Quality Lines

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A PATIENT DECISION AID TO SUPPORT SHARED DECISION MAKING

Engaging patients in shared decisions regarding their treatment now benefits from increasing numbers of patient decision aids. This article presents the results of a randomised controlled trial of strategies to support patients with atrial fibrillation in their choice of either asprin or warfarin to prevent stroke. It compared a computerised patient decision aid with paper-based guidelines used in a more directive way. Participants supported by the patient decision aid in a shared decision making consultation had lower decision conflict after its use. Patients who were not already taking warfarin were less likely to start anticoagulation treatment after using the patient decision aid. These findings raise important questions about the impact of shared decision making and enlarge the list of issues that can be addressed in the future.

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HOW DO SURGEONS MAKE INTRA-OPERATIVE DECISIONS?

Few studies have directly examined the cognitive skills that underlie decision making during operations. Active teaching of this component of care may be important for improving surgical care. From the available evidence in surgery, and drawing from research in other safety-critical occupations, there are at least four core decision making strategies that may be relevant: intuitive (recognition-primed), rule based, option comparison and creative. Surgeon's decision making processes offer an opportunity to improve effectiveness and safety during operations.

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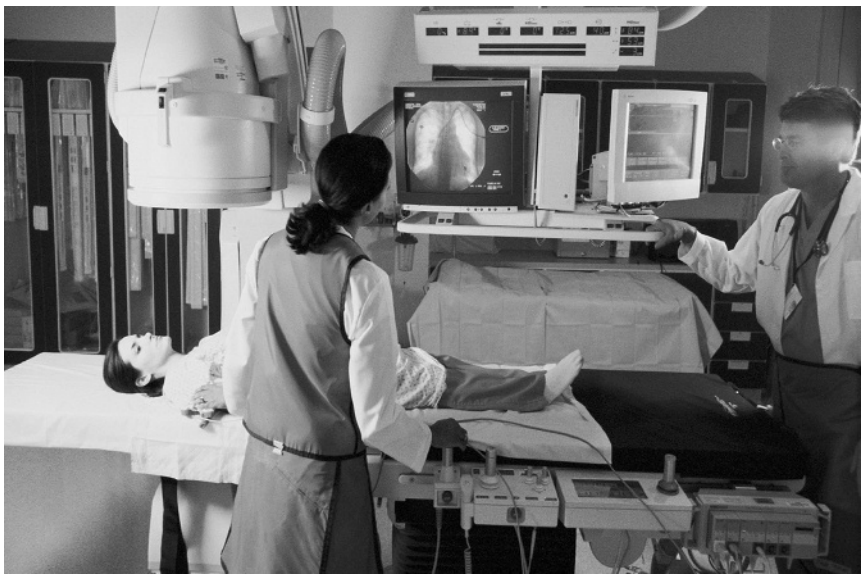

PATIENTS USE AN INTERNET TECHNOLOGY TO REPORT WHEN THINGS GO WRONG

Knowledge about adverse events is generally estimated from incident reports, medical record audits, clinician opinions and litigation. Systematically measured patient experience is frequently missing. This article describes an internet health check-up that can be used by patients to identify health-related harms. It includes findings from the responses of nearly 50 000 Americans to the question, ''Have you been harmed by health care in the past year?'' It is not surprising that sicker patients more often reported health-related harms. Moreover, when the authors subjected the patient reports to a legal assessment, the results were unsettling. Clinicians may be able to use such patient reports to improve the delivery of care and make it safer.

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ADVERSE EVENT REPORTS IN TWO US HOSPITALS: WHO REPORTS WHAT?

Although US hospitals have employed voluntary adverse incident reporting systems, their effectiveness remains unclear. This study examined ~2000 incident reports filed during the hospitalisations of 16 575 inpatients at two affiliated US hospitals in 2001. Providers reported 17 incidents per 1000 patient-days. Medication incidents, falls and operative incidents were among the most common reported incidents. Nurses filed 90% of reports and appeared to be involved in 43% of potentially preventable incidents. Physicians filed 2% of reports and appeared to be involved in 16% of potentially preventable incidents. Very few physician incidents involved operations, high-risk procedures or prescribing errors. Prior studies of adverse events in US hospitals indicate that the vast majority involve physician care. If the results of the current study apply to other US hospitals, increasing the reporting of physician incidents will be essential to improving the effectiveness of hospital reporting systems.

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