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EUROPEAN ASSOCIATION OF SENIOR HOSPITAL PHYSICIANS  
EUROPÄISCHE VEREINIGUNG DER LEITENDEN KRANKENHAUSÄRZTE  
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ΕΥΡΩ ΑΙΚΟΣΙΙΕΥΛΛΟΓΟΓΟΣ ΔΙΕΥΟΥΝΤΩΝ ΝΟΣΟΚΟΜΕΙΩΝ  
ASSOCIAZIONE EUROPEA DEI MEDICI OSPEDALIERI  
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<b>Author :</b>	<b>UEMS / Dr. Borman</b>
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# QUALITY ASSURANCE OF CLINICAL PRACTICE

UEMS policy paper, draft 6

## SECTION 1: INTRODUCTION

### The role of the UEMS

1) The Union Européenne des Médecins Spécialistes/ European Union of Medical Specialists (UEMS) is the representative organisation for specialist doctors from the national associations of all EU/EEA states and a number of non-EU/EEA countries. Its activities cover the full range associated with specialised medical practice and are jointly carried out by its Management Council and more than thirty Specialist Sections.

### Stakeholders

2) The UEMS recognises that six broad groups of stakeholders have a legitimate interest in ensuring that the highest standards of medical performance are achieved in the provision of healthcare. These groups can be summarised as: society as a whole; individual patients; the professionals who care for them; health service employers; the providers of funding for healthcare; and the regulatory authorities. Due to the differences in the health service systems in Europe, considerable variations exist in the relationships between these groups.

### Accountability

3) In modern society there is greater emphasis than ever before on accountability within healthcare. The UEMS recognises that this will require greater openness regarding standards by each of the stakeholder groups. The UEMS believes that this can best be achieved by ensuring that appropriate methods for the Quality Assurance (QA) of clinical practice are implemented.

4) For specialist doctors this will entail a greater focus on the quality of their practise; for society and individual patients expectations will need to be appropriate to what can be provided; employers will need to take greater responsibility for those they employ; funders of healthcare for the extent to which funding is made available; and regulatory authorities will need to ensure that appropriate structures are in place to achieve these goals.

### The quality agenda

5) The UEMS believes strongly that components of quality management as applied to medical care have specific applicability. Quality Assurance (QA) should therefore be kept separate from Quality Improvement (QI) and Quality Control (QC). The UEMS has published a policy paper on QI – “The Basel Declaration on CPD” – and is preparing one on QC, which it believes is limited solely to the field of medical regulation.

6) In the context of this paper the UEMS defines Quality Assurance as the regular review against defined standards of clinical practice.

7) This definition should be taken as applicable to all factors affecting healthcare provision hence will have direct implications for each of the stakeholder groups. Factors such as resource availability, practice context, team-working and expectations – both medical and lay – all will influence the outcomes of clinical practice and how these are interpreted.

8) By comparing themselves against accepted professional standards QA allows individual doctors to demonstrate the quality of their clinical performance. It should also assist them in confirming their continuing fitness to practice.

### **Objectives**

9) This policy is intended to assure all stakeholders that specialist doctors collectively and individually accept their responsibility to demonstrate that they are committed to the delivery of high quality care for their patients.

10) This is coupled with a requirement for other stakeholder groups to recognise their responsibilities in this area. Each of these must consider the nature and extent of their influence on the quality of clinical practice and acknowledge the need to support high standards by their own actions.

11) It is further intended to provide additional impetus to the development of, and support for, the QA of clinical practice throughout Europe. There is a clear requirement for the continuing development of professional standards to match changing expectations, technologies and resource availability.

12) There is also an absolute requirement for the support of QA by all stakeholders. This will involve information technology and financial resources, time for practitioners to engage in QA activities, and the political recognition of the importance of these activities for all involved in the field of healthcare.

## **SECTION 2: THE DOCTOR IN CONTEXT**

### **The balance of responsibilities**

13) The UEMS accepts the principle that doctors should be able to demonstrate their continuing fitness to practice by engaging in a suitable QA process. However this can only correctly occur if a system of QA looks at doctors in the overall context of the health care system within which they practise.

14) An appropriate QA system therefore will consider all relevant components: the individual doctor; the team within which the doctor works; and their working environment. It is only by assessing all of these, and considering the influences of each, that valid assessments can be made.

### **Why quality assurance matters**

15) Each stakeholder group will recognise the importance of assessing and assuring the quality of healthcare. Patients consult doctors to have their health problems dealt with in an effective, safe and timely manner; practitioners want to know that when they prevent, cure or palliate illness, they are improving the health of their patients; regulatory authorities and employers want to be assured that the specialists in their hospitals are providing appropriate and high quality healthcare; and fund-holders want to know that they are receiving value for the money they provide for the medical care of the population for whom they have purchasing responsibilities.

## **Setting standards**

16) Throughout medical practice there is an increasing emphasis on the use of quality comparators either as a guide or as a point of reference. These have been classified according to the degree to which they are supported by evidence and, in order of increasing validity, are options, guidelines, recommendations or standards.

17) Standards may be established by a range of techniques. These include: determination by peers based on available relevant information; by comparison with norms of practice such as national procedure databases; by the scientific evaluation of new technologies or medicines; or by an acknowledged panel of experts. There are some common themes that should be considered, namely that while standards may vary according to national circumstances, standard-setting requires a solid evidence base, is likely to be medically-led and requires a high degree of consensus in order for these indicators of quality to become accepted.

## **Measures of performance**

18) Performance is a term that reflects all components of a doctor's practice. It is broader than, and incorporates the term competence, which refers to the knowledge that a doctor possesses. In its simplest form performance refers to what a doctor does and competence to what a doctor knows.

19) It is possible to set measures of performance, which may be independent of or informed by established standards. These performance outcome indicators can be individual, collective, or global. As such they may be reflective of the practice of individual doctors, the team within which they work, or their practice environment. Outcome indicators may be defined as measures of the results of clinical practice, and may be direct or indirect indicators of performance.

## **Influences on outcomes**

20) As with any discrete assessment measure, performance outcome indicators are subject to factors that may affect their validity. It is essential when setting, measuring and considering the results of performance indicators to recognise the potential influence of such factors.

21) These may include the case-mix of patients an individual doctor cares for; practitioners vary in the extent to which they specialise, and in dealing with patients who may have more advanced or complicated disease. Their outcomes will need to be measured against standards that reflect this.

22) The influence of other team members also must be considered. One example is that the results of a surgeon's practice will be influenced by the results of the anaesthesiologist(s) with whom they work, and the many other members of the pre- and post-operative care teams. Another might be that of a physician, whose treatment outcomes will be dependant on the many other members of the in-patient and rehabilitation teams that contribute to the care of their patients.

23) The environment within which doctors work also must be considered. Factors such as resource availability, numbers of patients, their expectations and other recognised safety variables – regarding the nature, quality and extent of their care – may have a significant influence.

24) When developing or monitoring a QA system it is essential therefore to ensure that appropriate consideration is given to the potentially significant influence these variables may have on the measured outcomes of medical practice.

#### **Which outcomes?**

25) The UEMS considers it essential that Quality Assurance systems are designed around methodologies that have the confidence of all stakeholders and reflect outcomes that are recognised by all as valid.

### **SECTION 3: CURRENT QUALITY ASSURANCE SYSTEMS**

#### **The working environment**

26) In many European countries systems have long been established for the inspection and accreditation of healthcare institutions. Many models exist: from organisations established by governments for this purpose, professional associations and independent inspecting bodies. The UEMS itself, through its Specialist Sections has active visitation programmes in many speciality areas that have assisted in the assurance and further development of high standards throughout Europe.

27) The best developed and supported model is that of external audit by peer review, in which a team of visiting specialists drawn from either a national or international pool of trained inspectors will assess an institution according to defined criteria. These standards typically will cover practice facilities, the provision of resources and the management of these, collated outcomes of clinical practice, and teaching facilities. Greater emphasis increasingly is being placed on local quality assurance initiatives such as standard-setting and healthcare process analysis.

28) The support of practitioners by their employing institution is a further important standard. Criteria frequently include the provision of resources for continuing professional development, teaching and research. The inclusion of employees in all aspects of the institution's function, most notably their involvement in the maintenance of high standards, is also important.

#### **The healthcare team**

29) Inspection by outside visiting teams is also a well established method for the assurance of the quality of care provided by teams. The consideration of communication and team-determined outcomes are frequently emphasised criteria, as is the existence and function of local quality monitoring methods.

30) Most notable amongst these is the use of internal audit by a clinical department or speciality team. Audit has been defined as the continuing review of practice against defined standards. It has been implemented widely throughout Europe with well-established systems at local, regional and national levels and a comprehensive supporting literature.

#### **The individual doctor**

31) While individual doctors should always be considered within a broader practice context, methods exist for assuring the quality of their overall performance or separate components such

as knowledge, skills, behaviour and engagement in CPD. Individual outcomes can be considered by methods such the audit of individual practise and review of performance with peers. More recent innovations have included surveys of patients and colleagues regarding their experience of a practitioner's work.

32) A wide variation exists as to the manner in which these measures of an individual specialist's performance are considered. Some models emphasise developmental and supportive review, others a more managerial approach. The UEMS believes that due recognition must be made of the professional nature of specialised medical practice when establishing quality assurance systems that focus on individual practitioners.

### **Methods common to all three**

33) A growing awareness of the importance of risk management as reflecting all three levels of assessment has led to its inclusion in many QA systems. This may be achieved through the reliance on confidential incident reporting or more active patient safety programmes such as the reviewing of audit results.

## **SECTION 4: THE NEED FOR RESOURCES**

### **The need for resources**

34) It is an absolute requirement for any quality assurance system that it is supported by appropriate resources. The nature and amount of these will vary according the system that is established, but must include: time, for practitioners to engage in all aspects of the QA cycle; people, to staff the system itself; money, to provide for all agreed components; and information technology, to assist with the collection, collation and analysis of results.

### **The source of financial resources**

35) Any such system of quality assurance should be funded openly. Ultimately it is patients, either directly or as taxpayers, who will pay for this; as stakeholders they have a right to know that QA systems are appropriately funded and are financially accountable.

36) The UEMS believes strongly that if a quality assurance system is established, it is the responsibility of any organisation or body that has required this to ensure that adequate initial and ongoing funding is provided.

## **SECTION 5: A WORKABLE MODEL**

### **UEMS proposal**

37) The UEMS believes that, building on the experience already gained around Europe, a generic workable model may be developed and recommended for implementation. This would itself provide a standard against which further systems could be compared.

38) An essential concept is that of the quality assurance cycle: of standard-setting, monitoring of existing practice, the review of results, seeking improvement by feedback and other changes, and the setting of new standards for the next cycle.

39) Such a system may be established at any tier of function: whether team, departmental, cross-speciality or even hospital-wide. It is essential also to ensure that this system itself is subject to regular external assessment and review. Accordingly the UEMS recommends that the structure and function of such systems themselves are inspected regularly.

40) Ideally, in the context of hospital medical practice, the development and functioning of such systems should involve more than one stakeholder group. Patient and public groups may be represented where appropriate in the setting of standards; regulatory authorities will often have contributed to this process; employers and fund-holders will be important to the implementation of change following the review of results.

41) The monitoring of clinical practice must be valid and sensible in order to maintain the co-operation of all stakeholder groups. Non-medical stakeholders will have little confidence in systems that do not – or are not seen to – address relevant matters according to accepted standards, and introduce improvements where necessary. At the same time, professional groups will need to feel engaged in a system that they recognise as relevant to their practice and supported in an appropriate manner.

42) All parties must recognise that – other than in the rare situation of when major problems are identified – feedback should be constructive and developmental. It is more important to maintain long-term confidence in good quality assurance mechanisms than to lose this by inappropriate intervention.

43) In addition to their defined role of confirming the extent of good practice, QA systems will also identify practice that lies outside recommended and accepted standards. Ideally it should be from the commencement of QA monitoring that mechanisms are established to ensure that such “outliers” can be examined in greater detail. In the case of excellent practice potentially to provide an example for others to follow, in the case of poor practice to ensure that this is examined fully and resolved.

### **Other mechanisms**

44) Other mechanisms have been suggested to ensure the maintenance of high standards of medical practice. Systems have been suggested, and in some areas established, that are based on ensuring the compliance of practitioners. This may be either by the recertification of their practice privileges or admitting rights, or by the revalidation of their registration to practice as doctors. There is no evidence that demonstrates the additional effectiveness – beyond that achieved by the systems described above – of such mandatory systems.