WMA DECLARATION ON GUIDELINES FOR CONTINUOUS QUALITY IMPROVEMENT IN HEALTHCARE

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PREAMBLE

The purpose of health care is to prevent, diagnose and treat illness and to maintain and to promote the health of the population. The goal of quality review in health care is continuous improvement of the quality of services provided for patients and the population, and of the ways and means of producing these services. The ultimate goal is to improve both individual patient outcomes and population health.

The obligation to continuously improve one's professional ability and to rigorously evaluate the methods one uses has long been a fundamental tenet of the ethical codes of physicians. According to these codes, a physician must always strive to maintain and increase his/her knowledge and skills. The physician shall recommend only examinations and treatments that are believed to be effective and appropriate according to the best available evidence-based medicine.

Physicians and health care institutions have an ethical and professional obligation to strive for continuous quality improvement of services and patient safety, as stated in particular in WMA International Code of Medical Ethics, the Lisbon Declaration on the Rights of the Patient and the Resolution on Standardisation in Medical Practice and Patient Safety. These guidelines are intended to articulate the ethical grounds for these obligations and to strengthen quality review practices.

Ethical guidelines for health care quality improvement matter to all physicians, as well as to institutions providing health care services for patients, those providing continuous quality improvement services to assist physicians and organizations, health care payers and regulators, patients, and every other stakeholder in the health care system.

The Obligation to Establish Standards for Good Quality Work

Professionals, by definition, are responsible for specifying the standards that constitute good quality in their work and the processes needed for the evaluation of that quality. Health professionals, therefore, must define high quality health care and determine the best methods of measuring the quality of care delivered.

The Obligation to Collect Data

In order to assess quality of care, it is necessary to obtain reliable data on the patients and populations served as well as on care processes and outcomes. Patient records, whether recorded on paper, digitally or in any other way, must be created written and preserved with care and, with attention to confidentiality requirements in accordance with the WMA Declaration of Taipei. Procedures, decisions and other matters connected with patients should be recorded in a format that will allow information for measuring specific standards to be available on a timely basis when needed.

The Role of Professional Education

Health care professionals should have adequate opportunities to maintain and develop their knowledge and skills by participating in continuing medical education and/or continuing professional development. Clinical guidelines based on professional standards for high quality care should be created and made easily available to those requiring them. Health care training should include specific instruction in quality improvement techniques, including opportunities for hands-on practice in measuring and improving quality. Health care institutions should create quality improvement systems for their own use and to ensure that instructions concerning such systems are followed.

Good quality work requires resources. Every effort should be made to make sure that adequate time and economic means are available for quality work.

Attention to inappropriate use of services

Inappropriate use of health care services includes overuse, underuse and misuse. Quality measurement in health care should include a balanced set of measures in all three areas.

Overuse of services occurs when health care services are provided under circumstances in which the potential for harm exceeds the possible benefit. Physicians can improve quality by reducing overuse, thus sparing patients the unnecessary risk that results from inappropriate health services.

Underuse of services is the failure to provide health care services that would be likely to produce a favourable outcome for the patient. Physicians should strive to expand the use of beneficial health care services that are underused.

Misuse of services occurs when an incorrect diagnosis is made or when an appropriate service has been selected for a correct diagnosis but the patient does not receive the full potential benefit of the service because of a preventable adverse event. Misuse of services can be greatly reduced by using risk management and error prevention strategies.

Monitoring Quality: Clinical Audits

Active participation in critical self-evaluation, usually through clinical audit programs, is a useful mechanism for healthcare professionals, including healthcare administrators and physicians, and the institutions in which they work, to improve the quality of their work. External independent examination and accreditation of the institution can also be of use, when carried out appropriately and with due attention to potential unintended effects.

Healthcare professionals and institutions should systematically record and reflect on adverse incidents and medical error for the purposes of learning and quality improvement. This should occur in an environment of trust (and confidentiality when appropriate) and to actively avoid a blame culture.

Internal and External Quality Assessment

At the individual level, a physician should continuously update their knowledge and skills and subject their level of ability to critical self-appraisal.

In organizations, the quality of health care can be assessed by both internal and external methods.

Health care institutions should create internal quality improvement systems for their own use and ensure that instructions concerning such systems are followed. These systems should include continuous conducting of internal clinical peer review and learning from adverse incidents, review examination and treatment methods and their attendant results, tracking of the organization's ability to react to quality data, and monitoring of patient feedback.

External quality review initiatives, such as external peer review and audit, should be carried out regularly and with a frequency corresponding to the evolution of the field or when there is special reason for external assessment. Any review should take into account risk adjustment of the patient population under consideration.

Whether internal or external, if the results of any quality assessment carry significant opportunities for benefit or threats of harms for the organization or individual being assessed, special attention must be paid to potential unintended and dangerous consequences of such quality assessments. It is especially important to monitor the results of quality improvement measurement and intervention strategies over time, with attention to their effects on especially vulnerable patient populations.

Protocols to be used for quality review should be replicable and transparent. Appeals mechanisms should be built into the protocols.

Confidentiality of Patient Records

Patient records are an invaluable source of data for quality improvement. As with other uses of individually identifiable patient-based information, consent is usually required from the patient prior to use. If consent cannot reasonably be obtained, then all attempts should be made to ensure that medical records are anonymised or pseudonimised for use in quality improvement efforts. In every case, patient records used for quality improvement must only be accessible to those who need to see them for the purposes of quality improvement.

Confidentiality of Peer Review

For peer review to be most effective, all parties involved must participate and recognize its importance. It is recommended that informed voluntary consent be obtained from those to be reviewed. Within a healthcare team, the work of each physician must be able to be evaluated. Information regarding an individual physician's

evaluation should not be published without the consent of the physician concerned. It is recommended that consent be obtained prior to publishing information regarding an individual physician's evaluation.

A provider of services may inform his/her patients about the results of quality review.

If reviews are made available to the public, careful monitoring must be undertaken to track the effects, intended and unintended, of such public reporting of performance data.

Ethical Review of Quality Improvement Activities

National codes of medical ethics and ethical principles and guidelines that relate to continuous quality improvement, audit and clinical review must be followed.

Quality improvement should be an ongoing and integral part of the operations of every health care organization. As such, the majority of quality improvement projects will not require specific review by an ethics committee. If there are doubts about specific issues or if a project poses more than minimal risk compared to the existing processes for care, then the project should be referred to an appropriate ethics committee or institutional review board. When such formal ethical review is needed, it should be undertaken by a committee with members who are knowledgeable about quality improvement techniques.

Competence and Impartiality of the Reviewer

Those who conduct performance reviews must be competent in quality improvement techniques and in clinical audit as well as experienced in the clinical field relating to the review. Where medical care is being reviewed, the reviewer should be a physician whose knowledge and experience is accepted by those being reviewed.

The reviewer should be impartial and independent. Whilst he/she must be aware of the activities under review, he/she must be objective in the report and base conclusions on critical evaluation of observation and facts. Commercial or competitive matters should not be allowed to influence the content of the reviewer's report.

Separation of Quality Reviews and Supervision by Authorities

Quality improvement of services and of health care systems is a requirement for every physician and health care institution. It is not supervision of professional activities by authorities and it must be kept independent of this. The results of performance reviews or audits of physician activities should be used by supervising authorities only subject to a separate agreement between them and the physicians concerned unless national legislation mandates an alternative approach. These activities must be fully cognizant of the local legal framework and must not expose participating physicians to litigation.