QUALITY
IN HEALTH
CARE

Editorials

International collaboration: harnessing differences to meet common needs in improving quality of care

See article on page 181

A growing number of countries worldwide are recognising a common need to build systemic capacity for safeguarding and improving quality of health care. Each country has a unique set of priorities and dynamics driving the speed and the substance of the quality agenda, constrained by the reality of the availability and distribution of resources. While acknowledging the considerable variation in context between countries, it is imperative to explore the role for, and potential of, cross-national collaboration to advance our common goals regarding improved performance in health care quality.

Often the conventional basis for collaboration is a perception of similar need and/or convergent initiatives. As useful as such collaboration may be, building a partnership on common needs but *different* initiatives may be more useful. It could build on the complementarity of experience and expertise, as well as the commonalties. Divergent legacies and orientations may point to the richest areas for learning through cross-fertilisation to facilitate transfer of insights and expertise.

One example of binational collaboration, building on both common challenges and different solutions, is the emerging repertoire of partnerships between the USA and UK in health care quality. These two countries, with stark differences in their health care systems, easily recognise their commonality of need as quality becomes a prominent focus of national health policy.

Identifying commonality of experience and need

Collaboration between the UK and the USA derives from the understanding that there are significant areas of convergence and divergence. In both these countries, as well as a growing number of others worldwide, the following dynamics are influencing the quality movement: increasing evidence of widespread problems in quality of care; attention to the gaps between research and practice highlighted by evidence-based medicine; increasing concern of the public about the quality and safety of their care; heightened debates regarding the role of professional self-regulation versus external oversight or government regulation; and pressures for investment in the infrastructure required to systematically improve care (e.g. information technology). Propelling the quality agenda in both the US and the UK are the growing number of movements at the citizen level which are nominally patient-centred in the UK and consumer-orientated in the US, but both focused on shared decision making and divested authority by health care professionals. In both countries accountability has become a part of routine discourse, though questionably yet a part of consistent execution in either.

Harnessing complementary experience

The USA and UK provide an interesting case study of how health systems can learn from one another—in fact, how the dramatic differences in structure, ethos, and resources which have predisposed the countries in contrasting directions provide a fertile basis for cross-learning.

Building systemic national capacity to remedy and improve quality in health care requires coordination and integration of activity at four levels:

- national policy formulation;
- national and system level infrastructure for monitoring and oversight;
- system level governance and operational management;
- clinical provision of services.[1]

The US and the UK exhibit strengths in different levels. The UK has produced exemplary national policy, created new infrastructure (such as the National Institute of Clinical Excellence and the Commission for Health Improvement), and designed functions for system level management and monitoring such as the National Service Frameworks and the National Performance Framework. These accomplishments derive from the monolithic structure of the NHS where policy, processes, and resources are more readily aligned. The USA is recognised internationally as a leader in quality measurement and reporting approaches, a strength largely explained by its market approach to the delivery of health care with a concentration of quality efforts at the level of corporate governance and operations management. The most powerful role of government in quality is that of purchaser (through the Medicare programme), with its ability to require compliance in order for providers to qualify for payment. The national commitment to developing quality measurement and improvement strategies for both public and private sectors is manifest in the re-authorisation and renaming of the Agency for Healthcare Research and Quality. Likewise, the decentralised market system in the US has driven significant investment in informatics and information technologies. Although the primary motivation has generally been to maximise revenue through improved electronic accounting and billing systems, a secondary gain is that these systems can facilitate expansion and diffusion of quality measurement and improvement initiatives. This potential for building quality improvement on information technology

has been demonstrated in those few US institutions that have taken advantage of the opportunity.

Recognition of such complementarity of expertise and experience has resulted in Anglo-American collaboration. Assisted by The Commonwealth Fund (USA) and The Nuffield Trust (UK) and facilitated by two annual meetings of leaders from both countries at Ditchley Park, UK, agreements are being completed to pursue work in mutually identified priority areas. Among the areas targeted for collaboration are national quality reporting, informatics, and patient safety and adverse event/error reduction. The first—national quality reporting—is a prime example of complementary experience where the UK has developed the template for a national approach while the USA has developed significant expertise in measure development and has had a fitful experience in the public disclosure of quality performance data.[2] In the second area, that of medical informatics, Dr Detmer's paper in this issue of *QHC* reinforces the point that "the national differences have resulted in complementary strengths" in information technology at the same time as both countries face common challenges in policy issues such as capitalisation of their information technology needs, data standards, privacy, and confidentiality.[3] The third area is that of adverse events and medical errors; optimising patient safety has attracted substantial public and press attention, and both governments have labelled patient safety as a priority. In both countries significant new reporting systems have recently been recommended[4 5] and the proposed approach for the NHS is the subject of Lucian Leape's editorial in this issue of *QHC*.[6]

Above and beyond the specific areas noted, the policy, managerial and academic leadership at the Ditchley Park conference unanimously agreed that a major challenge for the state of the art is to improve the evidence basis for the effectiveness of interventions to improve quality. Despite some investment in evaluating the scientific basis for health care quality measurement and improvement in both nations, much remains to be learned, especially in translating the research into practice and policy. The evidence base is insufficient and/or equivocal in evaluating the strengths and weaknesses of critical levers for change such as professionalism, regulation, financial incentives, performance feedback, and governance.

Advancing multinational collaboration

Recognition of both the commonality and complementarity of experience and expertise can provide a foundation for international collaborations. Three compelling arguments for organised international collaboration can be put forward. Firstly, the field of quality evaluation and improvement has universally applicable goals, methods, and intended outputs. Secondly, because the necessary research and development is resource intensive, technology transfer and expertise sharing are desirable. Thirdly, fair and valid international comparisons are possible only through formal international cooperation.

To provide support for international collaboration, a more systematic assessment and sharing of the experience and expertise of various countries will be valuable. Binational collaboration, such as that emerging between the US and the UK, as well as multinational collaboration such as that orchestrated by the World Health Organization, will need more than periodic conferences. It will require development of shared languages of measurement and evaluation, implementation of complementary programmes in each nation in keeping with its national character and its health care culture, and long term commitment to maintaining programmes for mutual benefit.

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Reporting of medical errors: time for a reality check

Earlier this summer an expert group chaired by the Chief Medical Officer in the UK produced a comprehensive and thoughtful analysis of the current unacceptable state of identifying, analysing, and learning from medical mishaps.[1] Although this report, provocatively named *An Organisation with a Memory*, applies specifically to the UK National Health Service (NHS), its analysis—and prescriptions—apply to health organisations the world over. The report embraces the insight from industrial safety research pioneered in the UK by Reason and others that human errors typically result, not from carelessness or incompetence, but from systems failures that are sometimes complex and difficult to analyse and correct.[2]

The call for better reporting, a more open culture, better mechanisms for ensuring that necessary changes are made, and a much wider appreciation of the value of the systems approach is welcome. The cornerstone of the recommendations is a greatly enhanced system of national reporting of adverse events. Although the benefits of such a programme seem self-evident, two questions must be addressed before proceeding with such a plan—namely: "Why aren't these events being reported now?" and "What would be the cost of such a system?"

Charles Billings, architect of the highly successful Aviation Safety Reporting System in the USA, has pointed out that there are two major reasons why people don't report adverse events: fear and lack of belief that reporting will lead to improvement.[3] Fear is multidimensional—fear of embarrassment, fear of punishment of self, fear of punishment of others, fear of litigation. Fear arises from the belief that errors and mishaps are caused by carelessness for

which the responsible individual should be punished. Doctors and nurses have been taught to believe this, so they fear both making a mistake and being caught. They and the public are quick to blame individuals when they make errors.

The expert group notes that "blame cultures . . . can encourage people to cover up errors for fear of retribution." This masterful understatement conceals the heavy price that the blaming culture extracts from doctors and nurses whose errors are discovered.[4] Interestingly, these punishments are usually calibrated to the gravity of the injury, not the gravity of the error. The nurse who administers a tenfold overdose of morphine that is fatal will be severely punished, but the same dosing error with a harmless drug may barely be noted. For a severe injury, loss of the right to practise or a malpractice suit may result. Moderate injuries may result in a reprimand or some restriction in practice. Punishment for less serious infractions are more varied: retraining, reassignment, or sometimes just shunning or other subtle forms of disapproval.

But the worst punishments are often self-inflicted: shame and guilt.[5] The expectation of perfect performance is deeply ingrained in doctors and nurses, beginning in school and continually reinforced in everyday practice. Shame results when we fail, which we inevitably do. Not surprisingly, doctors and nurses often will not admit errors—to themselves or to others. They don't report errors they can hide.

Reporting also rarely leads to improvement. Typically, the inquiry stops with the identification of the person who made the mistake; organisations learn little about underlying causes and are not motivated to make changes that would prevent the error recurring. Medical staff are aware of this and react accordingly. Why expose yourself or a colleague to the risk of punishment when no benefit will result? Curing this dysfunctional system—creating the learning organisation that the report calls for—will not come easily.

But if these obstacles could be overcome and a national reporting system were implemented, what would it cost to collect and analyse reports and make recommendations? The Aviation Safety Reporting System spends about $3 million annually to analyse roughly 30 000 reports, or about $100 (£66) per case. These "near miss" situations are far simpler to analyse than actual accidents, thorough investigation of which would almost certainly cost far more. It would be interesting to know, for example, the cost per case of investigations reported to the confidential enquiries. However, if we applied the figure from the Aviation Safety Reporting System to the 850 000 adverse events that are estimated to occur annually in the UK,[1] the cost of investigation would be £50 million annually.

Assuming that such expenditure is unlikely to be forthcoming, what are the alternatives? One might be to randomly sample and analyse, say, 10% of events. While such a sample might not be truly representative, it could produce useful information. Alternatively, analysis could focus only on fatal injuries which probably represent about 5–10% of all events. This might produce the most reliable data since deaths are easy to identify and hard to conceal. Another option is to identify a group of egregious—or "sentinel"—events that suggest a serious breakdown of safety such as surgery on the wrong part of the body, suicide of a patient under precautions, or maternal deaths. This would provide a more manageable number and have the advantage of possibly leading to changes that would be universally appreciated. Yet another approach is to identify a target condition for study—for example, patient falls or mishaps associated with use of certain types of drugs such as anticoagulants, chemotherapy, or insulin. All institutions would be asked to identify all target events during a one year period, conduct internal investigations, and report findings for national collation and learning. The costs of the investigations would be borne by the reporting institutions.

Whichever approach is taken, the NHS would be wise to test the method before implementing it by assembling a group of expert analysts to process a batch of cases to determine both the yield and the cost of collecting and analysing data and of making recommendations. Consultation with managers of the British Airways Safety Information System on the costs of running that highly successful reporting system would also be worthwhile. The costs of a properly performed investigation are probably such that only a few can be afforded annually. If that is so, then great care must be exercised in deciding what reports are required to be filed by whom, for unanalysed reports are worse than no reports, breeding discouragement, cynicism, and distrust.

Although the fiscal constraints to implementing any of these alternatives are considerable, the more formidable barrier remains the punitive environment that pervades our institutions. Changing that will be difficult indeed, for it is so deeply embedded in our hearts and minds. One way of changing hearts and minds is to change behaviour. Vincent and his colleagues at University College, London have pioneered the use of a medical accident investigative tool that leads hospital staff through a comprehensive and rigorous examination of all of the factors that could have played a part in causing an injury.[6] Not only does this process invariably uncover multiple systems defects, the process of using it imprints on the users the inescapable fact that accidents result from multiple causes, of which the obvious human error is often the least important. If the findings are used by the hospital to correct defects, internal reporting will skyrocket. This tool, a protocol for the investigation and analysis of clinical incidents,[7] should be in the safety armamentarium of every hospital.

The NHS has a historic opportunity. *An Organisation with a Memory* gives much needed guidance and issues a mandate that must not be ignored. Wisely implemented and adequately funded, it can lead to substantial improvements in the safety of health care.

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