Health professions education
....

Turn up the heat on health professions education

D P Stevens
....

Five initiatives from *QSHC*

One year ago we posed three questions to address the potential contribution that *QSHC* might make to increase the momentum for healthcare quality improvement and patient safety.[1] In response to an invitation to comment, this journal's readers submitted dozens of responses that have served to guide the work of the journal. It is worth re-examining the three original questions one year later in the perspective of those comments. We start in this issue by revisiting the question: ''How can *QSHC* serve to heighten awareness of the knowledge for improvement and safety for the next generation of health profession students and trainees?''[1]

QSHC received many comments and recommendations from readers that address how the journal might contribute more effectively to health professions education. Themes from these comments included the following.

QSHC should:

- report model curricula;
- encourage studies that engage students and trainees in improvement initiatives;
- publish reviews of topics that might serve lecturers and tutors;
- offer case reports of learning from errors and near misses;
- report strategies for engaging teachers and tutors in quality improvement topics;
- publish studies of the academic culture and its relationship to implementing education and research for improvement;
- extend an explicit invitation to students and trainees to submit high quality reports for publication.

Articles have appeared in recent issues of *QSHC* that provide examples of safety curricula[2] and the need for improvement of care in clinical settings where students and trainees learn.[3 4] However, it is clear that the publication pace for such topics in *QSHC* does not address the urgency of this issue—both for the benefit of developing health professionals and for their future patients. It is time to turn up the heat.

Others have effectively addressed the barriers and challenges to health professions education for quality improvement and patient safety.[5] We want to reflect briefly on potential drivers for change that *QSHC* can offer. Here are five initiatives in this area.

(1) By its editorial policy, *QSHC* will encourage scholarly contributions to the fields of education for improvement and safety

Teachers and tutors in health professions schools and teaching hospitals must fulfil multiple missions including research, education, and patient care. As a consequence, improving clinical practice per se may not always be a first priority. It is frequently performed as a part time task by many clinicians who must also meet their obligations to teaching and research. On the other hand, there is an emerging cohort of teachers and researchers who are gaining academic promotion for their innovative work in quality improvement education. *QSHC* intends to harvest their work by providing a forum for their scholarly publications.

(2) *QSHC* invites reports of curricula in the ''basic sciences'' of improvement and safety, particularly as they relate to health professions education

The systematic identification of the scholarly sciences and topics that underpin improvement—for example, statistics, change psychology, and process improvement—has led to the evolution of the field. There exists an opportunity to frame these basic sciences alongside the existing basic sciences of medicine such as anatomy, physiology, and biochemistry to build an even more sound curricular foundation for the next generation of health professionals. Examples of programs that have established such curricula include the intensive 2 year National Quality Scholars Fellowship Program offered at five sites by the US Department of Veterans Affairs (http://www.va.gov/oaa/SF_NQSF_default.asp) and the Master's degree program offered by the Center for Evaluative Clinical Sciences at Dartmouth College in the US (http://www.dartmouth.edu/~cecs/). *QSHC* welcomes reports of these and similar programs, as well as critical evaluations of their outcomes.

(3) *QSHC* invites articles and commentaries that focus explicitly on linking the improvement of patient care with health professions education

Healthcare improvement as a topic for medical education frequently falls victim to challenges such as ''there's no more room in the curriculum for another topic'' or ''it won't be on the test''. However, these issues have been successfully overcome in some academic settings by integrating improvement across all patient care settings. One strategy that has provided a fresh and strategic focus on improvement and systems has been the Outcomes Project adopted by the Accreditation Council for Graduate Medical Education (ACGME), the US accreditation agency for postgraduate training. Specifically, the ACGME has anchored accreditation of graduate medical education (postgraduate) programs in six general competencies: patient care, medical knowledge, communication, professionalism, *practice based learning and improvement*, and *knowledge of systems*.[6] The clarity with which this initiative focuses on both care and education in the more than 7000 postgraduate training programs in the US has had a profound impact by elevating healthcare quality improvement and systems knowledge to a high priority. The literature on quality improvement needs more reports of efforts to implement this and similar initiatives.

(4) *QSHC* will contribute to building the community of improvement teachers by providing a publication medium for scholarly organizations and educational consortia that focus on education for improvement and safety

For example, the recent establishment of the Academy for Healthcare Improvement (https://a4hi.org/) provides a venue for advocacy for careers in both research and education in healthcare improvement. *QSHC* will provide opportunities for this and similar organizations to build momentum within the academic community for teachers' academic career development.

(5) *QSHC* invites manuscripts from students and trainees that report strategies for quality improvement and patient safety

Students and trainees provide a fresh perspective and a critical lens on quality and safety in patient care. That having been said, the editors of *QSHC* will apply the same rigorous review criteria to these submissions that apply to all manuscripts on these topics. The editorial expectation of excellent scholarship in these reports will provide both an obligation and an opportunity for teachers and investigators to use their students' preparation of such manuscripts as the context for effective teaching in these fields.

Our readers have provided excellent advice that *QSHC* can readily adopt. We invite your submissions as we endeavor to accelerate the formation of the next generation of health professionals for healthcare quality improvement and patient safety. It is time to turn up the heat.

Correspondence to: Dr D P Stevens, Association of American Medical Colleges, 2450 N Street NW, Washington, DC 20037, USA; dstevens@aamc.org

REFERENCES

1 **Stevens DP**. Three questions for QSHC. *Qual Saf Health Care* 2005;**14**:2–3.
2 **Coyle YM**, Mercer SQ, Murphy-Cullen CL, *et al.* Effectiveness of a graduate medical education program for improving medical event reporting attitude and behavior. *Qual Saf Health Care* 2005;**14**:383–8.
3 **Arora Y**, Johnson J, Lovinger D, *et al.* Communication failures in patient sign-out and suggestions for improvement: a critical incident analysis. *Qual Saf Health Care* 2005;**14**:401–7.
4 **Philibert I**, Leach D. Re-framing continuity of care for this century. *Qual Saf Health Care* 2005;**14**:394–6.
5 **Aron DC**, Headrick LA. Educating physicians prepared to improve care and safety is no accident: it requires a systematic approach. *Qual Saf Health Care* 2002;**11**:168–73.
6 **Leach DC**. Competence is a habit. *JAMA* 2002;**287**:243–44.

Racial and ethnic disparities in health care
....

Reducing racial and ethnic disparities in health care: an integral part of quality improvement scholarship

M H Chin, A T Chien
....

It is vital that quality improvement interventions address this unacceptable problem

We advocate three fundamental additions to the draft guidelines for quality improvement (QI) manuscripts proposed by Davidoff and Batalden.[1] The purpose of these additions is to highlight the opportunity that the guidelines offer for reducing racial and ethnic disparities in health care.

Equity is one of the six quality aims defined by the US Institute of Medicine in their 2001 report ''*Crossing the Quality Chasm*'', along with safety, effectiveness, patient centeredness, timeliness, and efficiency.[2] So far, effectiveness has been a frequent target of QI programs. Clearly, effectiveness is an important goal, but addressing equity offers great opportunities for profound improvement for both individual patients and society as a whole.

Racial inequity in health care is common to many pluralistic societies and is increasingly regarded as unacceptable. The Institute of Medicine's 2003 report ''*Unequal Treatment*'' documented substantial racial and ethnic differences in the quality of care in the USA.[3] The UK's National Health Service (NHS) and Commission for Racial Equality recently released ''*Race Equality Guide 2004*'' which provides a framework for achieving racial equality in the care of patients at NHS facilities.[4] Racial gaps in care are important because they lead to needless morbidity, medical complications, and mortality.[3] We know a considerable amount about the mechanisms causing these disparities.[3] There is therefore a crying need for solutions to reduce disparities, and QI interventions must play a key role.

We advocate the addition of three questions to the publication guidelines:

- What is the effect of the QI intervention on racial and ethnic disparities?
- What is the plan for addressing racial and ethnic disparities in health care with the QI intervention?
- Are there important unintended positive or negative consequences from the QI intervention that affect racial and ethnic disparities in health care?

(1) What is the effect of the QI intervention on racial and ethnic disparities?

What is not measured may not be seen. Most of us believe we are unbiased. We are moral and equitable and treat everyone the same. However, time and again health providers, organizations, and plans are surprised to find that disparities exist when they examine their own data, perhaps because some of the root causes of the differences are subtle or seamlessly embedded within the system of care such as the process by which patients are assigned to physicians or nursing floors. Organizations need to collect accurate racial data as part of routine care, and then reflect upon any differences in care by ethnicity.

(2) What is the plan for addressing racial and ethnic disparities in health care with the QI intervention?

A variety of conceptual models explain the mechanisms leading to differences in care.[3 5 6] These models describe multiple levers for influencing change including healthcare organization, financing, provider, and patient. What levers relevant for disparities does the QI intervention affect? Does the intervention meld general QI techniques and ethnically tailored solutions to ensure that patients of all races benefit maximally?

(3) Are there important unintended positive or negative consequences from the QI intervention that affect racial and ethnic disparities in health care?

For example, if the QI intervention includes provider profiling, does it penalize physicians who care for ethnic minority patients who are more sick, more poor, or non-English speaking, and thus unintentionally give incentives to dump such challenging patients? Is any case mix adjustment tool used? Are the direct costs or opportunity costs of the QI initiative disproportionately borne by racial groups? For example, are the resources used for QI taken from programs serving racial minority groups?