

Proceeding Paper

Healthcare Quality Indicators as a Tool for Safeguarding Patients with Limited Capacity and Physician Rights [†]

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Abstract: In line with the United Nations' (UN) sustainable development goal, value-based healthcare (VBHC) aims to deliver outcomes that truly matter to patients at a reasonable cost. A reimbursement system in VBHC encourages physicians to refrain from activities that do not contribute to achieving the goals and to meet the quality indicators (QI). This transforms person–physician relationships and restricts patients' and physicians' professional autonomy. Therefore, patients with limited capacity become especially vulnerable, lacking legal protection and dignity. Such practices do not comply with the principles and requirements set out in national and international legislation. The aim of this article is to explore if the legal framework and healthcare QI in Latvia correspond to the principles of patient-centered care and respect the physician's professional autonomy as enshrined in the law. This research has been implemented by applying a literature review methodology for collecting and analyzing data from legal and medical research focused on the safety, quality of treatment, protection of persons with limited capacity, freedom from coercion; normative legal basis—law and regulations of the Republic of Latvia, case law and policy documents. Within this article, we can conclude, that the current QI do not represent the outcomes and the ability to reach the patient-centered goals, limit physician autonomy and place an excessive administrative burden, jeopardize the patient's risk of unnecessary interventions. Therefore, patient-centered care standards, clear care goals, and novel QI must be developed. In order to implement international legal norms binding on Latvia, the clash of values between the physician's right to fair pay and the prohibition of unnecessary medical intervention has to be eliminated.

Keywords: value-based healthcare; patient rights; limited capacity; physician autonomy



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1. Introduction

In 2000 the Committee on Economic, Social, and Cultural Rights (ESCR Committee) set four essential elements of the right to health: availability, accessibility, acceptability, and quality (known as the AAAQ framework) [1]. This framework has been adopted by a number of the United Nations (UN) Treaty Monitoring Bodies and domestic courts in assessing states' obligations under the right to health [2], including Latvia. Medicine is both an art and a science. However, the art and biomedical progress have no limits and the demand for healthcare is growing. One of the reasons is so-called defensive medicine—the practice of ordering tests, procedures, hospitalization, and other medical care to reduce the risk of patient dissatisfaction and the threat of malpractice liability. Healthcare can thus become a “black hole” that consumes any state budget, without improving overall public health, as long as healthcare providers are paid for the quantity of the delivered service (so-called “fee-for-service”) rather than for quality and outcome. The legal framework should, in turn, guarantee the protection and development of this art and science. During the COVID-19 pandemic, it became evident, that healthcare is a part of national security, the just allocation of healthcare resources is crucial, and providing essential healthcare is a state

administration task. Therefore, incorporating human rights protections and safeguards into our shared responses is essential to successfully address public health challenges [3].

In line with the UN sustainable development goal [4], value-based healthcare (VBHC) aims to deliver outcomes that truly matter to patients at a reasonable cost [5]. VBHC reimbursement system encourages physicians to refrain from activities that do not contribute to achieving the goals and to meet the quality indicators (QI). Various benchmarks, compliance with the treatment guidelines, and the indicators of the outcome, patient-reported experience measures (so-called PREMs), and patient-reported outcome measures (PROs) have the leading role in value-based policymaking. We believe this transforms person–physician relationships and restricts patients’ and physicians’ professional autonomy: patients vary widely in their needs and beliefs and therefore in individual values. The very concept of evidence-based medicine (EBM) rests on this shaky foundation—EBM is defined as the “integration of best research evidence with clinical expertise and patient values” [6]. On the other hand, clinical expertise is not codifiable and comprises physicians’ tacit knowledge [7].

In addition, patients with limited capacity, who fail to detect and communicate their own goals and be active participants in the treatment process and policy making, become especially vulnerable. They are unable to exercise their right to autonomy, including the right to consent in healthcare, and the legal protection derived from this principle. On the other hand, physicians’ well-being [8] appears to be terra incognita for policymakers and deserves closer attention.

According to a recent survey, healthcare and the economic situation are the two top concerns in Latvia [9]. Therefore, the current study was performed to explore, whether the legal regulation of healthcare QI in Latvia corresponds to the principles of patient-centered care and respects the physicians’ professional autonomy.

2. Safety for the Healthcare Staff—Violence and Trust in Legal Justice

2.1. Violence

It comes without saying that modern healthcare facilities must be safe—for the patients, the staff, and the visitors. Overall safety and human dignity at the workplace and in general for the staff are an integral part of the healthcare system and are closely connected to the concept of professional autonomy, quality of care, and burnout prevention.

The right to the legal protection of physicians’ professional freedom and independence is guaranteed both in the legal framework [10] and in ethical norms [11]. Physicians’ safety and legal protection of their professional autonomy are inextricably linked to the patient’s safety—as we all know from the history of Nazism, the Soviet Union, and facts of the political abuse of medicine in modern China.

Despite guaranteed protection and the right to security, patient violence towards the healthcare staff remains a worldwide concern—it includes verbal and physical assault, stalking, harassment, and others (negative feedback, defamation).

In this case, patients’ safety is on the same scale as the safety of healthcare staff. The number of incidents of verbal and physical violence must be monitored regularly as a part of the annual quality assessment; corresponding risk management and support for the assaulted staff must be provided [12]. Recently, the European Medical Organizations launched a statement that reaffirms safety at work as being paramount for the provision of quality healthcare, emphasizes the need for an effective reporting and assistance mechanism for victims of violence, for the implementation of violence prevention programs, and the enforcement of existing laws concerning violence against all healthcare professionals across Europe [13].

According to the national statistical analysis (2016–2020), in Latvia violent accidents in mental health settings are under-reported—only cases of physical assault are registered, their number is under-reported, and the severity of trauma is underestimated [14]. We can only estimate, that in other health sectors, the situation is similar. Given the above,

no action to improve safety event reporting or increase safety at workplace awareness is mentioned in the Latvia Public Health Policy Guidelines 2021–2027 [15].

2.2. Legal Awareness

The novel and nebulous concept of ‘maintaining public confidence’ in the healthcare system is usually conceptualized as a part of a physician’s duty to protect patients or the public [16]. Furthermore, in Latvia, cases of patients being abused by doctors have been made public [17].

The relationship between patients and healthcare practitioners has historically been shaped by greater legal protection for patients, which has been enshrined in the legal framework. Firstly, in the international legal framework, and later, through the implementation and incorporation of these legal norms into the national legal system. International legislation has contributed to the protection of patients’ rights and legal interests by enshrining fundamental principles of patients’ rights.

In our view, the physicians’ legal awareness and trust in justice are no less important. A proper investigation and fair judgment in malpractice cases are crucial for this aspect of physicians’ well-being and safety. The problems of medical negligence cases’ investigation in Latvia have been described before and mainly comprise the poor quality of the healthcare assessment (without applying an objective standard of negligence—so-called the standard of the prudent and competent physician), lack of the evaluation of signs of the vicarious liability, ignoring the signs of patients’ abuse of their rights [18]. In addition, it should be emphasized that physicians’ attitude toward the legal system and trust in fair trial or physicians’ well-being level has never been studied in Latvia.

3. Safety for the Patients

Reporting of Safety Events and National Statistical Data

Patients’ rights are relatively often shaped by policies and laws that strengthen the patient’s role and legal position [19]. According to the so-called Safety-1 approach [20] and in line with the European Parliament resolution on safer healthcare in Europe 2014/2207(INI) every medical institution in Latvia ought to establish and maintain an internal patient safety reporting-learning system that provides the collection and analysis of on patient safety incidents to prevent their recurrence [21].

The World Health Organization has also recognized the decade 2020–2030 as the Decade of Patient Safety. In addition, the pandemic has shown the importance of patient safety as well as protecting the well-being of all healthcare workers, as demonstrated by the WHO’s World Patient Safety Day in 2020 [22]. So far, the aim is far from being successful, in line with established practice in Latvian healthcare institutions.

According to one of the authors’ professional experiences in mental health facilities, the injuries, acquired during the hospital stay (e.g., as a result of a fight or self-harm), are not coded and reported at discharge, so they are unavailable for monitoring. A sad example of such an event is mentioned in the ECtHR judgment Rita Šteina against Latvia: the applicant’s father, who was suffering from paranoid schizophrenia, had been a patient in a closed psychiatric hospital since January 1998. In 2013 he died from multiple traumas following an altercation with another patient. The offender had an insanity defense [23].

Suicide attempts and intentional self-harm by inpatients, especially in mental hospitals, are considered a “never event”. From 2000 to 2020 Latvia has reported zero suicide cases in mental hospitals [24], which does not correspond to the results of the Health Inspectorate inpatient death cases audit in 2019: two relevant deaths were revealed—in one case, the patient endured severe head trauma; in the second case, the patient jumped out a window and froze to death; no measures to reduce the chances of recurrence of relevant situations were taken by the hospital [25].

4. Safety for the Patients

According to ESCR Committee “quality” means that health facilities, goods, and services must be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation [26].

According to a recent survey, the healthcare system in Latvia is not yet prepared for the implementation of VBHC, and the QI issue is one of the reasons [27].

We studied the legal regulation of generalists’ quality assessment and reimbursement [28] (practically used since 2011) and the set of the QI for specialists [29] in Latvia. Most of the existing indicators are mostly process indicators and benchmarks (such as children’s immunization rates or annual low-density lipoprotein measurements)—but not outcome indicators, PREMs, or PROMs—this determines their non-suitability for VBHC implementation [27]. Obviously, they better correspond to the concept of the fee-for-service method and do not represent the outcome.

In healthcare one of the least discussed human rights is the right to enjoy the benefits of scientific progress and its applications. It is included in the Universal Declaration of Human Rights and the International Covenant on Economic, Social, and Cultural Rights [30] and is closely related to the concept of quality. The provisions of international agreements that protect rights to the right to health are binding on Latvia and must be respected.

Core state obligations of this right could include respect for the freedom indispensable for scientific research; promotion of access to the benefits of science and its applications on a non-discriminatory basis; prevention of harmful effects of science and technology; strengthening international cooperation, including respect for collaboration of scientists across borders [31].

We argue that core obligations are not necessarily very costly and could be easily guaranteed: for example, the excessive pushing the physicians to stick to the treatment guidelines and product summaries disrespects the right to scientific benefits—e.g., according to the judgment of the Health Inspectorate, the administration of Memantine (a medication well-known for its safety and cognition-improving properties [32]) for the patient primarily diagnosed with the major vascular neurocognitive disorder is considered to be non-evidence-based and a target for elimination (as Memantine is not included in the national vascular dementia medical treatment guidelines and vascular dementia is not a registered indication according to the product summary) [33].

Probably, to represent this right, the corresponding QI must demonstrate the availability and prevalence of the costly and/or unlicensed treatment: experimental and off-label.

5. Special Protection for Persons with Limited Capacity

Capacity to Act

In 2013, a reform of the Institute of Capacity to Act came into force in Latvia, which can be traced back to a fundamental judgment of the Constitutional Court. As a result of the reform, and based on the judgment, the country fulfilled its obligations under Article 12 of the UN Convention on the Rights of Persons with Disabilities. The reform introduced significant changes in the capacity to act of natural persons by excluding from the Civil Code the regulation on declaring a natural person fully legally incapacitated and instead introducing the regulation on limiting the capacity to act of a natural person.

As the Council of Europe Commissioner for Human Rights has stated, “Reforming existing institutions of capacity to act is one of the most important human rights issues in Europe today. The capacity to act is more than the decision-making capacity; it is a question of what it means to be human. The choices we make in life are part of who we are” [34]. In 2006, the adoption of the UN Convention ushered in a new era of human rights, guaranteeing human rights for people with disabilities. The Convention marked a fundamental paradigm shift from an understanding of disability centered on medical limitations to an approach that respects the full and equal rights of persons with disabilities [35]. The human rights approach requires ensuring that persons with disabilities

can enjoy the right to consent to or reject medical interventions on an equal basis with others [36]. In circumstances where the decision-making capacity of the patient is limited, it is necessary to provide special protection for such patients and their rights, especially during the pandemic [37].

It abolished full guardianship and introduced partial limitations on the capacity to act, which allow only personal non-financial rights to be limited. This meets the requirements of the UN Convention. However, the amendments did not introduce supported decision-making mechanisms to ensure that all persons with disabilities are able to exercise their full capacity to act and that they have the right to take decisions.

The capacity assessment is the cornerstone of protective legal instruments application. When expressing will in health care, every patient must possess a decision-making capacity [38]. The concept of decision-making capacity has not been defined per se in Latvian national law until now [39]. Many people with disabilities exercise their rights and responsibilities without support. Data from studies carried out abroad indicated that in healthcare institutions 34% of cases, but in psychiatric institutions 45% of cases, patients are characterized by decision-making capacity disorders [40]. Therefore, the necessary measures must be taken to provide adequate and effective safeguards to ensure the necessary support and to protect the rights and legitimate interests of individuals. This applies in particular to people whose actual capacities are limited because of impairments. We would therefore suggest that the corresponding QI could reflect the number of people who have received supported decision-making for medical and social issues.

6. Mental Healthcare

The sign of the correlation coefficient defines the direction of the relationship, either positive or negative. A positive correlation coefficient means that as the value of one variable increases, the value of the other variable increases as one decreases the other decreases. A negative correlation coefficient indicates that as one variable increases, the other decreases, and vice versa. [41] There are various aspects and standards for mental healthcare nowadays. For example, according to the OECD experts [42], a high-performing mental health system must be person-centered, focusing on the individual who is experiencing mental ill-health, have accessible and high-quality mental health services, that have to be evidence-based, be developed close to the community, be provided in a timely manner, account for and respect the unique needs of vulnerable groups, ensure continuity of care, deliver improvement of individual's condition, and be safe. In addition, it should take an integrated and multi-sectoral approach to mental health, prevent mental illness, and promote mental well-being, also have strong leadership and good governance, as well as be future-focused and innovative [43].

One of the important aspects of modern mental healthcare is freedom from coercion and the promotion of voluntary measures [44]. Considering the above, in 2019 the Parliamentary Assembly of the Council of Europe issued a resolution "Ending coercion in mental health: the need for a human rights-based approach" [45]. In addition, in 2021, Dunja Mijatović, Commissioner for Human Rights of the Council of Europe, urged European Union Member States to reform their mental health systems without delay. The Commissioner recognized that they must be based on human rights principles, i.e., protecting human dignity, autonomy, and the risk of inhuman and degrading treatment [46]. For the time being there have been no efforts aiming to reduce compulsory or coercive psychiatric care in Latvia. The current policy plan does not comprise any efforts to promote voluntary measures [47].

Although there are various QIs specially designed for mental healthcare assessment in Latvia, they are mostly process and structure indicators and do not represent the outcome, PROMs, or PREMs: for example, the number of patients with depression who were screened for suicidal ideation at every visit [29]. The ability of this action to meet the target is doubtful, as the traditional risk prediction measures have been shown repeatedly in studies

from high-income countries to be ineffective [48]. It also poses a risk of unnecessary intervention, introduces defensive medicine, and supports a fee-for-service approach.

The only routinely monitoring mental health QI in Latvia (and one eligible for VBHC) is the unplanned 30-day hospital re-admission rate for patients with schizophrenia spectrum disorder [47].

We propose that the mental health QI for VBHC could be the number of prevented hospitalizations for patients with previously diagnosed neurodevelopmental disorders, dementia, and severe mental illness; this QI would also represent the ability of mental health facilities to provide continuity of care outside the hospital ward.

Another important aspect that represents the values of the patients with limited capacity and could be routinely measured is the assessment of medical decision-making capacity, level of family/caregiver burden, use of coercive measures and covert administration of medicines, level of perceived coercion (both formal and informal); and at the outcome—the overall functioning, work, and social adjustment indicators.

7. Conclusions and Recommendations

In Latvia, the existing QI set does not represent the treatment outcomes and the ability to reach the patient-centered goals, they promote the fee-for-service method, limit physicians' autonomy and place an excessive administrative burden, jeopardize the patients' risk of unnecessary interventions.

The patient-centered care standards, clear care goals, and novel QI must be developed. The clash of values between the physicians' right to fair pay and the prohibition of unnecessary medical intervention must be eliminated.

Legal reinforcement of modern aspects in healthcare such as safety for the patients, safety, and dignity in the work settings for the staff, public trust in healthcare and medical personnel, legal awareness, safeguarding the rights of patients with limited capacity, and their value-oriented care standards must be accomplished.

Since 2013, there have been no significant changes in the national legal framework to implement the principles of the CRPD. Incorporating the principles of the Convention into national legislation should not be limited to excluding the institution of incapacity from the legal framework. It requires the legislator to put in place the necessary support mechanisms to ensure the protection and safety of persons with disabilities, as well as to guarantee their autonomy over their health and how they trust their local government to take care of its citizens.

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