Sowing the seeds for quality improvement in health care: does the solution lie with medical schools?

Sir,

We read with interest the article on the importance of encouraging doctors to engage with quality improvement and patient safety initiatives (vol. 76(3), 2015, p. 166). We believe that the solution to widening junior physician engagement with quality improvement programmes lies within medical school curricula.

Medical students, as observers of patient care, are empowered by an extrospective point of view that enables them to identify deficits in patient care (Haidet et al, 2002). Unlike qualified doctors, they are rarely bound by clinical responsibility or target-based time constraints when interacting with patients. These qualities are only a few which make them ideal advocates for patient care (Ward et al, 2013) and quality improvement initiatives.

However, current knowledge of patient safety and quality improvement among medical students is low (Teigland et al, 2013) which is likely to explain the limited quality improvement engagement observed in junior doctors. Students often gain knowledge through informal 'word-of-mouth', but not through the embedment of quality improvement-specific teaching (e.g. identifying issues, developing protocols) within the core medical school curriculum. Provision of these skills would be likely to encourage wider participation in quality improvement (Levitt et al, 2012) as well as lay down an academic foundation that can be later used as a clinician, further driving an environment that creates 'bottom-up' change. Establishing a quality improvement database within medical schools will also engage students to undertake existing projects, thereby providing practical experience, while overcoming short-comings such as lack of continuity as a result of short student rotations.

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Clinical examination in ascites

Sir,

Given the fact that constrictive pericarditis is potentially more reversible than most of the more common causes of ascites, clinical evaluation of a patient with ascites should be made not only when the patient is in the supine position, as emphasized by Chavda and Bloom (vol. 76(2), 2015, p. C23), but also when the patient is sitting up. This will identify marked elevation of the jugular venous pressure (up to the angle of the jaw, for example), as this is a clinical sign that should raise the index of suspicion for constrictive pericarditis.

In one series, jugular venous pressure elevation of this degree was documented in 46 (75%) of 62 patients with constrictive pericarditis, and ascites documented in 27 (44%) of those 62 patients (Gimlette, 1959). When the index of suspicion for constrictive pericarditis is low patients with a mistaken diagnosis of cirrhosis with ascites run the risk of inappropriate invasive diagnostic tests such as transjugular liver biopsy (Marshall et al, 2006). In another instance, where constrictive pericarditis-related ascites was misdiagnosed as refractory ascites attributable to cirrhosis, the correct diagnosis was only made when the patient was admitted for intended implantation of a transjugular intrahepatic shunt (Wettstein and Haussinger, 2000).

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