assumed.

An alternative solution to this problem is to provide high quality care for a restricted range of disorders, limiting access to secondary NHS care to those with serious conditions and restricting the availability of treatment for non-serious conditions. This alternative – providing a mediocre quality of care for all disorders – cannot be a realistic option. Choices need to be made between low-volume, high quality out-patient clinics and high-volume, low-quality clinics.

When considering time availability in out-patients, issues of teaching and training cannot be ignored. Trusts should carefully consider the probity of accepting large sums of 'SIFT' money from Universities and half of a trainee's salary from the Postgraduate Dean, and then failing to allow their consultant staff time to deliver the teaching and training that these bodies have paid for. A fundamental part of this training must occur in out-patients and time must be allowed for this. In the past there has been almost no monitoring of the availability, let alone quality, of teaching in out-patients. With the rising importance of the Teaching

https://doi.org/10.1258/0022215001904527 Published online by Cambridge University Press

Quality Assessment exercise, medical schools are looking very critically at these issues. In post-graduate education, how long will it be before a failing Specialist Registrar points critically at the quality of his or her training in out-patients?

Facilities. High quality 21st century otolaryngological care cannot be delivered without high-quality equipment and resources. It can no longer be acceptable for the professional surgeon to be persuaded to deliver a safe and high quality service in a 'Portakabin'. The resources available in out-patient departments vary widely across the country. The minimum levels required for training have been set out by the SAC of the Royal Colleges and professional associations have expressed a view. The availability of appropriate equipment should be an issue at the heart of risk management and clinical governance. In the Oxford Region all the consultants meet twice yearly as the ENT Professional Development Group. This body has tried to seize the initiative in one aspect of clinical governance and has established a mechanism whereby each ENT Department is visited on a rolling basis (two Departments per year) by a small team comprising three consultants chosen at random, a senior SpR, and a manager. This team prepares a report for the Group and the Department concerned commenting, *inter alia,* on the appropriateness of the facilities available for high quality care. The strengths and weaknesses of the Department can be highlighted and the recommendations used to emphasize and support the Department's need for better resources.

Teamwork. The medical professional is not alone in its pursuit of quality. It is important to recognize that colleagues are going through similar processes; indeed 'clinical governance' initiatives affect all individuals in a hospital. Otolaryngologists may have several roles to play. As teachers and facilitators they may be able to contribute to the training and CPD of others. At the very least they may need to be aware that other groups will also need to undertake audit, training, etc. This may require them to collect data for others, to understand why clinical activity needs to be curtailed or cancelled, etc.

The availability of supporting staff may become an issue when it adversely affects the otolaryngologist's ability to work safely and effectively. There are no clearly defined standards as far as the amount and level of nursing support in out-patients is concerned. Yet we are all aware of the difference which a competent, vigilant and forward thinking assistant can make to our perception of the quality of an out-patient clinic.

There is an expanding role for specialist nurses in such areas as aural care and head and neck cancer work. When provided by able individuals, these undoubtedly enhance the quality of service offered to patients. Again there is a cost in terms not only of the individual's salary but also the space and facilities they need to practice effectively.

Diagnostic procedures and therapeutic interventions provided

The longest consultation, in the most sophisticated setting, will be as naught if the care provided is not sound. Although all of the foregoing should make it clear that the practice of 'evidence-based medicine' is not the sole, or necessarily the most important, contributor to the delivery of high quality care, it is extremely important. The term 'evidence-based medicine' has almost become a pejorative one, but this paradigm of medical practice is here to stay and the practitioner who believes in 'the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients' should be congratulated for practising it. It has rightly been pointed out that as yet there is little evidence that 'evidence-based medicine' results in consistently higher quality care. Nonetheless, wide variations in clinical practice across the country, in conjunction with variable results, makes it untenable to continue the practice of 'intuition-based' or 'post-code' medicine.

It is likely that various 'evidence-based' guidelines, protocols and care pathways will be produced and implemented in the coming years. One of the key components of evidence-based practice is a focus on the individual patient. The slavish following of restrictive rules has no place in evidence-based practice. It is vital that otolaryngologists are closely involved in drawing up these documents and that all practitioners understand the underlying principles. Only in this way can they make sensible and appropriate choices about their generalisability and applicability to individual patients.

One way the individual practitioner may endeavour to improve the quality of evidence available is to become involved in randomized controlled trials (RCTs). There is good empirical evidence that patients entered into RCTs receive better treatment in general than those who are not enrolled. The desire to obtain high quality evidence should drive the conscientious practitioner in a desire to be involved himself, and to involve his patients in the generation of good evidence using this methodology. Otolaryngologists who participate in trials may find their own day-to-day practice changing even before the formal results of a trial are available. There is anecdotal evidence, for example, that during the recent TARGET trial into the management of otitis media with effusion, participating otolaryngologists changed their routine practice outside the confines of the trial. The trial protocol necessitated close attention to such things as 'watchful waiting' and documented evidence of hearing impairment. As a result, these good practice habits became part of the participating surgeons' day-to-day practice.

The absence of high quality evidence does not mean that high quality care cannot be provided. On the contrary, some very high quality treatments are undoubtedly based on little or no quality evidence. What is more important for the individual practi-

https://doi.org/10.1258/0022215001904527 Published online by Cambridge University Press

tioner, committed to a high quality service, is insight into the quality of the evidence on which she or he is basing decisions.

Providers of care

Last month's editorial discussed the quality of training but the issue in terms of producing appropriately qualified 'generalists' and 'super-specialists' was not examined. This is another important quality issue. Should the bulk of otolaryngological care in the UK be provided by a large number of 'generalists', working in general hospitals supported by base 'hubs' manned by super-specialists? Or is every patient entitled to see a practitioner specialising in his or her own complaint? In the past, the British consultant was trained to a high level in all areas of the speciality and could reasonably be expected to provide care for his or her patients with all but the most complex of problems. Often this was possible because junior staff dealt with many routine problems. Now the relative number of juniors is falling, and for this and many other reasons, the consultant is expected to have much more hands-on involvement with all cases.

What quality standards apply to the training of generalists? It has been suggested that the surgeon committed to this type of practice would train for four years, like some of their counterparts abroad. What type of trainee would want this type of position? Would the overall quality of care delivered to the population be improved by adopting this strategy? Many other healthcare systems (especially those of continental Europe) have systems in which the majority of otolaryngologists work as generalists, dealing with the many routine problems which make up the bulk of practice. This system appears to work well but in almost all cases it is within the framework of a private or semi-private healthcare system.

Whilst the concept of super-specialists in a tertiary centre is an attractive one, who provides the routine care in the immediate surrounding area? Can these specialists provide such a service? Have they the time to do so? Already, many head and neck oncologists working in busy multi-disciplinary team settings, have little spare capacity for routine surgery. Can super-specialists provide a quality on-call emergency service for problems outside their own areas of special expertise? What role does private practice have in shaping the degree to which a practitioner becomes a specialist or generalist?

In the British National Health Service at the beginning of the 21st century there appears to be one of those many tensions, so characteristic of the Service. The need for a high volume of general work to be done wrestles with the desire to provide world-class super-specialist care. In recent years it has been possible to select for otolaryngology training programmes the 'elite' amongst a group of very competent young men and women seeking a surgical career. It perhaps then comes as no surprise that almost all of them want the opportunity to super-specialize. Very few express the wish to be generalists, especially as the number of surgical procedures regarded as suitable for them to undertake decreases. Yet many of those coming to the end of a six-year training programme have had significantly less surgical experience than their predecessors. If it is decided that high quality generalists are desirable, something will have to be done to make this role attractive for the trainee. Will private practice opportunities have an influence here? The default position – *not* making it attractive to be a generalist but making it the only option for individuals who fail to secure one of a falling number of super-specialists training posts – is much less favourable. Sadly, the history of British medical manpower planning is blighted by negative changes being effected by a failure to consider positive alternatives.

Outcomes and audit of results

Many practitioners express a wish to audit their results. Rarely is this audit in the true sense of evaluating a process, implementing a change and then re-evaluating the revised process. Nonetheless, whatever it is called, there will be an increasing need to demonstrate one's own results. In this it is tempting to think exclusively in terms of surgical results. This would be a mistake, as so much of the treatment we provide is medical. Even when standard treatment is surgical, the decision to undertake this, and the exact nature of the operation performed, must be as important as a knowledge of the results of that particular intervention in one's own hands.

How are surgical outcomes measured? This has always been a challenging question and is an area requiring further study. Outcomes of surgery for hearing has been discussed before.[2] Similar attempts have been made to define appropriate outcomes in rhinology. In head and neck oncology, there are well recognized (and more easily measured) outcomes of survival, with and without recurrent disease, and disease control.

Equally important are methods of defining the nature and severity of the underlying disease, prior to therapeutic intervention. Much more robust techniques are required to allow categorization of pre-intervention status. It is well known that the best way to have superb results from myringoplasty is only to operate on small dry, stable perforations in patients with ideal eustachian tube function. Several authors have proposed systems for this purpose, but none has achieved widespread recognition. Universal agreement on seemingly simple diagnoses may not always be present. For example, when does a thin sheet of squamous epithelium on the medial wall of the middle ear become a cholesteatoma rather than a retraction pocket? If all such epithelium is defined as cholesteatoma, some of the spectacular results of 'cholesteatoma' surgery reported in the literature may be explicable.

Yet more time, research energy, and on the ground resources must be made available if otolaryngologists are to be able to audit the results of their management decisions and results of specific treatment interventions. Professional guidance from the

https://doi.org/10.1258/0022215001904527 Published online by Cambridge University Press

BAO-HNS is also required, setting out the best methods for auditing the management of various conditions.

Conclusions

High quality healthcare costs time and money. In caring for their individual patients, clinicians are in the best position to recognise this. We should welcome the current very explicit focus on quality and use this as an opportunity to highlight the need for more time and manpower. Only with these will we be able to provide an appropriate service for the 21st century.

References

Lesser T. Is it safe to see more than fourteen patients per doctor in an ENT clinic? [letter] *ENT News* 2000;**9**:35
Browning GG. *Clinical Otology and Audiology,* 2nd edn. London: Butterworth-Heinemann, 1998

Address for correspondence:
Professor G Browning,
Department of Otolaryngology,
Royal Infirmary,
Glasgow G31 2ER, UK.

https://doi.org/10.1258/0022215001904527 Published online by Cambridge University Press