Quality Lines

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SPECIALISTS, PRIMARY CARE DOCTORS AND SYSTEMS IN THE TREATMENT OF DIABETES MELLITUS

In Canada it was found that consultation from endocrinologists or internists in concert with primary care doctors for people with newly diagnosed diabetes led to better disease-specific process measures but did not lead to improved survival. The authors carefully examine the methods, as well as their limitations, whereby this study concludes that ''more is not necessarily better''. An accompanying commentary explores further the specialist/primary care issue for persons with diabetes and concludes by proposing an alternative argument for improving care by improving *systems* of care.
See p 3 and 6

WHICH DOCTORS IN ENGLAND ARE INFLUENCED BY THE PATIENT'S AGE?

A survey of 85 doctors in England investigated whether, and how, individual doctor's clinical decisions were influenced by a patient's age. It looked at GPs, care of the elderly specialists, and cardiologists who were asked to make judgements about hypothetical electronic patients, followed by semi-structured interviews. Just under half of the doctors in each specialty treated elderly patients differently, independent of co-morbidity. Such patients were less likely to be prescribed a statin, given a cholesterol test, referred to a cardiologist or given an exercise tolerance test, angiography or revascularisation. Interviews revealed that some doctors saw old age, and age-associated influences, as a contra-indication to treat. These findings argue for the need to include age in investigations of social inequalities in access to appropriate healthcare.
See p 23

STAKEHOLDERS' ADVICE ABOUT USING INFORMATION SYSTEMS TO ENHANCE SAFETY IN PRIMARY CARE

Semi-structured interviews with a wide range of stakeholders in the UK were used to identify opportunities to enhance patient safety by more effective use of primary care information systems. They emphasised the need for better training and more effective applications of call, recall and reminders. Computer systems are used almost universally in primary care in the UK, yet there are ways these systems can be better used to enhance patient safety.
See p 28

A SAFETY SURVEY TO ASSESS SYSTEM FAILURES IN OPERATING ROOMS AND INTENSIVE CARE UNITS

Proactive methods that detect structural shortcomings before mishaps occur are widely used in other high-risk industries, but sparsely in healthcare. This report offers a strategy by describing the development and psychometric properties of a safety scale—implemented through inquiries among healthcare workers in operating rooms and intensive care units—that can be used to assess system failures and monitor improvement.
See p 45

HEROES AND MARTYRS: ARE RANDOMISED TRIALS ALWAYS NECESSARY IN QI RESEARCH?

This month's Heroes and Martyrs section looks at a contemporary hero and asks the question ''Must good quality improvement research be carried out only as a randomised clinical trial?'' Good research is based on generalisable theory, hypothesis testing and replication. If a QI project is generalisable and repeatable, it is probably good science. A randomised trial may not be the only way to answer the question ''Are we making healthcare better?''
See p 77

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