In Response to: A Quality Conundrum: Well Done but Not Enough—Quality Improvement Conundrums: Looking Back Before Moving Forward

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If clinician-quality improvers are to gain traction as academicians, their first objective should be to bring quality improvement (QI) sandly into the world of scientific method. We believe that Dr. Chakraborti’s 2 points—that the reasons for afferent limb failure need to be more closely investigated, and that lessons learned from 1 hospital’s rapid response system (RRS) may not generalize to other hospitals—reflect the immaturity of QI as a science. In clinical science, 3 well-defined testing phases bring 1 homogeneous, rigorously tested product to market that is monitored in a fourth phase. While Dr. Chakraborti urges us to examine our afferent limb failures more closely, the monitoring and reporting strategies used in the Josie King Patient Safety Program resonate with the postmarketing surveillance of Phase IV trials.

Although necessary and valid, we believe that the majority of the QI conundrum of RRS lies in the lack of premarket, stepwise testing of QI products. QI initiatives are often promulgated before an appropriate evidence base has been established. This lack of scientific rigor has resulted in RRS with calling criteria that have poor operating characteristics, undetermined methods for achieving afferent success, and efferent response arms of varying sizes and compositions. Consequently, a heterogeneous group of RRS have produced equivocal outcomes and diminished the applicability of lessons learned across institutions.

Indeed, while it is important to ask, “What do we do now?,” it may be more informative to answer the question, “How did we get here?”

References