

An American View of the UK's Patient Safety Enterprise: Top Down vs. Bottom Up

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Perspective

I was privileged to spend much of 2011 in the United Kingdom studying patient safety under a Fulbright scholarship. I came away highly impressed with many aspects of the British health care system, particularly the fact that the country manages to provide universal insurance and achieve good health outcomes at a level of spending about 60% of the United States. But, in the patient safety arena, I found significant challenges, ones that hold lessons for the American system. In this article, I'll summarize my observations.

The History of Two Movements

In many ways, the American patient safety movement owes its origins to the work of English psychologist James Reason and his theory of error (including the now-famous Swiss cheese model).^(1,2) Reason's work profoundly influenced [Dr. Lucian Leape](#), whose 1994 article "Error in Medicine" was the first in a major journal to translate the science of safety into health care terms.⁽³⁾ This, in turn, helped build the intellectual scaffolding for the patient safety field in the US.

Six years after Leape's article, both the American and British safety fields were launched by two highly influential national reports: the Institute of Medicine's (IOM) *To Err is Human* and the UK's *An Organisation with a Memory*, produced by the Department of Health.^(4,5) As British safety expert Professor [Charles Vincent](#) points out, the fact that *To Err* was produced by a non-governmental organization (the IOM) while *An Organisation* came from a government-run agency, prefigured the safety journeys that each nation would take over the next dozen years.

In the US, no single agency was charged with owning patient safety. Certainly, there were significant government contributions. For example, the Agency for Healthcare Research and Quality (AHRQ) was charged with funding research and other tools (including this Web site), but not tasked to develop and implement a national patient safety strategy. But, American efforts to promote safety can best be seen as a

tapestry of policies and initiatives by many actors—accreditors, non-governmental organizations, foundations, and others—each using their particular levers to influence the field ([Table](#)). Government was simply one of these actors, and often not the most important one.[\(6,7\)](#)

This absence of a centralized, top-down set of initiatives created an interesting dynamic for providers—both hospitals and individual clinicians. Although both felt mounting pressures to address safety problems, the fact that these pressures came from myriad sources (often in the form of guidance rather than inviolable rules) provided the time and room to engage and to innovate. The result was that a significant number of (though sadly not all) US clinicians became engaged in the safety field, at both local and national levels. Many, probably most, of the key national figures (leaders and researchers) in safety in the US are physicians (some are nurses), and many are still active clinically. (Simply scan the list of [past interviewees](#) in our "In Conversation With?" series to get a sense of this.)

In the UK, pressure to improve safety came largely from the National Health Service (NHS), which owns the hospitals and employs all the doctors who practice in them. (Primary care physicians, known as general practitioners [GPs], are independent contractors but receive virtually all of their income and patients from the NHS.) As a large centralized bureaucracy, the NHS responded predictably to the safety imperative: with a series of rules and initiatives that were far more "top down" than what we saw in America. A new government organization, the National Patient Safety Agency (NPSA), was created to oversee safety.[\(8\)](#) The NPSA launched a national reporting system, which has collected several million reports. As Vincent notes in the interview and elsewhere, there are serious questions about the value of this (and other large-scale incident reporting systems) in health care.[\(9\)](#) The NPSA and other government agencies developed rules and policies, all well meaning but many of which failed to achieve the desired goals.[\(10\)](#)

During my time in Britain, I came to believe that this centralized approach tended to dampen the level of engagement by frontline personnel. In contrast with the US, relatively few of the UK's top researchers and leaders in patient safety are clinicians; most tend to be social scientists like Reason and Vincent.[\(1,2,9\)](#) While these individuals, and others like them, have made spectacular contributions, their influence and perspective cannot fully match those of engaged clinicians.

The Checklist Story

These top-down vs. bottom-up differences are well illustrated by the history of one of the patient safety field's greatest successes to date: the checklist.[\(11,12\)](#) Its use in safety began when the conceptual framework of bundling a series of safety processes and employing a checklist to promote implementation of the bundle was embraced by a clinician–scientist (Dr. Peter Pronovost) at a prominent academic health center (Johns Hopkins).[\(12-14\)](#) Applying the concept to a single safety target (central line–associated bloodstream infections), Pronovost and colleagues achieved proof of concept at their home institution.[\(15\)](#) Then, with federal support, they scaled up these efforts across more than 100 intensive care units (ICUs) in Michigan. The results, published in the *New England Journal of Medicine*, were spectacular.[\(16\)](#) Harvard's Dr. Atul Gawande (another clinician–investigator) profiled Pronovost and his checklist work in a *New Yorker* article, which raised public awareness and interest [\(17\)](#), and Gawande extended the checklist idea by working with World Health Organization collaborators to develop and test a surgical safety version. It too was strikingly successful.[\(18\)](#)

In other words, the checklist story is a classic tale of an effective bottom-up intervention, in which a single entrepreneurial and effective clinician–investigator took an idea, implemented it, and tested it—all the while respecting the need in complex systems for local adaptation and buy-in.[\(11,12,19\)](#) The government was supportive (and even more so after the publication of the Michigan results, when it helped disseminate the project nationally), but it was not a central driver, at least in the early stages.

And how did the checklist notion play out in the UK? During my time there, a number of hospitals were trying to implement both ICU and surgical checklists. But, rather than a bottom-up intervention, the dissemination in the UK came via a governmental mandate issued in 2009 by the NPSA.[\(20\)](#) On several occasions, I heard physicians complain that the checklist was "just one more bureaucratic NHS rule."

This sentiment, of course, was ironic because the checklist began as a quintessential bottom-up intervention. I found myself asking whether a checklist-like story could have happened in the UK, based on the system's instinct to manage safety from the top down and the relative absence of people like Pronovost and Gawande, clinician–researchers at respected institutions with the freedom and wherewithal to innovate and disseminate in the areas of patient safety and quality. My answer, sadly, was no.

Conclusion

The UK's experience in patient safety offers an important cautionary note for the US. As frustration rises with our limited progress in patient safety [\(21\)](#), the instinct to centralize and to promulgate more rules will likely become irresistible. Dr. Ken Kizer, who led the strikingly successful early efforts in safety, quality, and computerization at the US Department of Veterans Affairs (VA), recently lamented that the VA's system is becoming more rule-bound and bureaucratic, leading to less provider engagement.[\(22\)](#) Kizer worries that this may ultimately harm efforts to improve safety and quality.

The balance between appropriate central control and use of rules and standards vs. the need to engage frontline providers and researchers and to promote innovation may well be the toughest policy question in safety.[\(11\)](#) In the US, we have erred on the side of bottom up, which has led to some breathtaking innovations and relatively high degrees of provider engagement (at least in some quarters), but it can also be maddeningly slow. In the UK, the instinctive response was more centralized and rule-oriented, which offers the promise of rapid change but often the reality of an overly bureaucratic program that stifles innovation and individual engagement. As always in issues this complex, the right answer is likely to be a thoughtful blend of the two approaches.

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Table

Table. Some examples of organizations that influenced the patient safety landscape in the United States.

[\(Go to table citation in the text\)](#)

Organization	Organization Type	Examples of Initiative in Response to Safety Movement
Agency for Healthcare Research and Quality (AHRQ)	Government (research funder and support organization)	• Support for safety research• A variety of tools and other resources, including this Web site
Medicare	Government (payer and regulator)	• Promotion of transparency via Hospital Compare Web site• Pay-for-performance and no-pay-for-errors initiatives
The Joint Commission	NGO (accreditor)	• Switching to unannounced hospital surveys• Development of National Patient Safety Goals
Accreditation Council for Graduate Medical Education (ACGME)	NGO (accreditor)	• New limits on duty hours for trainees
Institute for Healthcare Improvement	NGO (consulting and support)	• 100,000 Lives Campaign
Leapfrog Group	NGO (consortium of large employers)	• Development of list of safe practices

National Quality Forum

NGO

- Development of list of "Serious Reportable Events" (often known as "Never Events")
- Development of list of "safe practices"

National Patient Safety Foundation

Foundation

- Educational offerings, including training for safety professionals

* NGO = non-governmental organization