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Quality control in nursing homes

Jean Chouinard's[1] comment that nursing home "quality of care should be measured ... on an ongoing basis" deserves applause. However, to characterize the Miminimum Data Set (MDS) as a good first step hardly describes the benefit realized by Ontario's system-wide implementation of the instrument in chronic care hospitals. It is now possible to benchmark hospital performance on at least 24 valid and reliable indicators of the process and outcome of care.[2] In an Ottawa hospital study, Maxwell and colleagues[3] showed how the MDS addresses problems such as falls, incontinence, restraints and common infections.

To suggest that the MDS "fails to link defined outcomes to specific processes of care" confuses questions of measurement with questions of analysis. Using Chouinard's example of the need to assess skin care and nutritional support as predictors of pressure sores, one can find 9 items devoted to skin care and 15 dealing with nutritional status that can be related in longitudinal analyses to 14 items on pressure ulcers and skin condition in the MDS. The data are clearly there. One need only take the time to do the analysis to answer Chouinard's question.

The call for standardized assessment to address the needs of older people is more than a decade old. Now we hear a chorus of voices rising to say that quality of care in nursing homes must be evaluated on a systematic basis. The MDS is the best available tool to address these questions and more. Canadian long-term care facilities could continue to gaze into the distant future in search of a perfect system that will win the unanimous applause of all people interested in health care for the elderly. However, that day may never come. The MDS is here today, and it represents a giant leap forward from where we were yesterday.

John P. Hirdes, PhD
Department of Health Studies and Gerontology
University of Waterloo
Waterloo, Ont.

Competing interests: Dr. Hirdes is a member of the Board of Directors of interRAI, which owns the international copyright for the MDS series of instruments.

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[The author responds:]

John Hirdes' thoughtful comments deserve clarification. The epistemology of health outcomes in institutions is as yet poorly defined, although we generally agree on what should *not* happen to nursing home patients. What is surprising is the lack of empirical data supporting the effectiveness of interventions for common clinical problems,[1,2] although fortunately this is changing.[3] Can the MDS help in this regard? It does provide standardized, risk-adjusted outcome data that can be used to compare facilities and specific patient subgroups. However, it does not further qualify or quantify the interventions being carried out on each patient, nor does it support prognostication even at a crude level. Therein lies the problem. The mere existence of a care process does not ipso facto lend support to its effectiveness.

The MDS provides a sound, validated, systematic approach to care planning, costing and outcome evaluation. It should be broadly implemented not only in chronic care facilities but in home care, nursing home and ambulatory care settings. It is, however, only part of the answer. Formal research is needed to improve clinical care in these settings. Methinks inferences on the effectiveness of specific interventions on the basis of MDS data smack uncomfortably of *deus ex machina*.

Jean A. Chouinard, MD
Sisters of Charity at Ottawa Health Service
Ottawa, Ont.

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Evolving attitudes

The recent report by Susan P. Phillips and Karen E. Ferguson[1] on the changes that occur in students' attitudes about women as they progress through their undergraduate medical curriculum is encouraging. However, because their novel assessment tool lacks normative data it is difficult to know how the attitudes of the students compare with those of the patients they will serve and the other health care professionals with whom they will work.

The sex role ideology scale of Kalin and Tilby[2] is a validated scale that defines prescriptive beliefs about behaviour appropriate to men and women. A study involving health care professionals in Manitoba[3] showed that physicians were at least as advanced in sex role ideology as the general population they served. However, there were striking differences between members of various health professions even after such variables as age and sex were controlled for. The most feminist groups were social workers and psychologists. The least feminist were registered nurses and licensed practical nurses.[3] Physi-

cians were somewhere in between. In related studies, psychiatrists were found to be significantly more feminist than their other medical colleagues.[4,5]

It is important to address this ideological gap in the training of health care professionals. Many of my patients teach me that I still have far to go in breaking free from patriarchy. For other patients, collaboration in care is an unfamiliar concept, and I must educate them that such collaboration will produce better outcomes.

Christel A. Woodward's editorial[6] in the same issue suggests that the changes in medical students' attitudes reflect the changes we see in society itself. The challenge for physicians is to deal with a diversity of attitudes and beliefs among our patients and our colleagues as we work with them to ensure a relationship that promotes the greatest health gains.

S.H. McNevin, MD
Kingston, Ont.

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[One of the authors responds:]

Dr. McNevin addresses the question of whether physicians hold more stereotypical views of the role of women than do other health care professionals, or the public. I share his interest in the question, and his belief that medical education must address diversity and minimize patriarchy. Our study[1] did not, however, attempt to answer this question. Instead, we examined the association between medical education and changes in stereotypical thinking, willingness to control decision-making of female patients and conceptualization of women as other or abnormal because they were women. We did not compare beliefs with those of any external group, nor did we attempt to state absolutely whether students were, for example, feminist or patriarchal. Only relative changes among the students themselves, over time, were described.

Portions of the sex role ideology scale were extracted and used in our questionnaire, as were questions from several other validated and nonvalidated survey instruments (these are cited in our article, as is Kalin and Tilby's scale). As researchers, a major challenge we faced was finding a survey that would address all aspects of our study and elicit truthful rather than socially desirable responses. Pilot testing was invaluable in helping us to create the questionnaire we ultimately used.

McNevin's willingness to learn from and work with patients, rather than control them, exemplifies attitudes I believe are positively transforming the pedagogy and practice of medicine.

Susan P. Phillips, MD
Department of Family Medicine
Queen's University
Kingston, Ont.

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Educating med students about alternative therapies

I read with interest the recent Research Letter on complementary and alternative medicine (CAM) in Canadian medical schools.[1] History taking is fundamental in undergraduate and postgraduate teaching, but students should also be taught to ask patients about their use of CAM.[2] Only 39.8% and 38.7% of alternative therapies being used by patients were being disclosed to physicians according to surveys conducted in 1990[3] and 1997.[4]

Despite some claims that CAM preparations are harmless, these products have been documented to cause allergic[5,6] and other adverse drug reactions