Patient Safety Strategies: A Call for Physician Leadership

The American health care enterprise, by far the most expensive in the world, continues to deliver, on average, a mediocre product (1). At its best, health care in the United States can be superb. It is fraught, however, with uneven quality, extremely expensive interventions, and an environment that continues to be remarkably unsafe for the patients it serves (2).

Work highlighted in the supplement on patient safety strategies that accompanies this issue (3) shows that there has been some progress since the publication in 2000 of the landmark Institute of Medicine report “To Err is Human: Building a Safer Health System” (4). A project team (supported by the Agency of Healthcare Research and Quality, from the RAND Corporation; Stanford University; the University of California, San Francisco; Johns Hopkins University; and ECRI Institute) examined the evidence base underpinning particular patient safety practices. With the help of an international panel of experts, they created a framework for reviewing studies about patient safety strategies. The group scrutinized 158 patient safety topics and selected 41 for either an in-depth systematic review (18 topics) or a brief review (23 topics) that focused on emerging data or new insights about implementing the strategy. Reviews entailed current literature searches; a priori–determined selection criteria; assessments of the quality of studies of safety interventions; and evaluation of context, implementation, and adoption issues. On the basis of the reviews, the expert panel rated the strength of evidence for each safety strategy: They recommended that 10 patient safety strategies should be “strongly encouraged” for adoption and 12 strategies should be “encouraged” for adoption.

The methods and findings of this review process are thoughtfully constructed and should be useful in future evaluations of evidence about strategies. In many cases, further evidence and validation are needed before the patient safety intervention can be accepted as proven.

Regardless, the analysis raises questions about why it has been so difficult over the past 12 years to obtain meaningful safety data and more substantially improve patient safety. The report reveals important clues and possible remedies. Physicians have been notoriously unwilling to consider treatment protocols, checklists, and, more recently, “bundles” that describe approaches to patient care (5). These have been criticized and labeled as “cookbook medicine,” while physicians argued for tailored care, emphasizing the uniqueness of every patient. The data that were reviewed, however, clearly demonstrate that checklists and bundles can substantially improve patient safety and quality of care. In training and in practice, it is essential that health care professionals understand that bundles of care provide a touchstone on which reproducible quality can be achieved while making the modifications that may be required for each patient. Some electronic health records have begun to incorporate this kind of information for the practitioner.

The enormous variability of care provided is a major challenge to the identification of evidence-based, safe care. Increasingly, it is important that physicians in each hospital and practice identify the steps that they will take in the diagnosis and care of the most common clinical problems they confront and follow these protocols with appropriate individual variation. Sometimes, they can build on work of professional societies and other organizations that provide such guidelines, but there is nothing to prevent the orthopedic surgeons in a given hospital from agreeing on the fundamental approaches that they will take in the care of a patient requiring a knee replacement, which will impact everything from prophylactic antibiotic use to protocols for increasing physical activity. Agreement among colleagues on a standard approach to community-acquired infection, hospital-acquired infection, or initial treatment of hypertension would not only provide a much higher consistency in patient care but also provide the basis for serious clinical investigation to compare outcomes when variations in these protocols are considered. In many cases, the evidence is unclear about the proper protocol, but until existing approaches are systemized, it will be very difficult to obtain the evidence.

Another lesson from these reviews is the importance of the system of care provided by a health care team. Some of the most successful programs have been those that minimize the roles of the physicians and maximize those of nursing or respiratory staff. It is ironic but often the case that the less the physician is required to do in the course of maintaining a bundle of care, the more likely it is that protocols will be followed and outcomes improved. As health care insurance coverage increases and the population grows with increasing amounts of chronic illness, the roles of nonphysician health professionals, including nurses and pharmacists, to provide quality and timely care can only expand. They are essential parts of an effective team that requires physicians to understand team function and their own leadership roles. Teams will be central to newer delivery models.

Hand hygiene represents another extraordinary example of the importance of physician behavior in reducing hospital-acquired infections. Despite all of the evidence about the germ theory of infection, many physicians somehow believed that their hands and stethoscopes were immune from the transmission of these organisms. Creating situations in which physicians demonstrate the key role they have as models for other members of the health care team is critical. Once again, the physician must be a leader.

We are very proud of the health sciences research enterprise, which has produced remarkable results in improv-
ing outcomes in many aspects of disease, such as cancer and congestive heart failure. However, it is remarkable that, despite the loss of life from lapses in quality of care and patient safety, so little money is invested in research in this area. The project team in the supplement calls for enhanced education and training for those interested in health care and patient safety research. Providing adequate funding for well-designed research in health care delivery would be an important magnet to bring the best and the brightest health care professionals and researchers into these studies. To improve survival from illness through biomedical research only to lose patients because of poor quality of care is unacceptable.

The articles in the supplement provide important opportunities for the future. Success depends on multiplicity of factors, including policies, reimbursement models, health care delivery models, systems, education, and financing. Critical to all of them is the role of the individual physician who is fully committed to the effort and is adaptable in a changing world in which bundles, protocols, team care, electronic data collection, and evidence-based treatment paradigms are undertaken. Historically, when physicians have not responded to the key elements of health care, such as access, cost, and quality, others have imposed solutions on them. Quality of care remains the arena in which physician leadership can still provide direction, innovation, and enhanced satisfaction for patients and caregivers.

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References