

# The context is the 'news' in healthcare improvement case reports

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The clinical case report is viewed with circumspection in an era of clinical evidence that is often measured by the rigour of the randomised controlled trial.<sup>1</sup> Nevertheless, case reports have enjoyed resurgence, particularly given their accessibility provided by electronic publication.<sup>2–4</sup> At a minimum, they broaden clinical experience from the comfort of one's study, and at their most profound, they provide fresh insights into pathogenesis and treatment.

## ENHANCE SIGNAL; REDUCE NOISE

Authors and editors must respect two increasingly scarce resources: readers' time and publications' space. What, then, might a more precise definition of a healthcare improvement case report add to the scholarly improvement literature? If crafted too broadly, it runs the risk of backsliding from efforts to bring order to the heterogeneity in quality improvement implementation reports.<sup>5</sup> However, a narrowed definition could enhance signal and reduce noise in the expanding scholarly literature.

Case report journals generally require their authors' adherence to guidelines.<sup>2–4</sup> Vandenbrouke offers additional refinement of these guidelines with a short list of rules for useful clinical case reports.<sup>1</sup> The list includes an imperative for a clear, single message, the explanation for how a report runs counter to an expected truth, a description of how it strikes the prepared mind, that is, what is the background that makes way for this report, and the need to 'lay bare' the author's thought process in crisp prose.

Are there comparable rules for the healthcare improvement case report? I would include Vandenbrouke's and suggest three more. Simply put, the report should also explicitly provide the 'news,' and answer the questions, how and why.

## WHAT'S THE NEWS?

The most profound clinical case reports, viewed in retrospect, described early clues to pathogenesis for known or emerging diseases. A classic example is found in the early reports of what came to be identified—with the perspective of time—as HIV/AIDS.

On reflection, the reader will have their favourite examples of classic healthcare improvement case reports. Mine include Murray and Berwick's description of advanced access for reducing waiting times,<sup>6</sup> or Lee *et al*'s original report of the Medical Emergency Team (Rapid Response Team).<sup>7</sup> These healthcare improvement case reports reflect Jenicek's characterisation of the best of clinical case reports. It is 'where everything begins.'<sup>8</sup>

One defines where everything began only in retrospect, a perspective that is sketched one report at a time. A central element of this perspective for improvement is provided by reports of fresh contexts. This issue of QSHC offers several examples. They include examples of fresh validation and refined context-specific strategies for reducing waits and delays for psychiatric,<sup>9</sup> primary care,<sup>10</sup> or emergency (casualty) patients,<sup>11</sup> safer identification of hospitalised children,<sup>12</sup> and reduction of blood transfusions<sup>13</sup>—all in new contexts (*see pages 234, 248, 200, 244, 239*). Please take a look at each one, and measure them by the criteria listed below.

## IN MOST REPORTS, THE CONTEXT IS THE 'NEWS'

I propose that for most healthcare improvement case reports, the context is the 'news.' Such reflection on the interaction between a strategy for improvement and a unique setting<sup>14</sup> builds the scholarship of healthcare improvement, one report at a time. The most important contribution that a healthcare improvement case report will offer—the 'news'—will be found most often in the author's deep exploration of that interaction.

Readers have come to expect that clinical case reports will adhere to an explicit format.<sup>1–3</sup> Similarly, authors of healthcare

improvement case reports should craft their reports mindful of similar reader's expectations. One could argue that the Quality Improvement Report (QIR) format comes close.<sup>15</sup> The format was advanced in *Quality and Safety in Health Care* by Moss and Thomson in 1991—explicit guidelines in a checklist-like format. As of this publication, over 100 such reports have been published by QSHC and BMJ, but certainly nowhere near the thousands of clinical case reports that fill the literature.

In addition, it will be helpful to explore the expanded dimensions of context offered by the SQUIRE publication guidelines.<sup>16</sup> For example, SQUIRE calls for explicit attention to the author's local problem and setting, exploration of the impact these elements have on outcomes, and greater mindfulness of external validation (generalisability to other settings).

In sum, I propose that a valuable approach to the healthcare improvement case report may be less about a rigid format, and more about reflective writing (box 1). This is a renewed call for clarity, simplicity and relevance. Above all, it invites the author to provide their news. That news most often will be discovered by deep

### Box 1 Reporting the 'news' in a useful healthcare improvement case report

1. Start with the Quality Improvement Report<sup>6</sup> as a framework
2. Attend to Vandenbrouke's rules<sup>1</sup>:
  - a. Provide a clear single message
  - b. How does this report run counter to an expected truth?
  - c. What is the background that makes way for this report?
  - d. 'Lay bare' the author's thought process
3. Provide unambiguous attention to why and how
4. Identify the news: write with explicit mindfulness of context
  - a. Maintain awareness of the readers' context
  - b. Address in clear, simple terms both the author's local problem and setting, and their impact on the outcomes
  - c. Use the discussion section generously to characterise how the results are both unique to the author's setting, but also generalisable to other settings

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reflection on the challenges and opportunities for improvement that are presented by the author's unique setting.

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