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In the Literature

PATIENT-REPORTED SAFETY AND QUALITY OF CARE IN OUTPATIENT ONCOLOGY

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Consumer surveys indicate that between 12 percent and 42 percent of U.S. adults report that they or a loved one has experienced a medical injury. Little is known, however, about patients' ability to recognize such events or understand the definition of clinical terms like "medical error" or "adverse event."

In the Commonwealth Fund-supported study, "Patient-Reported Safety and Quality of Care in Outpatient Oncology," (*Joint Commission Journal on Quality and Patient Safety*; Feb. 2007), researchers led by Saul N. Weingart, M.D., Ph.D., of the Dana-Farber Cancer Institute, sought to determine the extent to which patients can recognize medical errors.

Although one of five patients reported an unsafe experience, the researchers determined that only 31 percent of these patients actually identified a close call, medical error, or injury. Most reports, they found, could be categorized as service quality problems: long waits, miscommunication with clinicians, or dissatisfaction with the environment and amenities.

Categorizing Medical Errors

The researchers conducted their study at a Boston-based cancer center between February and September 2004, using four volunteer "patient-safety liaisons" to interview patients to identify possible incidences of medical error and injuries. Responses were reviewed and coded by the investigators in four categories: adverse events (injuries due to medical care rather than the natural course of illness); close calls (errors that could have caused injury but resulted in no harm); medical errors with minimal risk of harm (including tests or treatments that did not affect outcomes); and service quality issues (including waits and delays, poor communication and information, and lack of respect for patient needs and preferences).

Defining Unsafe Care

Twenty-two percent of patients interviewed reported having experienced a "recent unsafe experience." But when the researchers examined the reports, they concluded that only 1 percent of the reported incidents resulted from medically induced injuries, and only 2 percent from close calls. Instead, more than half of the events reported by patients were classified by the reviewers as service quality incidents.

The authors give several possible reasons for this discrepancy, including a potential reporting bias on the part of long-term patients, who interact regularly and at length with the medical establishment. Experienced patients, the authors reason, "were more likely to report episodes of unsafe care, perhaps because they had more opportunities to be harmed." Experienced patients were also assumed to be less worried about alienating their caregivers with critical feedback. In addition, patients may have different ideas than clinicians about what constitutes an unsafe episode. "The vocabulary of patient safety is confusing to patients, and we offered no explicit definition," write the authors, adding that for patients, the idea of "unsafe care" brought up complaints about parking, security, delays, and emotional distress.

Service Matters

Of 193 patients interviewed, 93 (48%) reported 121 separate incidents during the course of their care that caused them concern. Of these reports, the reviewers classified two incidents as adverse events, four as close calls, 14 as medical errors without a risk of harm, and 101 as service quality incidents. The adverse events included an MRI procedure in which a technician missed the vein and caused a tissue infiltration, and an incident where a patient who was not given antiemetics before radiation became nauseated.

Of the 101 service quality incidents, 30 percent could be attributed to waits and delays, including waiting for physicians or lab tests, scheduling an appointment, and getting admitted to the hospital. Another 21 percent of service complaints resulted from poor communication, and an additional 12 percent from environmental factors, ranging from bad elevator service to inadequate coffee and snacks. "Patients may perceive that these inconveniences signal problems with the overall process of care," write the authors. "If the pharmacy experiences chronic delays, how do we trust that the chemotherapy is prepared reliably?"

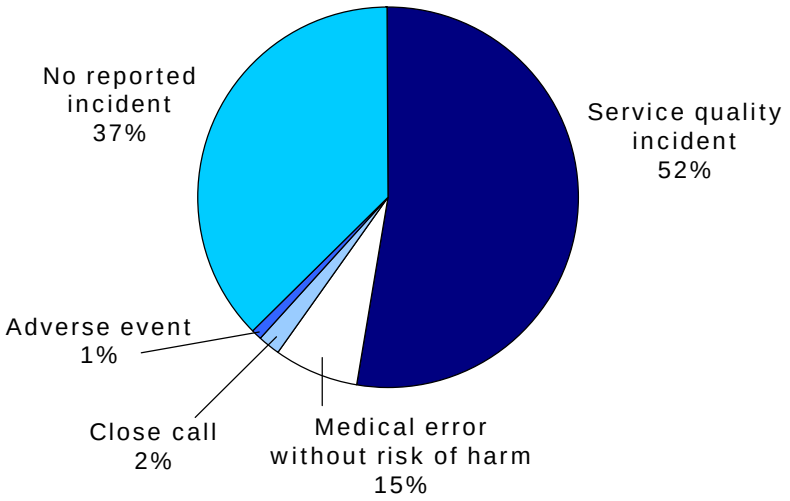
Future Directions

Despite a few limitations—analysis restricted to a single facility, possible bias among patient safety liaisons, interviews not monitored or recorded—this study indicates that patients can play a role in patient safety and also that patients view service problems as potential red flags about the quality and safety of treatment. "This association between patient perception of safe care, medical injury, and service quality merits further study," the authors conclude.

Facts and Figures

- The nurse, clinic assistant or facilitator, or attending oncologist were involved in one-third of the service quality incidents. In about 40% of the cases, investigators were not able to identify the involved party.
- Investigators confirmed no adverse events, close calls, or harmless errors among 29 of the 42 patients who reported "unsafe episodes."
- Patients who received care at the center for more than three years were more likely to report a recent experience of unsafe care than patients with a shorter duration of care.

Patient-Reported Incidents



Note: Incidents per 100 patients, N = 193; 95% confidence interval; numbers may not add due to rounding.
Source: Adapted from S. N. Weingart, J. Price, D. Duncombe et al., "Patient-Reported Safety and Quality of Care in Outpatient Oncology," *Joint Commission Journal on Quality and Patient Safety,* Feb. 2007 33(2):83–94.