Accreditation of services would improve patient safety

Bodies such as the UK royal colleges and related professional organisations should develop systems for peer review of clinical services to drive up quality, says **Narinder Kapur**

The health secretary, Jeremy Hunt, is reported as saying of the NHS, "We tend to default too quickly to top-down rather than peer review as the best way of improving standards."[1]

Accreditation is a well established form of external peer review that takes place in education. In healthcare, however, it is patchy, and some clinical services have none. Although accreditation is not a panacea for failings in healthcare and is only one part of the jigsaw that makes up the pursuit of clinical excellence and patient safety,[2 3] it can help substantially in reducing medical errors[4]; in one study the improvement was found to be around a 50% reduction in medical administration errors.[5]

Accreditation may help to raise standards by highlighting trusts that have poor staffing levels, allow poor practice, or fail to follow professional guidelines. Patients benefit from confidence that the services they are using have accreditation, and they can make informed choices if some services have not achieved accreditation. Commissioners of clinical services can also benefit from knowing that the services they fund meet key standards.

Emerging evidence shows the benefits of accreditation systems.[6-8] Shaw and colleagues[9] found that accreditation was positively associated with having strong clinical leadership, systems for patient safety, and clinical review. Other evidence has shown that accreditation may help to introduce a mindset and culture of high performance.[10] Accreditation is often considered in terms of hospitals, but it presents opportunities (and challenges) for general practices too.[11]

Accrediting bodies

In the United States, accreditation by the non-governmental Joint Commission is recognised as a symbol of quality that reflects an organisation's commitment to meeting specific performance standards, and its international wing accredits clinical services worldwide. Another independent non-profit organisation, the Commission on Accreditation of Rehabilitation Facilities, has developed tools for accrediting rehabilitation services in the US and elsewhere. The Organisation of European Cancer Institutes has an accreditation programme for cancer services, and UK cancer centres such as the Christie Hospital in Manchester have used the scheme.

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In the United Kingdom, the guidelines body the National Institute for Health and Care Excellence has a process to help introduce accreditation schemes. The United Kingdom Accreditation Service is a private body recognised by the government to assess, against internationally agreed standards, organisations that provide certification, testing, inspection, and calibration services. It manages accreditation of services such as clinical pathology and diagnostic imaging.

Valori and colleagues[12] have presented a sound case for UK royal colleges and related bodies to be actively engaged in introducing accreditation systems. The Royal College of Physicians already operates four accreditation schemes that deal with gastrointestinal endoscopy, occupational health, physiological diagnostic services, and allergy services. The Royal College of Psychiatrists has an accreditation and rating system for memory clinic services. And the Royal College of General Practitioners has piloted an accreditation scheme that incorporates a "quality practice award."

Some websites, such as that of Accreditation Canada, provide accreditation resources, and private healthcare organisations provide accreditation services (for example, CHKS—part of Capita, the private outsourcing company). Barriers to accreditation vary with healthcare context and may sometimes be related to attitude, motivation, and leadership rather than desirability or cost.

CQC inspections

Although the Care Quality Commission (CQC) now has specialists in its inspection teams, this cannot replace dedicated systems for accreditation led by a professional body. If the CQC inspects a clinical service in depth, it may often have only one expert in the specialty in question; and, on any particular hospital visit, it has only the time and resources to inspect a few selected services.

The CQC's inspection of a service would generally not have the same depth or degree of peer scrutiny as accreditation, which would always have clear standards and requirements to be met. Accreditation would not make the CQC redundant, because it investigates and reports on a wide range of measures, and services, such as pathology, which have a long history of accreditation, have not seen their accreditation system diminished after the introduction of hospital inspections by the CQC.

Accreditation takes resources

Accreditation demands time and resources, such as staff to carry out the accreditation, travel costs, and administrative support. Recently retired senior NHS and clinical-academic staff may form a ready panel of experts. Systems must be in place to monitor the implementation of any improvements recommended after an accreditation process, and such systems may have costs associated. However, the bulk of costs are associated with achieving the standards required to meet accreditation, especially if a service is seriously lacking.

"The creation of a caring culture would be greatly assisted if all those involved in the provision of healthcare are prepared to learn lessons from others and to offer up their own practices for peer review," noted Robert Francis QC in the executive summary of his report on Mid-Staffordshire Hospitals NHS Foundation Trust.[13] Professional bodies are in a unique position to play a part in creating this caring culture by putting accreditation schemes in place now.

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YANKEE DOODLING Douglas Kamerow

Fuming about e-cigarettes and harm

An English report is all for vaping while Americans still await promised regulation

Among the criticisms that public health officials have levelled at electronic cigarettes are that they are dangerous to health and that their flavours and easy availability are enticing and recruiting new smokers, especially young people. A new report from Public Health England, however, takes a surprisingly different view.[1]

The English study updated two previous reports on e-cigarettes and made headlines with a judgment that e-cigarettes may not be so bad after all. Taking a strong harm reduction approach, the report concluded that e-cigarettes were about 95% safer than combustibles and thus could be "one of the key strategies to reduce smoking related disease and death."[1] Since smoking in England, as in the United States, is increasingly concentrated among economically disadvantaged groups,[1] the report found that e-cigarettes could provide a widely available low cost means to reduce smoking and improve health in these groups. This could help decrease health inequalities. The report also advocates incorporation of e-cigarettes into smoking cessation programmes.[2]

Further, the report dismissed concerns about the use of e-cigarettes by young people, saying it was "rare" in England, with a prevalence of at least monthly use among otherwise never smoking young people of 0.3% or less. The report concluded that e-cigarettes "are attracting few people who have never smoked into regular use."

Experimentation by young people

These opinions are not all widely shared in the UK and certainly contrast sharply with a much more negative stance on e-cigarettes taken by public health authorities in the US. The Centers for Disease Control and Prevention's director, Tom Frieden, for example, has crusaded against e-cigarettes for the harm they can cause both adults and young people.[3] CDC surveys have focused on the striking growth in e-cigarette experimentation by young people, even though most of them will likely not become regular users of either e-cigarettes or combustibles. The proportion of high school students who said that they had used an e-cigarette in the previous month tripled from 2013 to 2014, from 4.5% to more than 13%.[4] This was, however, accompanied by a decrease (from 12.7% to 9.2%) in use of traditional cigarettes, leading to a tantalising question: is e-cigarette use in adults and adolescents a good thing (replacing tobacco cigarette use) or a bad thing (leading to cigarette use)?

Are e-cigarette manufacturers increasingly enticing impressionable adolescents to try their products with "cool" advertising, fruit flavours, and easy availability and use? US survey data would say unequivocally yes. But do e-cigarettes attract young people who would otherwise not smoke and get them hooked on nicotine, thus resulting in them becoming regular cigarette smokers? That's much less clear.

Until recently, the only research published on this question has used cross sectional studies that are, by their nature, unable to establish causality.[5] Theses studies have shown increases in e-cigarette use among young people and varying increases and decreases in use of cigarettes and other combustible tobacco products.

A longitudinal study of e-cigarette use among high school students has now been published, however, and it begins to answer the question of whether e-cigarettes lead to tobacco cigarette use.[6] The authors found that students who had used e-cigarettes at baseline were two to three times more likely to start using tobacco cigarettes in the next year than those who did not use e-cigarettes at baseline. The study was adjusted for many confounders but still does not provide definitive evidence of causality, for several reasons.

> **Nobody thinks it a good idea for young people to use e-cigarettes. Young brains are very sensitive and easily addicted to nicotine**

Firstly, it examined only smoking initiation rates and thus cannot address whether these students just experimented with various substances or actually became regular users of tobacco products. Secondly, the longitudinal effect found was bidirectional—that is, those who used tobacco products at baseline were also more likely to try e-cigarettes in the coming year. This only further muddies the waters in the controversy of what leads to what.

Banning sale to minors

That said, nobody thinks it a good idea for young people to use e-cigarettes. Young brains are very sensitive and easily addicted to nicotine, and there seems to be no reason to expose them to a product whose only proper use is to help adult smokers decrease or eliminate smoking. England, at least, is doing something about this, and in October a strict ban on e-cigarette sales to minors will begin to be enforced. The same cannot be said for the US.

We have been waiting since April 2014 for the Food and Drug Administration to issue its final national regulations on e-cigarettes. We are still waiting. Most—but not all—US states have banned sales to minors, but there are still no national regulations. Also, the FDA made no mention in 2014 of another regulation crucial to decreasing young people's vaping: severely limiting the flavourings for e-cigarettes. Why can we have cherry crush e-cigarettes when cherry crush tobacco products are banned?

The bottom line here, as always, is that we need more research—but also sensible regulations until that research proves conclusive.

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NO HOLDS BARRED Margaret McCartney

The power of patients' stories

Stories in medicine are often rich in fascination and inspiration. We tell stories to each other all the time: which patients we saw, which ones we visited—and who we have only just realised is related to whom. Stories create sense out of disparate happenings, melding understandings of why things happen and who is affected when they do.

Doctors have always written about how patients made them feel, sometimes in excruciating detail. Stories about patients by healthcare professionals appear in blogs, newspapers, magazines, and books, and they follow a fashionable formula. Patient meets doctor; patient has an unusual symptom or a grim prognosis; doctor faces a dilemma, followed by some combination of self examination, something going wrong, doubt, guilt, and then denouement.

Doctors often write under their own name. Sometimes they admit to changing patients' names. But patients, relatives, and carers may still recognise themselves—or think that they do. What if the story contains new, painful, or worrying information? Such stories could affect the doctor-patient interaction.

And whose stories are these, anyway? Do they belong to patients? Should doctors be telling these tales at all?

As a patient I wouldn't want to feel unable to be completely frank with my doctors, and I would fear publication of my consultations, even if they were anonymised. I assume that many patients want the same. As a doctor I value the privacy of the consulting room and the confidentiality that allows patients to be completely open. Without trust, doctors cannot work.

Here's an admission: in writing my book *Living with Dying* I wanted to portray how medicine can be used badly at the end of life. I thought that the statistics would make sense only if I could relate them to real life. So I wrote two stories, each a version of the same death. Each was an anecdote, but anecdotes are stories, and stories are powerful illustrations that can make statistics meaningful. I removed all traces of real patients, but I had bought into the common narrative drive.

I was caught in the tension between an absolute need to preserve confidentiality and a

Whose stories are these, anyway? Do they belong to patients? Should doctors be telling these tales at all?

wish to explain to a lay audience in human terms some of the muddles we commonly see at the end of life. Was I wrong to include these stories? Doctors have created a marketplace for medical dramatic narrative—but written only in a particular mould.

Medicine, like life, is messy and often uncertain. And much of medicine lacks drama but is still of deep importance. If popular accounts of medicine all rely on the same dramatic arc they may impinge on the patient-doctor relationship, undermining patients' trust that doctors rely on so heavily.

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BLOG William E Cayley Jr

Advocacy for the vulnerable

Reading the Monday morning paper, I was greeted by stories about ongoing fights over whether or how to undo the Affordable Care Act ("Obamacare") and controversies over solitary confinement. Later, while driving to work, I heard more news on the challenges facing those in eastern Europe who are confronted by a rising influx of immigrants. One final check of the news before starting clinic reminded me of the unfolding economic uncertainty that seems related to China's stock market volatility.

What a way to start the week. And while each of these news stories seems to cast a pall of gloom over the start of the week, at the same time, I think they should serve as a reminder to doctors of what a central piece of our vocation (or calling) needs to be.

To paraphrase the good Dr McCoy, "I'm a doctor—not a politician, a judge, a policy maker, or an economist." But that's entirely the point: as doctors, our primary calling is to be healers and comforters, who are present with our patients. As put in the aphorism

We need to hold ourselves accountable for how we advocate for the most vulnerable

that seems to have originated with Edward Livingstone Trudeau (and which is often misattributed to Hippocrates), in medicine we are called to "to cure sometimes, to relieve often, and to comfort always."

Health insurance, imprisonment, immigration, and insecurity in the economy are all important topics—and there are many and varied facets to each issue that must be considered. However, as has been said in a number of different ways over the centuries (including by Jimmy Carter, Dietrich Bonhoeffer, Samuel Johnson, and Hubert Humphrey), a society can be measured by how it treats the most vulnerable.

While we are called to provide "comfort always" to those under our care, we are also called to bring that perspective to the larger conversation about how to deal with matters that put people—whether they are our patients or the general population—at risk. Furthermore, in this day and age of multiple quality measures and patient surveys on satisfaction with care, we need to remember that the true measure of our faithfulness to our calling is how we care for and advocate for the vulnerable.

Yes, there are manifold legal, economic, and political facets to the challenges confronting us today and every day. As doctors, part of our calling is to remind the broader community that these problems are not solely about legality, finances, and politics. Rather, they are fundamentally about people, and we need to hold ourselves accountable for how we advocate for the most vulnerable.

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