PostScript

LETTER

Patient agencies and complaints in Italy

According to Bismark *et al.*,¹ complaints that are brought to a Commissioner in New Zealand offer a potentially valuable “window” on serious threats to patient safety. In Italy, the Consultative and Conciliatory Commissions (“Commissioni miste conciliative”) and the ombudsmen (second level organisations) supply unsatisfactory results or are not even established.² Furthermore, epidemiological data such as those of the NZQHS are very scarce. We therefore carried out a survey to explore whether an independent patient agency could facilitate local learning and action to improve the quality of health services.

Two hundred and forty complaints and accounts of presumed untoward events presented by people to our voluntary patient agency in Milan (Cittadinanzattiva) were analysed. Every complaint included one or more clinical record. Our aim was to compare allegations contained in the written complaints and the results of a retrospective review of the case records. An expert physician examined all the clinical records produced and identified when an “avoidable adverse event” was present.³ A medicolegal expert independently reviewed 89 complaints. The causes of the complaints according to the complainants are shown in table 1.

In the physician record review, 87 of the 240 complaints were associated with a preventable adverse event (mainly occurring in hospital); 22 were serious and preventable and 12 resulted from a failure or a complication of an indicated operation.

This study has a number of potential shortcomings. Nevertheless, the survey confirms the kind of useful information that can be gathered about substandard medical care from this type of documentation. With no patient lawyer or representative present in the hospital⁴ and with the management of claims firmly controlled by the medical experts, those wishing to complain will be more motivated if the management of the claims is supported by an independent

agency to ensure objectivity before the disputes, taking on responsibility for reporting the incident to the interested organization and providing feedback to the citizen.

In my opinion, however, the Italian voluntary patient agencies have a very weak voice.

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BOOK REVIEWS

Medical Emergency Teams: A Guide to Implementation and Outcome Measurement

Edited by M A DeVita, K Hillman, R Bellomo. Berlin: Springer, 2005. 316 pages. \$49.95. ISBN 0387279202

The rapid adoption of hospital Medical Emergency Teams (METs), also called Rapid Response Teams, has been remarkable. This has been hastened by the inclusion of METs as one of the six strategies employed by the Institute for Healthcare Improvement's 100 000 Lives Campaign. More than 3000 US hospitals have indicated their participation in this ambitious initiative.

METs consist of two or three health professionals—often a nurse, respiratory therapist, and physician—working as a team

with a specific plan for responding to a patient crisis. Using defined criteria, a team is called to the bedside of a hospitalized patient whose clinical condition has become unstable. This simple strategy is designed to cut through hospital hierarchy and lead to quick recognition, rapid response, and swift treatment. The aim is to treat patients before they enter a critical state where their chances of recovery are poor. While the idea is simple, implementation of METs can be daunting because of the complicated logistical, cultural, and information challenges faced by hospital administrators and health professionals.

This book offers a world class guide for navigating these challenges. Readers who are charged with leading the implementation of METs in their hospitals will find much that is of value in it. Several chapters address strategies for success in MET design and provide warning signs for predictable pitfalls in strategy. Other chapters provide general models of METs as well as formulae for adapting MET design to local variables such as the size, type, and location of a hospital and the department in which the MET is implemented. A particularly pragmatic chapter describes the equipment, medications, and supplies necessary for an emergency cart. The chapter by Hillman and colleagues entitled “The Evolution of the Health Care System” explores how METs address the mismatch of needs and resources in many healthcare systems. Mininni and Scholle explore the positive impact METs can have on nursing morale and retention, and provide helpful blueprints for much needed inter-professional teamwork. The chapter by Duncan on nurse led METs is complete with practical examples and tools for implementation. Lam and Flabouris' chapter entitled “Medical Trainees and Patient Safety” addresses with clarity one of the more complex issues surrounding MET implementation—namely, the linking of resident education with the teamwork, system redesign, and error detection and prevention inherent in the implementation of METs in teaching hospitals. In a complementary chapter, Lighthall explains how METs can enhance resident education. Two chapters address the role for technology; Fiedor *et al* explore the place for simulation while Young *et al* address the central role of information systems in tracking the effectiveness of METs.

The book is divided into three sections: (1) salient aspects of patient safety and its context for METs, (2) implementation of METs, and (3) MET measurement and evaluation. The book has few drawbacks. The chapters do not always flow logically from one to the next and some chapters seem somewhat tangentially related to METs—for example, the chapter on early goal-directed therapy as a means of treating severe sepsis and another on general quality improvement methods such as root cause and failure mode and effect analysis.

Most readers will find this text is best used as a resource from which they can pick and choose. There is indeed something here for a broad readership including administrators, educators, and frontline health professionals. The book is actually about more than the specific topic of METs; it serves as a useful

Table 1 Patients' complaints and preventable adverse events (AEs)

Reasons for complaining according to complainant	Total	Preventable AEs according to the expert	
		All preventable	Preventable and serious
Delay in diagnosis and treatment	89	36	7
Failure or complication in the technical performance of an indicated operation	82	30	12
Failure of complication in the technical performance of an indicated invasive procedure	24	9	1
Lack of care or attention, lack of monitoring	19	3	1
Delay or failure in treatment	9	2	
Others	9	7	1
No reason	8		
Total	240	87	22