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5 million lives campaign で推奨される 12 施策の手引き、文献、ツール、情報源の URL

（以下の資料は http://www.ihi.org/IHI/Programs/Campaign/Campaign.htm?TabId=2 のページに全てあります。資料のダウンロードにはメールアドレス登録（無料）が必要です。）

● 褥創予防 Prevent Pressure Ulcers

手引き

http://www.ihi.org/ihi/download.aspx?file=/NR/rdonlyres/5ABABB51-93B3-4D88-AE19-BE88B7D96858/0/PressureUlcerHowtoGuide.doc

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http://www.ihi.org/ihi/download.aspx?file=/NR/rdonlyres/E583E279-5539-481A-9671-3F3A9731F35B/0/PressureUlcerBibliography.doc

ツール

http://www.ihi.org/IHI/Topics/MedicalSurgicalCare/MedicalSurgicalCareGeneral/Tools/PreventingPressureUlcersTurnClockTool.htm

● MRSA 感染の低減 Reduce Methicillin-Resistant *Staphylococcus aureus* (MRSA) Infection

手引き

http://www.ihi.org/ihi/download.aspx?file=/NR/rdonlyres/F4D9DE7A-3952-4AE7-BBAC-4E4222084A03/0/MRSAHowtoGuide.doc

文献

http://www.ihi.org/ihi/download.aspx?file=/NR/rdonlyres/DAEB2EBC-975A-4C71-A5AE-6CBE76E0F9E3/0/MRSABibliography.doc

ツール

http://www.who.int/patientsafety/information_centre/ghhad_download/en/

http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Tools/HowtoGuideImprovingHandHygiene.htmhttp://www.apic.org/Content/NavigationMenu/GovernmentAdvocacy/MethicillinResistantStaphylococcusAureusMRSA/Resources/MRSAguide.pdf

http://www.apic.org/Content/NavigationMenu/PracticeGuidance/Reports/hai_whitepaper.pdf

● 危険度の高い薬物の誤投与防止 Prevent Harm from High-Alert

Medications

手引き

http://www.ihi.org/ihi/download.aspx?file=/NR/rdonlyres/8B2475CD-56C7-4D9B-B359-801F3CC3A8D5/0/HighAlertMedicationsHowtoGuide.doc

文献

http://www.ihi.org/ihi/download.aspx?file=/NR/rdonlyres/FC5C4EDC-CDCD-4A2F-B327-D0044EB3960D/0/HighAlertMedicationsBibliography.doc

情報源

http://www.ihi.org/IHI/Topics/PatientSafety/MedicationSystems/Resources/ISMP.htm

● 外科的合併症の低減 Reduce Surgical Complications

手引き

http://www.ihi.org/ihi/download.aspx?file=/NR/rdonlyres/AC9AAEED-7516-4371-8810-8BF45B8CE9C2/0/SCIPHowtoGuide.doc

文献

http://www.medqic.org/dcs/ContentServer?cid=1137346750659&pagename=Medqic%2FListingPages%2FMainListingTemplate&parentName=TopicCat&level3=Literature&resetSessionForTopic=Yes&c=MQParents

ツール

http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/HospitalAcquiredVTEIncidenceCalculator.htm

情報源

http://www.medqic.org/scip/scip_homepage.html

● うっ血性心不全に対する信頼できるエビデンスのある治療の提供 Deliver Reliable, Evidence-Based Care for Congestive Heart Failure

手引き

http://www.ihi.org/ihi/download.aspx?file=/NR/rdonlyres/1E046BA4-9FB0-4532-BB23-5439EC34B321/0/CHFHowToGuide.doc

文献

http://www.ihi.org/ihi/download.aspx?file=/NR/rdonlyres/5F889153-E54D-48B8-97B4-33E3EDE0129A/0/CHFbibliography.doc

ツール

http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Tools/GeneralDischargeInstructionSheetCHF.htm

http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Tools/InterdisciplinaryPatient

FamilyEducationRecordCHF.htm
http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Tools/PhysicanAdmissionOrdersCHF.htm
http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Tools/PhysicianDischargeOrdersCHF.htm
http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Tools/PreliminaryDischargeInstructions.htm
情報源
http://www.americanheart.org/presenter.jhtml?identifier=1165
http://www.abouthf.org/
http://www.heartfailure.org/
http://www.americantelemed.org/
http://www.medic.org/
http://www.heartfailure.org/

● 理事会を引き入れよう Get Boards on Board

手引き(文献含む)
http://www.ihi.org/ihi/download.aspx?file=/NR/rdonlyres/95EADB8F-3AD6-4E09-8734-FB7149CFDF14/0/BoardHowToGuide.doc
ツール
http://www.ihi.org/IHI/Topics/LeadingSystemImprovement/Leadership/Tools/GuidelinesforUsingPatientStorieswithBoardsofDirectors.htm
http://www.ihi.org/IHI/Topics/ReducingMortality/ReducingMortalityGeneral/Literature/MoveYourDot™MeasuringEvaluatingandReducingHospitalMortalityRates.htm
http://www.ihi.org/IHI/Topics/ReducingMortality/ReducingMortalityGeneral/Literature/ReducingHospitalMortalityRatesPart2.htm
http://www.ihi.org/IHI/Topics/LeadingSystemImprovement/Leadership/EmergingContent/WholeSystemMeasuresToolKit.htm
http://www.macoalition.org/Initiatives/docs/Dana-Farber_PrinciplesJustCulture.pdf
http://www.ihi.org/ihi/files/Forum/2006/Handouts/C12_BLloyd_LMartin_GNelson_MStiefel_Dashboard.pdf
http://www.ihi.org/NR/rdonlyres/41A1F682-2AF3-4B2C-BE39-52A1E532A04F/0/BoardsonBoardGovernancequestionsquality.pdf
情報源
http://www.greatboards.org/
http://www.webmm.ahrq.gov/perspective.aspx?perspectiveID=45

● 急速対応チームの配置 Deploy Rapid Response Teams

手引き

http://www.ihi.org/ihi/download.aspx?file=/NR/rdonlyres/6541BE00-00BC-4AD8-A049-CD76EDE5F171/0/RRTHowtoGuide.doc

手引き（小児用補遺）

http://www.nichq.org/NR/rdonlyres/8FD722C8-BBE3-4D31-869C-D901ADA27356/3612/RRTsupplementversionAug8th.pdf

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http://www.ihi.org/ihi/download.aspx?file=/NR/rdonlyres/FE873F29-9F5B-44BA-9123-9F56F412AB94/0/RRTBibliography.doc

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http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Tools/2x2MortalityMatrixforHospitalsWithoutanICU.htm

http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Tools/SampleRapidResponseTeamStandingOrders.htm

http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Tools/SampleRapid+ResponseTeamEvaluationCriticalAssessmentTeamCritique.htm

http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Tools/SampleRapidResponseTeamEvaluationTool.htm

http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Tools/SampleFAQforRapidResponseTeamTrainingandEducation.htm

http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Tools/SampleRapidResponseTeamEducationandTrainingOnePager.htm

http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Tools/SampleRapidResponseTeamEducationandTrainingPacket.htm

http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Tools/SamplePolicyforRapidResponseTeams.htm

http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Tools/SampleRapidResponseTeamDocumentationTool.htm

http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Tools/RapidResponseTeamRecord.htm

http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/SampleSBARCommunicationTool.htm

http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Tools/BusinessCaseforImplementingRRTsPresentation.htm

http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Tools/RapidResponseTeamROICalculator.htm

http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Tools/RRTDataCollectionandSBARTool.htm

http://www.ihi.org/NR/rdonlyres/46B1EB30-2401-45CE-86C5-AA1D4DD7AEFA/0/FAQforRRTFINALpostedtoweb6206.doc

http://www.nichq.org/NR/rdonlyres/8FD722C8-BBE3-4D31-869C-D901ADA27356/3616/Recognitionofinstability.pdf

http://www.ihi.org/NR/rdonlyres/FC95F69A-4C01-4074-BEE1-3E5C440A0C34/0/PDSARRTworksheetstool.doc

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http://www.ihi.org/NR/rdonlyres/AD65F9E5-5262-44AB-9DB6-2A5477795574/0/RapidResponseTeamschecklist.doc

http://www.ihi.org/NR/rdonlyres/33EA56C3-3210-4234-9B14-B3D58A67F2C9/0/RapidResponseTeamsPtsandFam.pdf

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http://www.ihi.org/IHI/Results/WhitePapers/MoveYourDotMeasuringEvaluatingandReducingHospitalMortalityRates.htm

http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/

http://www.ihi.org/IHI/Programs/AudioAndWebPrograms/GausModelforImprovement.htm

http://www.nrcpr.org/nrcpr_met.html

● 薬物有害事象の防止 Prevent Adverse Drug Events

手引き

http://www.ihi.org/ihi/download.aspx?file=/NR/rdonlyres/98096387-C903-4252-8276-5BFC181C0C7F/0/ADEHowtoGuide.doc

手引き（小児用補遺）

http://www.nichq.org/NR/rdonlyres/8FD722C8-BBE3-4D31-869C-D901ADA27356/3576/ADEsupplementversionJuy26.pdf

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http://www.ihi.org/IHI/Topics/PatientSafety/MedicationSystems/Tools/MedicationSafetyReconciliationToolKit.htm

http://www.ihi.org/NR/rdonlyres/EAC128CA-6672-4FDC-B0DC-CD0D666B3B8F/0/WorksheetForTestingChangeCycle1and2Combined.doc

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http://www.ihi.org/IHI/Topics/PatientSafety/MedicationSystems/Tools/Medication+Reconciliation+Review+Data+Collection+Form.htm

http://www.ihi.org/IHI/Topics/PatientSafety/MedicationSystems/Measures/Errors+Related+to+Unreconciled+Medications+per+100+Admissions.htm

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http://www.ihi.org/IHI/Topics/PatientSafety/MedicationSystems/Tools/UniversalMedicationForm.htm

http://www.ihi.org/IHI/Topics/PatientSafety/MedicationSystems/Tools/TheMedForm.htm

http://www.ihi.org/IHI/Topics/PatientSafety/MedicationSystems/Tools/YourRoleinSafeMedicationUseAGuideforPatientsandFamilies.htm

http://www.ihi.org/IHI/Topics/PatientSafety/MedicationSystems/Tools/YourRoleinSafeMedicationUseAGuideforPatientsandFamilies.htm

http://www.ihi.org/NR/rdonlyres/2703D9D5-0113-4DD9-ABFE-C8FC37357D6F/0/MedicationReconciliationPtsandFam.pdf

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http://www.ihi.org/IHI/Topics/PatientSafety/MedicationSystems/Tools/BMHMemphisMedicationReconciliationForm.htm

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m.htm
http://www.ihi.org/NR/rdonlyres/4975EF0A-B81B-46FF-9675-B7710E70CB6F/5293/208106PreHospitalMedicationListOrderSheetMedReconc.doc
http://www.ihi.org/NR/rdonlyres/4975EF0A-B81B-46FF-9675-B7710E70CB6F/5289/ClinOpsPolicy263MedicationReconciliation1.doc
http://www.ihi.org/NR/rdonlyres/4975EF0A-B81B-46FF-9675-B7710E70CB6F/5290/MedCard0905.pdf
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http://www.ihi.org/IHI/Topics/PatientSafety/MedicationSystems/Literature/Reconcilingdoses.htm
http://www.ihi.org/Products/ProductDetail.aspx?Product=31
http://www.ihi.org/IHI/Topics/PatientSafety/MedicationSystems/Tools/Trigger+Tool+for+Measuring+Adverse+Drug+Events+%28IHI+Tool%29.htm
http://www.macoalition.org/
http://www.medpathways.info/medpathways/index.jsp
http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/
http://www.ihi.org/IHI/Programs/AudioAndWebPrograms/GausModelforImprovement.htm

● 急性心筋梗塞の治療の改善 Improve Care for Acute Myocardial Infarction
手引き
http://www.ihi.org/ihi/download.aspx?file=/NR/rdonlyres/4A61BD0F-56E0-44B2-8F6D-FABA49C017B2/0/AMIHowToGuide.doc
文献
http://www.ihi.org/ihi/download.aspx?file=/NR/rdonlyres/3D41D301-C2D2-4ADB-A0D7-837EE8F924F8/0/AMIBibliography.doc
ツール
http://www.ihi.org/NR/rdonlyres/FEBE8DB7-138E-48EF-B447-BF3E76F57464/0/DischargeCommunityVersionOctober2004.pdf
http://www.ihi.org/NR/rdonlyres/F78753AB-FEC8-4252-806F-CFFAE32AB8AF/0/AMIchecklist.pdf
http://www.ihi.org/NR/rdonlyres/BF6EBD0E-D20D-41C0-8009-211BDD94FE5B/0/AcuteMyocardialInfarctionPtsandFamilies.pdf
http://www.ihi.org/NR/rdonlyres/1F33C18B-50CB-4A7D-8AF9-52F4C1B90A39/0/AcuteMyocardialInfarctionPtsandFamilies_Spanish_.pdf
情報源

http://www.medqic.org/content/nationalpriorities/topics/projectdes.jsp?topicID=421
http://www.jcaho.org/pms/core+measures/changeinaceiforlvsdmeasuresincorparbs.pdf
http://www.acc.org/index.htm
http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/
http://www.ihi.org/IHI/Programs/AudioAndWebPrograms/GausModelforImprovement.htm

● 創感染の予防 Prevent Surgical Site Infection

手引き
http://www.ihi.org/ihi/download.aspx?file=/NR/rdonlyres/C54B5133-F4BB-4360-A3E4-2952C08C9B59/0/SSIHowtoGuide.doc
手引き（小児用補遺）
http://www.nichq.org/NR/rdonlyres/8FD722C8-BBE3-4D31-869C-D901ADA27356/3577/SSIsupplement.pdf
文献
http://www.ihi.org/ihi/download.aspx?file=/NR/rdonlyres/93401CD3-AA83-48A1-B304-0E3E36870F05/0/SSIBibliography.doc
ツール
http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/TipsforSaferSurgery.htm
http://www.ihi.org/NR/rdonlyres/C8EC0B78-C5C5-4556-B34D-CBC508D91777/0/SSIFAQfortheweb.doc
http://www.ihi.org/NR/rdonlyres/55C187F5-A901-4E60-B1F6-CABB5E97B65F/0/SSIchecklist.pdf
http://www.ihi.org/NR/rdonlyres/0EE409F4-2F6A-4B55-AB01-16B6D6935EC5/0/SurgicalSiteInfectionsPtsandFam.pdf
http://www.ihi.org/NR/rdonlyres/1EF206CD-F588-47CD-AC3E-3D304AA46CBD/0/SurgicalSiteInfectionsPtsandFam_Spanish_.pdf
http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Tools/HowtoGuideImprovingHandHygiene.htm
情報源
http://www.ihi.org/IHI/Topics/PatientSafety/SurgicalSiteInfections/Tools/CMS+Collaborative+Framework.htm
http://www.medqic.org/scip
http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/
http://www.ihi.org/IHI/Programs/AudioAndWebPrograms/GausModelforImprovement.h

tm

● 中心静脈ライン関連血流感染の予防 Prevent Central Line-Associated Bloodstream Infection

手引き

http://www.ihi.org/ihi/download.aspx?file=/NR/rdonlyres/0AD706AA-0E76-457B-A4B0-78C31A5172D8/0/CentralLineInfectionsHowtoGuide.doc

手引き（小児用補遺）

http://www.nichq.org/NR/rdonlyres/8FD722C8-BBE3-4D31-869C-D901ADA27356/3634/PediatricSupplementBSI.pdf

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ツール

http://www.ihi.org/NR/rdonlyres/F97F1525-3F89-4D3E-9E07-8538E7E0DF96/0/FrequentlyAskedQuestionsFINALpostedtotheweb6206.doc

http://www.ihi.org/NR/rdonlyres/6EC98A37-8B5E-4821-B0FE-DA1AB651D834/0/CentralLineInfectionsPtsandFam.pdf

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http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Tools/CentralLineInsertionChecklist.htm

http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Tools/HowtoGuideImprovingHandHygiene.htm

情報源

http://www.asahq.org/publicationsAndServices/infectioncontrol.pdf

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http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/

http://www.ihi.org/IHI/Programs/AudioAndWebPrograms/GausModelforImprovement.htm

http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Tools/HowtoGuideImprovingHandHygiene.htm

● 人工呼吸器関連肺炎の予防 Prevent Ventilator-Associated Pneumonia

手引き

http://www.ihi.org/ihi/download.aspx?file=/NR/rdonlyres/D823E3FD-D10B-493E-A6A8-

37C767825780/0/VAPHowtoGuide.doc

手引き（小児用補遺）

http://www.nichq.org/NR/rdonlyres/8FD722C8-BBE3-4D31-869C-D901ADA27356/3613/VAPsupplementversionAug8th.pdf

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http://www.ihi.org/NR/rdonlyres/63A554FA-43F9-41DF-83AB-E5F3559D138D/0/FAQfortheweb.doc

http://www.ihi.org/NR/rdonlyres/818C1992-F318-4DBD-AE54-B45BCD3AD7DB/0/VentilatorAssociatedPneumoniaPtsandFam.pdf

http://www.ihi.org/NR/rdonlyres/E837498E-FC23-47E4-9486-20C2E67EE433/0/VentilatorAssociatedPneumoniaPtsandFam_Spanish_.pdf

http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Tools/HowtoGuideImprovingHandHygiene.htm

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Medical Professionalism in the New Millennium: A Physician Charter

Project of the ABIM Foundation, ACP–ASIM Foundation, and European Federation of Internal Medicine*

To our readers: I write briefly to introduce the Medical Professionalism Project and its principal product, the Charter on Medical Professionalism. The charter appears in print for the first time in this issue of *Annals* and simultaneously in *The Lancet.* I hope that we will look back upon its publication as a watershed event in medicine. Everyone who is involved with health care should read the charter and ponder its meaning.

The charter is the product of several years of work by leaders in the ABIM Foundation, the ACP–ASIM Foundation, and the European Federation of Internal Medicine. The charter consists of a brief introduction and rationale, three principles, and 10 commitments. The introduction contains the following premise: Changes in the health care delivery systems in countries throughout the industrialized world threaten the values of professionalism. The document conveys this message with chilling brevity. The authors apparently feel no need to defend this premise, perhaps because they believe that it is a universally held truth. The authors go further, stating that the conditions of medical practice are tempting physicians to abandon their commitment to the primacy of patient welfare. These are very strong words. Whether they are strictly true for the profession as a whole is almost beside the point. Each physician must decide if the circumstances of practice are threatening his or her adherence to the values that the medical profession has held dear for many millennia.

Three Fundamental Principles set the stage for the heart of the charter, a set of commitments. One of the three principles, the principle of primacy of patient welfare, dates from ancient times. Another, the principle of patient autonomy, has a more recent history. Only in the later part of the past century have people begun to view the physician as an advisor, often one of many, to an autonomous patient. According to this view, the center of patient care is not in the physician's office or the hospital. It is where people live their lives, in the home and the workplace. There, patients make the daily choices that determine their health. The principle of social justice is the last of the three principles. It calls upon the profession to promote a fair distribution of health care resources.

There is reason to expect that physicians from every point on the globe will read the charter. Does this document represent the traditions of medicine in cultures other than those in the West, where the authors of the charter have practiced medicine? We hope that readers everywhere will engage in dialogue about the charter, and we offer our pages as a place for that dialogue to take place. If the traditions of medical practice throughout the world are not congruent with one another, at least we may make progress toward understanding how physicians in different cultures understand their commitments to patients and the public.

Many physicians will recognize in the principles and commitments of the charter the ethical underpinning of their professional relationships, individually with their patients and collectively with the public. For them, the challenge will be to live by these precepts and to resist efforts to impose a corporate mentality on a profession of service to others. Forces that are largely beyond our control have brought us to circumstances that require a restatement of professional responsibility. The responsibility for acting on these principles and commitments lies squarely on our shoulders.

—Harold C. Sox, MD, Editor

Physicians today are experiencing frustration as changes in the health care delivery systems in virtually all industrialized countries threaten the very nature and values of medical professionalism. Meetings among the European Federation of Internal Medicine, the American College of Physicians–American Society of Internal Medicine (ACP–ASIM), and the American Board of Internal Medicine (ABIM) have confirmed that physician views on professionalism are similar in quite diverse systems of health care delivery. We share the view that medicine's commitment to the patient is being challenged by external forces of change within our societies.

Recently, voices from many countries have begun calling for a renewed sense of professionalism, one that

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is activist in reforming health care systems. Responding to this challenge, the European Federation of Internal Medicine, the ACP–ASIM Foundation, and the ABIM Foundation combined efforts to launch the Medical Professionalism Project (www.professionalism.org) in late 1999. These three organizations designated members to develop a "charter" to encompass a set of principles to which all medical professionals can and should aspire. The charter supports physicians' efforts to ensure that the health care systems and the physicians working within them remain committed both to patient welfare and to the basic tenets of social justice. Moreover, the charter is intended to be applicable to different cultures and political systems.

PREAMBLE

Professionalism is the basis of medicine's contract with society. It demands placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of health. The principles and responsibilities of medical professionalism must be clearly understood by both the profession and society. Essential to this contract is public trust in physicians, which depends on the integrity of both individual physicians and the whole profession.

At present, the medical profession is confronted by an explosion of technology, changing market forces, problems in health care delivery, bioterrorism, and globalization. As a result, physicians find it increasingly difficult to meet their responsibilities to patients and society. In these circumstances, reaffirming the fundamental and universal principles and values of medical professionalism, which remain ideals to be pursued by all physicians, becomes all the more important.

The medical profession everywhere is embedded in diverse cultures and national traditions, but its members share the role of healer, which has roots extending back to Hippocrates. Indeed, the medical profession must contend with complicated political, legal, and market forces. Moreover, there are wide variations in medical delivery and practice through which any general principles may be expressed in both complex and subtle ways. Despite these differences, common themes emerge and form the basis of this charter in the form of three fundamental principles and as a set of definitive professional responsibilities.

FUNDAMENTAL PRINCIPLES

Principle of primacy of patient welfare. This principle is based on a dedication to serving the interest of the patient. Altruism contributes to the trust that is central to the physician–patient relationship. Market forces, societal pressures, and administrative exigencies must not compromise this principle.

Principle of patient autonomy. Physicians must have respect for patient autonomy. Physicians must be honest with their patients and empower them to make informed decisions about their treatment. Patients' decisions about their care must be paramount, as long as those decisions are in keeping with ethical practice and do not lead to demands for inappropriate care.

Principle of social justice. The medical profession must promote justice in the health care system, including the fair distribution of health care resources. Physicians should work actively to eliminate discrimination in health care, whether based on race, gender, socioeconomic status, ethnicity, religion, or any other social category.

A SET OF PROFESSIONAL RESPONSIBILITIES

Commitment to professional competence. Physicians must be committed to lifelong learning and be responsible for maintaining the medical knowledge and clinical and team skills necessary for the provision of quality care. More broadly, the profession as a whole must strive to see that all of its members are competent and must ensure that appropriate mechanisms are available for physicians to accomplish this goal.

Commitment to honesty with patients. Physicians must ensure that patients are completely and honestly informed before the patient has consented to treatment and after treatment has occurred. This expectation does not mean that patients should be involved in every minute decision about medical care; rather, they must be empowered to decide on the course of therapy. Physicians should also acknowledge that in health care, medical errors that injure patients do sometimes occur. Whenever patients are injured as a consequence of medical care, patients should be informed promptly because failure to do so seriously compromises patient and societal trust. Reporting and analyzing medical mistakes provide the basis for appropriate prevention and im-

provement strategies and for appropriate compensation to injured parties.

Commitment to patient confidentiality. Earning the trust and confidence of patients requires that appropriate confidentiality safeguards be applied to disclosure of patient information. This commitment extends to discussions with persons acting on a patient's behalf when obtaining the patient's own consent is not feasible. Fulfilling the commitment to confidentiality is more pressing now than ever before, given the widespread use of electronic information systems for compiling patient data and an increasing availability of genetic information. Physicians recognize, however, that their commitment to patient confidentiality must occasionally yield to overriding considerations in the public interest (for example, when patients endanger others).

Commitment to maintaining appropriate relations with patients. Given the inherent vulnerability and dependency of patients, certain relationships between physicians and patients must be avoided. In particular, physicians should never exploit patients for any sexual advantage, personal financial gain, or other private purpose.

Commitment to improving quality of care. Physicians must be dedicated to continuous improvement in the quality of health care. This commitment entails not only maintaining clinical competence but also working collaboratively with other professionals to reduce medical error, increase patient safety, minimize overuse of health care resources, and optimize the outcomes of care. Physicians must actively participate in the development of better measures of quality of care and the application of quality measures to assess routinely the performance of all individuals, institutions, and systems responsible for health care delivery. Physicians, both individually and through their professional associations, must take responsibility for assisting in the creation and implementation of mechanisms designed to encourage continuous improvement in the quality of care.

Commitment to improving access to care. Medical professionalism demands that the objective of all health care systems be the availability of a uniform and adequate standard of care. Physicians must individually and collectively strive to reduce barriers to equitable health care. Within each system, the physician should work to eliminate barriers to access based on education, laws, finances, geography, and social discrimination. A commitment to equity entails the promotion of public health and preventive medicine, as well as public advocacy on the part of each physician, without concern for the self-interest of the physician or the profession.

Commitment to a just distribution of finite resources. While meeting the needs of individual patients, physicians are required to provide health care that is based on the wise and cost-effective management of limited clinical resources. They should be committed to working with other physicians, hospitals, and payers to develop guidelines for cost-effective care. The physician's professional responsibility for appropriate allocation of resources requires scrupulous avoidance of superfluous tests and procedures. The provision of unnecessary services not only exposes one's patients to avoidable harm and expense but also diminishes the resources available for others.

Commitment to scientific knowledge. Much of medicine's contract with society is based on the integrity and appropriate use of scientific knowledge and technology. Physicians have a duty to uphold scientific standards, to promote research, and to create new knowledge and ensure its appropriate use. The profession is responsible for the integrity of this knowledge, which is based on scientific evidence and physician experience.

Commitment to maintaining trust by managing conflicts of interest. Medical professionals and their organizations have many opportunities to compromise their professional responsibilities by pursuing private gain or personal advantage. Such compromises are especially threatening in the pursuit of personal or organizational interactions with for-profit industries, including medical equipment manufacturers, insurance companies, and pharmaceutical firms. Physicians have an obligation to recognize, disclose to the general public, and deal with conflicts of interest that arise in the course of their professional duties and activities. Relationships between industry and opinion leaders should be disclosed, especially when the latter determine the criteria for conducting and reporting clinical trials, writing editorials or therapeutic guidelines, or serving as editors of scientific journals.

Commitment to professional responsibilities. As members of a profession, physicians are expected to work collaboratively to maximize patient care, be respectful of one another, and participate in the processes of self-regulation, including remediation and discipline of members who have failed to meet professional standards. The profession should also define and organize the educational and standard-setting process for current and future members. Physicians have both individual and collective obligations to participate in these processes. These obligations include engaging in internal assessment and accepting external scrutiny of all aspects of their professional performance.

SUMMARY

The practice of medicine in the modern era is beset with unprecedented challenges in virtually all cultures and societies. These challenges center on increasing disparities among the legitimate needs of patients, the available resources to meet those needs, the increasing dependence on market forces to transform health care systems, and the temptation for physicians to forsake their traditional commitment to the primacy of patients' interests. To maintain the fidelity of medicine's social contract during this turbulent time, we believe that physicians must reaffirm their active dedication to the principles of professionalism, which entails not only their personal commitment to the welfare of their patients but also collective efforts to improve the health care system for the welfare of society. This Charter on Medical Professionalism is intended to encourage such dedication and to promote an action agenda for the profession of medicine that is universal in scope and purpose.

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Report to Congress

Improving the Medicare Quality Improvement Organization Program – Response to the Institute of Medicine Study

Michael O. Leavitt
Secretary of Health and Human Services
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Executive Summary

The Medicare Quality Improvement Organization (QIO) Program (formerly referred to as the Medicare Utilization and Quality Control Peer Review Program) was created by statute in 1982 to improve quality and efficiency of services delivered to Medicare beneficiaries. In its first phase, which concluded in the early nineties, the Program sought to accomplish its mission through peer review of cases to identify instances in which professional standards were not met for purposes of initiating corrective actions. In the second phase, quality measurement and improvement became the predominant mode of Program operation. As a result of significant changes that have occurred in our understanding of how to improve quality, as well as changes in the environment to promote public reporting of provider performance and the development of performance-based payment programs, the QIO Program launched the QIO 8th Scope of Work (SOW) with a revised approach to supporting high levels of provider performance.

Section 109(d)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandated that the Institute of Medicine (IOM) conduct a review of the Program and how its impact could be enhanced. The IOM issued a report based on its study on March 9, 2006. The Centers for Medicare & Medicaid Services (CMS) also undertook its own intensive internal review of the Program beginning the fall of 2005. As a result of the IOM study and the internal Agency review, CMS has determined that there is a need for improvement of the Program to enable it to effectively promote high quality, efficient, and person-centered care for Medicare beneficiaries. This report responds to Section 109(d)(2) of the MMA, which requires the Secretary to report on the results of the IOM Study, including any recommendations for legislation, and provides a discussion of how CMS is taking action to address the issues raised in the Study.

CMS views the QIO Program as a cornerstone in its efforts to improve quality and efficiency of care for Medicare beneficiaries. The Program has been instrumental in advancing national efforts to measure and improve quality, and it presents unique opportunities to support improvements in care in the future. Consequently, CMS is undertaking these activities to ensure that the Program is focused, structured, and managed so as to maximize its ability for creating value. These improvements support broader initiatives to provide transparency for beneficiaries and create performance-based payment programs for providers. Most health care providers deliver care to Medicare beneficiaries as well as patients insured by commercial insurers. Recent efforts to improve quality reflect the idea that shared quality improvement goals and consistent quality measures for all patients will result in less burden to providers, as well as the opportunity to identify and achieve meaningful performance improvements. Thus, to achieve demonstrable and significant improvement in care for Medicare beneficiaries, the Program is supporting partnerships that engage a broad group of stakeholders for the purpose of improving quality of care for all patients based on common goals and measures. This approach facilitates leveraging private sector resources and expertise at the local and national level, with a potentially more significant impact on the quality and efficiency of the health care system.

CMS' response to the IOM study includes the following important Program improvement actions:

- Strengthening evaluation design to better assess the impact of the Program
- Strengthening financial oversight and establishing requirements for QIO board governance to assure appropriate use of contractor funds and the representation of key constituencies
- Increasing competition for QIO contracts
- Enabling QIOs to release information to beneficiaries about QIO findings related to their complaints
- Directing QIOs to focus on the local achievement of national quality and efficiency goals, to improve care for beneficiaries with significant medical needs
- Directing QIOs to support local initiatives to develop and use information on quality and cost to help beneficiaries, their caregivers, and their health professionals make better choices about their treatment options, and self-care

The paper has three sections. The first provides a brief history of the Program, with an emphasis on recent activities relevant to Program improvement activities. The second describes IOM's mandate under the MMA as well as the IOM recommendations to the QIO Program to enhance its impact. The third summarizes CMS' response to the IOM recommendations. Generally, the IOM recommendations for restructuring and improving the QIO Program are consistent with the improvements that have been undertaken in the QIO Program. As part of CMS' ongoing internal review of the QIO Program, CMS will continue to consider the IOM recommendations and make changes as appropriate to the Program.

Also included are two appendices – QIO 8th SOW Performance Measures and Proposed QIO Contractor Governance Guidelines.

Section One: Background

In 1982, Congress established the Medicare Utilization and Quality Control Peer Review Program, which was incorporated into Title XI of the Social Security Act. The purpose of the Program, as stated in Section 1862(g), is to improve the efficiency, effectiveness, economy, and quality of services delivered to Medicare beneficiaries.

Initially, during the Program's first phase, case review by physician peers was the primary method of accomplishing its purpose. Peer Review Organizations (PROs) reviewed cases referred by beneficiaries and providers and selected via sampling to identify instances in which professional standards were not met, and required providers to implement corrective action plans or referred them for sanction proceedings where appropriate. Although case review may have resulted in improvement by individual providers, the improvement was not systematic or measurable, and the reliability of case review determinations was questionable.

In the early nineties, in part in response to the recommendations of a report by the Institute of Medicine (IOM), the Program made a major change in its method. Case review was supplemented by the collection of data for quality measures, and where there was opportunity for improvement, PROs (renamed Quality Improvement Organizations or QIOs several years ago) offered technical assistance to providers. During this second phase of the Program, improvement on quality measures occurred. However, the impact of QIO activities on these improvements was not clear, and in 2003, the MMA mandated a review by the IOM of the Program's effectiveness.

Also over the past decade, the quality improvement landscape in health care has changed dramatically in several respects:

- Gaps in healthcare quality are more widely recognized by policymakers, consumers, and provider organizations. The landmark IOM publication "To Err is Human," that documented safety issues in hospital care, stimulated such recognition.
- The need for more fundamental changes in health care processes and systems to deliver consistent high-quality care is also recognized, again in part as a result of another IOM report, "Crossing the Quality Chasm."
- Movement has begun and momentum has now developed toward consumer choice in healthcare, through public reporting of provider performance and, more recently, performance-based provider payment.

Cognizant of these trends, the Program launched a strategic planning process in preparation for the current contract period (the QIO 8th Scope of Work or 8th SOW—effective in August 2005). Through this process, the Program determined that although improvement had occurred on clinical quality measures during the recent contract periods, there was a need for improvement of the Program if it was to succeed in promoting broader, more rapid improvement that resulted in high levels of quality for Medicare beneficiaries and efficient use of Medicare resources. To accomplish this, CMS planned improvements of QIO quality improvement work in the 8th SOW around