ACTION POINTS

Compiled by Tim Albert

The purpose of this page is to encourage dissemination of the findings in QSHC, particularly to managers. Please feel free to photocopy this page and pass it on.

Q: Are doctors from some medical schools more likely to be sued?

The authors looked at 30 288 malpractice claims against doctors in three US states and analysed them according to where the doctor had graduated. They found "a consistent difference in the malpractice claims history of physicians who graduate from certain schools". Schools producing doctors with the highest rates of claims against them were more likely to be public institutions and more recently established. Schools producing doctors with the lowest rates had significantly fewer residents and fellows. The authors say that their research shows that "graduates of medical schools that have previously been identified as high or as low 'malpractice claims risk' outliers are significantly more or less likely, respectively, to be sued". There are still important questions to be answered, such as whether the differences between high and low outlier schools could be affected by their curricula or admission policies, or by organisational or cultural differences.
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▸ **ACTION POINT**

We need to identify those aspects of medical education that make a doctor more or less likely to be sued.

"What is clear is that graduates from different medical schools . . . differ . . . in their professional competence (or, more precisely, their incompetence). Understanding the reasons for this will tell us both about malpractice and about the enduring effects of different approaches to education" (commentary, page 324)

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Q: How well do national guidelines on clinical practice take account of ethnic differences?

The authors, from the Netherlands, examined primary care practice guidelines in the USA, Canada, the UK, and the Netherlands for type 2 diabetes mellitus, hypertension, and asthma. They looked at ethnic specific information and recommendations, and at the strength of the evidence given. They found that guidelines do take account of ethnic differences, but to a varying extent: the US guidelines contained the most ethnic specific statements, with the Dutch guidelines the fewest. The authors say this could reflect historical and cultural differences. "Whatever the explanations may be for these differences, guideline developers should be aware of the potential problems for patients from ethnic minority groups. Ethnic differences should play an important part in both screening the available evidence and in the development of the guideline—for example, the composition of the expert panel. With the increasing movement of people between countries, this aspect will become even more important in the future".
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▸ **ACTION POINT**

Those developing guidelines should make sure that they take into account the needs of those from ethnic minorities.

Q: How can we bring about quality improvements in a national health care service?

The French National Agency for Accreditation and Evaluation in Health was set up in 1996 to improve the quality and safety of health care in public and private health care and in general practice. In response to requests from French healthcare organisations, they designed a "compendium" for use in quality improvement. They did this by carrying out a literature review to compile a preliminary list of methods and tools, and they then refined this using interviews with three experts on quality, a selection panel of 13 healthcare professionals, and a review panel of more than 40 potential users. The final package, consisting of 14 methods and 20 tools, was posted on the world wide web in September 2000 and has since become one of the most popular agency publications, with 5400 downloads in the first 6 months. The authors comment: "This was, in our mind, a pragmatic way of inciting healthcare organisations to adopt a project orientated approach towards quality improvement and of helping them to choose the approach(es) that suited them best at a local level".
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▸ **ACTION POINT**

It is possible to undertake nationwide initiatives in an attempt to improve the quality of health care.

Q: Can we reduce intravenous medication errors?

The intravenous administration of drugs is complicated and errors often occur. To find out how to reduce them, trained observers watched 113 nurses (and one doctor who took over from a nurse) in two UK hospitals as they prepared 483 and administered 447 intravenous medications. The observers identified 265 errors, of which 10% were "slips" (process failures), 23 % "mistakes" (planning failures), and 67% "violations" (deliberate deviations from policies or procedures). The authors write: "Observation of actual practice has shown that IV drug errors are not only caused by the immediate individual act, but a range of organisational and managerial issues—including training, cultural context, choice of product, purchasing policy, and design of technology—also contribute to errors." In particular, nurses need to have better training in handling IV medications, pharmacists need to be more engaged with ward practice, and pharmaceutical companies need to be aware of potential problems, such as overcomplicated designs and ampoules that look similar.
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▸ **ACTION POINT**

If we are to reduce IV errors, we need concerted action from practitioners, regulators, and the pharmaceutical industry.

Qual Saf Health Care: first published as 10.1136/qhc.12.5.396 on 7 October 2003. Downloaded from http://qualitysafety.bmj.com/ on April 18, 2021 by guest. Protected by copyright.