IRISH MEDICAL ORGANISATION

Ceardchumann Dochtúirí na hÉireann

IMO Submission to the National Clinical Effectiveness Committee (NCEC) on the development of a National Suite of Clinical Guidelines.

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The IMO would like to make a short Submission to the National Clinical Effectiveness Committee (NCEC) on the general development of a National Suite of Clinical Guidelines and reiterate the following comments made to the Health Information and Quality Authority (HIQA) in relation to the Draft National Quality Assurance Criteria for Clinical Guidelines.

Scope and Purpose of Clinical Guidelines
Topics for Clinical Guidelines are to be selected because they are important to large numbers of people with substantial morbidity or mortality and where evidence of variation in care exists. Classical Quality Assurance (QA) seeks to control to a quality standard removing variation both below and above the standard chosen. Clinical guidelines must not require reducing quality of care where this is above standard. Recent national policy is for standardising care in a single tier system. Clinicians providing excellent care should not be required to deliver a lower standard of care.

Stakeholder Involvement
The frontline clinicians who have knowledge of effectiveness should be explicitly represented in the development of clinical guidelines. They should have appropriate clinical experience and should enjoy the confidence of their peer colleagues.

Service users involved in guideline development should be appropriate to the topic and bring practical experience to the table. Some patient representative organisations are not membership organisations. It is important that "the patient view" truly a representative one.

Application of Clinical Guidelines
While Clinical Guidelines are designed to be applied to groups (population care), clinical practitioners are required to respond to the expectation of patients for personalised care. Modern scientific developments are increasingly identifying individual factors that underlie disease and strengthen the evidence for the need to personalise care.

The matter of individual care needs to be dealt with in the application of clinical guidelines. Clinicians are expected to be wise in their application of data, information and knowledge. Clinicians judge the effectiveness and appropriateness of care by monitoring individual patient response and need to be able to react to this clinical feedback on the effects of any guidance they may be following. Guidelines are to be adhered to only if they result in an optimal clinical outcome. It seems that the role for guidelines is for an initial introduction of care for some conditions. Having options within each guideline is important.

The *Medical Council's Guide to Professional Conduct and Ethics* states that Medical Practitioners have a paramount responsibility to act in the best interest of their patients. Following a guideline or failure to follow a guideline (while acting in the best interest of a patient) should not create the basis for a complaint to the Medical Council.

Clinical Protocols that are defined as a *precise sequence of activities with little scope for variation* may in certain circumstances be incompatible with Medical Council Requirements of Medical Practitioners in so far as doctors have a duty to help patients make an informed decision about their own care.

Resource Constraints
Medical Practitioners have a paramount responsibility to act in the best interest of a patient and to advise patients on the different options of care available to them including the most effective care. It is not appropriate for a clinical guideline that is constrained by resources to propose conflict with this requirement.

Clinical guidelines in a country which is unable/unwilling to fund essential health care to normal international standards will impose further impossible targets on health care professionals. It is essential that Clinical Guidelines are directed at entities which fund health care provision and not solely at health care professionals who have no control over funding of service provisions.

The Dated Nature of Guidelines
Medical practice is a dynamic process and guidelines are quickly dated. Practitioners will be up to date in their field of practice through CPD/CME. Given the time lag involved in gathering the evidence for systemic reviews and the additional time for its incorporation into formally quality assured clinical guidelines, many guidelines will not be as up to date as the practitioners who may be requested to apply them. Provision should be made for clinicians to modify guidelines accordingly. Also the Medical Council in its competence assurance process could be frustrated by a mismatch between clinical guidelines and maintaining up to date practice.

Clinician Ownership of Quality Assurance
No Quality Assurance programme will succeed unless clinicians really engage with it. Clinicians must be given ownership of the QA agenda. The IMO benchmark survey (April 2011) found morale among consultants at an all-time low. Consultants do feel suitably involved in the running of their own clinical and speciality services. However, more broadly consultants do not feel their views carry enough weight in the overall hospital decision making process or indeed that they are consulted about changes taking place in the hospital. The NCEC have a duty not to contribute further to the alienation and demoralisation of clinicians by adopting a top-down approach to quality improvement.

Medical Advancement
Finally, the broader aspects of practice by guideline must be taken into consideration. If all practice were to be undertaken on the basis of guidelines medicine advancement would cease, innovation would be stifled and personalised care would cease. Guidelines are useful where what they are seeking to guide is a uniform simple linear process. However individual patients are not linear and change is constant. Realistic QA must be flexible and embrace the complexity of clinical care.