In the Literature

ADVISING PATIENTS ABOUT PATIENT SAFETY: CURRENT INITIATIVES RISK SHIFTING RESPONSIBILITY

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In the wake of *To Err Is Human*, the Institute of Medicine's ground-breaking report on patient safety, federal agencies, health care quality organizations, consumer advocacy groups, and others have created brochures to educate patients about ways to avoid harm from medical errors. But the advice contained in these materials—while well-intentioned—may not always be effective or appropriate, concludes a Commonwealth Fund-supported study.

For their study, "Advising Patients About Patient Safety: Current Initiatives Risk Shifting Responsibility," (*Joint Commission Journal on Quality and Patient Safety*, Sept. 2005) 2003–04 Harkness Fellow Vikki A. Entwistle, M.Sc., Ph.D., formerly of the University of Aberdeen, Scotland, and colleagues examined readily available educational resources distributed by leading proponents of patient safety. The team then chose five advisories for more detailed content analyses. The selected materials were developed by the following organizations: the Agency for Healthcare Research and Quality (AHRQ); U.S. Department of Health and Human Services (DHHS), with the American Hospital Association (AHA) and American Medical Association (AMA); the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and the National Patient Safety Foundation (NPSF).

In addition to performing their own analysis of the materials, the team conducted 40 interviews with patient safety and quality professionals from academic, clinical, consumer, and health care administrative backgrounds. The sample included eight individuals associated with the development and distribution of the five advisories.

Lack of Consumer Contribution

While the advisories were developed to encourage patients' contributions to safety, they were written from a provider perspective and drafted with relatively little input from patients, the study found. "We were surprised at the lack of formative testing of drafts of the advisories with patients," the researchers say. Furthermore, none of the advisories was formally evaluated before widespread distribution.

Missed Opportunities

The authors suggest the advisories have missed opportunities to increase public understanding. None explain the relationship between errors and poor outcomes, for example, or review current safety standards or discuss current patient safety initiatives. "They thus tend to leave patients ignorant of policies and practices that could offer them some grounds for reassurance," the authors write.

Role of the Patient

The advisories encourage patients to be active partners in the health care process and to voice their questions or concerns. However, many of the study's informants questioned whether health care professionals would reinforce and encourage such behavior. One interviewee, a consumer advocate, said, "We're providing consumers with information that is not well-founded or well-tested, and . . . the place they're supposed to be exercising that information is probably hostile to it, or at minimum not able to receive it effectively."

Challenging health providers' actions may be particularly problematic for patients who fear being labeled as "difficult" or for socially

disadvantaged or less well-educated patients. The sheer number of tips in some advisories, say the authors, would make it difficult for patients to follow all the guidance in all consultations.

In addition to exacerbating existing social disparities, shifting responsibility for the safety of care onto patients may also reduce the impetus for systems improvement and increase patients' tendency to feel guilty—and providers' tendency to deflect blame.

Recommendations

The authors conclude that health care leaders must work with patients and frontline clinical staff to develop protocols to help realize a safe, patient-centered health care system. According to the researchers, future efforts that involve patients in the promotion of health care safety should consider the following recommendations:

- Rigorous research and debate is needed to determine the appropriate role for patients in efforts to improve safety. Both patients and health care professionals must contribute to this conversation.
- Advice given to patients must be periodically examined. Assessments should take into account research-based evidence about various safety-promoting practices, the development of standards and protocols, patients' concerns and needs, and local safety problems, among other considerations.
- There are inherent limitations in advising patients on error-prevention strategies. "Rather than relying on patients to work around system deficiencies," the authors say, "systems should be designed to enable people to contribute appropriately by default."

Safety Tips from Selected Advisories

	Select providers carefully	Encourage providers to adopt safety-promoting practices	Be involved
AHRQ—*20 Tips to Help Prevent Medical Errors* (fact sheet)	■ If you have a choice, choose a hospital at which many patients have the procedure or surgery you need. Research shows…patients tend to have better results…in hospitals that have a great deal of experience with their condition.	■ If you are in a hospital, consider asking all health care workers who have direct contact with you whether they have washed their hands.	■ The single most important way you can help to prevent errors is to be an active member of your health care team.
DHHS with AHA and AMA—*Five Steps to Safer Health Care* (fact sheet)	■ Choose a doctor you feel comfortable talking to. ■ Talk to your doctor about which hospital is best for your needs. ■ Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from.	No tips recommending this.	■ Ask questions if you have doubts or concerns. ■ Make sure you understand what will happen if you need surgery.
JCAHO—*Speak Up: Help Prevent Errors in Your Care* (brochure)	■ Ask your doctor about the specialized training and experience that qualifies him or her to treat your illness…. ■ Use [a health care provider] that has [been evaluated] against established, state-of-the-art quality and safety standards, such as that provided by JCAHO.	■ Notice whether your caregivers have washed their hands…. Don't be afraid to gently remind a doctor or nurse to do this. ■ Make sure your nurse or doctor confirms your identity, that is, checks your wristband or asks your name, before he or she administers any medication or treatment.	■ Speak up if you have questions or concerns…. ■ Participate in all decisions about your treatment. You are the center of the health care team.
NPSF—*Your Role in Making Health Care Safer* (brochure)	No tips recommending this.	■ Ask everyone—caregivers and visitors—to wash their hands. Handwashing is the best way to fight the spread of infection. ■ Ask every person to identify himself or herself when they come into your room.	■ By becoming involved and actively participating in your care, you will make a big difference in ensuring your own safety. ■ Talk to your doctors, nurses, and pharmacists.
NPSF—*What You Can Do to Make Health Care Safer* (brochure)	■ Choose a doctor, clinic, pharmacy, and hospital experienced in the type of care you require.	■ Discuss any concerns about your safety with your health care team.	■ Work with your doctor and other health care professionals as a team.

Source: Excerpted from Table 4. V. A. Entwistle, M. M. Mello, and T. A. Brennan, "Advising Patients About Patient Safety: Current Initiatives Risk Shifting Responsibility," *Joint Commission Journal on Quality and Patient Safety* 31 (September 2005): 483–94.