Commentary

Health Care Complaints and Adverse Events as a Means of User Involvement for Quality and Safety Improvement

SØREN BIRKELAND

*Centre for Quality and Department of Regional Health Research,
University of Southern Denmark*

IN THE SEPTEMBER ISSUE OF *The Milbank Quarterly*, GILLESPIE AND Reader¹ point to the valuable and unique user-centered insights on quality and safety that can be revealed through an analysis of health care complaints (HCs) as an important indicator of adverse events (AEs) and near misses. An increasing research body substantiates this potential for HCs. Hence, half of the PubMed results for the search term "health care complaints" date to the last decade and the same is true for other related terms (eg, "malpractice complaints"). HCs provide essential information because they originate from the users' perspective and often point to "blind spots" in health care quality that may otherwise often be overlooked.¹

Two findings in Gillespie and Reader's study deserve particular notice. First, their approach to the study of HCs seems especially well-suited to provide insight on systemic problems, including continuity of care problems and "low-level caring neglect," which can be difficult to observe but are often reported in complaints. This finding points to a particular task for supervising bodies—rather than merely chase medical negligence, they should use this source of information about systemic shortcomings for further analysis and intervention for quality improvement. The recent case in the United Kingdom of Jack Adcock, in which health professionals were convicted of gross negligence manslaughter following the death of the six-year-old from sepsis, and similar highly debated cases in other countries illustrate the matter.^{2,3} In this regard, it is noteworthy that Gillespie and Reader find "institutional problems" to be particularly associated with "major and catastrophic harm" during admission, which was exactly the case in the aforementioned lawsuit.

Health authorities should consider it mandatory to deal systematically with the organizational issues implicated in such high-profile cases.

Second, the authors' analysis points to the significance of examination deficiencies and misdiagnoses in major harm cases. This agrees well with other research. In a content analysis of AEs in HCs, my colleagues and I found four major AE categories, with errors in interpretation of symptoms and findings being the most common.⁴ Likewise, in a literature review, Panesar and colleagues found diagnostic failings to be among the three most common categories of safety incidents.⁵ Failures of judgment, particularly in the formation and evaluation of diagnostic hypotheses, may result in medical mishaps that occur during the diagnostic process of interpreting clinical signs and findings.⁶ This points to problems that can in fact be addressed, for example, through information and education.

HCs represents only one of many ways to identify, analyze, and benefit from users' perceptions of health care. In countries with multiple ways to formally respond to medical mishaps, those measures may all provide valuable information for improving quality and safety.⁷ By way of example, the use of nonsanctioning AE reporting systems for patient safety purposes offers great potential for user involvement when patients and health professionals can make reports on equal terms. As mentioned earlier, however, the full-scale criminal law case also offers important learning opportunities on how to make health care safer.

There are approximately 1,000 HCs for every criminal law case.⁸ In systems with more complaint options, for every nonmonetary HC, there is one patient who has claimed compensation,⁹ and medical negligence has possibly been experienced by another ten.¹⁰ Concurrently, a comparable number of AE reports will have been filed, although AEs are likely largely underreported, with perhaps only one in ten ever being registered.¹¹ Furthermore, for every HC, 100 clinical encounters may have occurred in which health care users judge their health providers' conduct to be very dissatisfying and consider switching to a different provider.¹² To draw maximum benefit from information in this sphere, approaches similar to the one suggested by Gillespie and Reader must be considered for the other indicators of inadequate health care delivery. The health user perspective communicated through any means of expressing concerns and dissatisfaction should be taken into account to fully utilize the learning potential of AEs and near misses. This could inform future efforts to advance health care, such as enhanced supervision

between institutions and health professionals, as well as through educational, clinical, and regulatory changes. Patients and relatives make important observations that are different from those of managers and staff, and addressing such observations is a prerequisite for success in health care improvement.

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Address correspondence to: Søren Birkeland, LLM, MD, PhD, Centre for Quality and Department of Regional Health Research, University of Southern Denmark, PV Tuxensvej 3–5, 1st, 5500 Middelfart, Denmark (email: Sbirkeland@health.sdu.dk).