Reviewer's report

Title: Patient neglect in healthcare institutions: A systematic review and conceptual model

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Reviewer: Alastair J Ross

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MINOR ESSENTIAL REVISIONS
1 Missing bracket at the end of Results section in the abstract
2 22845 would read better as 22,845 on page 4

DISCRETIONARY REVISIONS

Overview
This paper reports on a systematic review of Pubmed, Science Direct, and Medline. Search terms are used to identify research studies investigating patient neglect. The review is narrative rather than meta-analytic.

Analysis focuses on three aspects: behaviour associated with neglect, reported frequency of neglect, and the causes of neglect. A preliminary conceptual model (Figure 2) is put forward in conclusion. A number of definitional concepts are introduced including outlines of neglect antecedents, two different concepts of neglect, and impact upon patients’ well-being.

Methodology
The paper follows standard protocol for literature reviews which is wise; however, as the authors recognise, the final number of identified studies is small at n= 14. In fact, the ratio from Stage 2 (selected papers) to Stage 1 (originally obtained papers) of the methodology (Figure 1) is 42/2,815 (i.e. just 1.5% retained).

The small literature may lend itself to possibilities for replicable analysis (an important criterion for papers of this type). However, it means the text must usually be tightly constrained to a quite specific area, matching both the search terms and papers included.

The small number of papers included for analysis (Table 1) suggests to the reviewer one or a combination of the following (the authors suggest broadly similar reasons in their conclusion):

• The area of interest is very specific/ specialised
  o The 2,815 papers originally obtained, and the introduction showing the importance of this issue in Europe and North America would tend to exclude this.
• The screening criteria are relatively strict
My feeling here is that the approach (focused on primary data) is conventional and not unduly selective (note the useful ‘hand search’ for associated items of interest).

- The search terms do not cover all dimensions across the area of interest ‘Patient neglect in healthcare institutions’

On examination of the conceptual model (Figure 2) I think this is the most plausible of the possible reasons for n=14 papers. It seems that perhaps the model draws on ideas which may not be reflected in the search terms in Figure 1.

**Breadth of the review**

The conceptual model in Figure 2 mentions staff attitudes under caring neglect (e.g. the first paper in Table 1 cites data on rudeness in nurses; Jewkes et al., 1998).

A wholly unscientific search in Science Direct (3.9.12) for [ALL ('nurses’ attitudes')] gives 1,729 papers.

A ‘glance’ at the first page shows some which might plausibly inform the conceptual model in Figure 2. For example (Kade et al. (2004) describe gaps and delays caused by nursing attitudes towards abortion procedures. To stress, it is not clear how many of these ‘other’ papers might be gathered by the original search on neglect and/or be excluded via screening for relevance, primary data etc. However, Kade et al. (Op Cit.) do not mention neglect but do cite the patient experience, staff rudeness and delays to procedure; thus their paper looks plausible for inclusion not in Table 1 (strict systematic protocol) but in Figure 2 (wider conceptual model). This confirms that the concepts within the model are broader than those within the search/ methodology.

The authors have searched for neglect literature then carefully examined that for antecedents (left), typologies (middle) and consequences (right) of neglect (Figure 2). This adds analytic strength to the review and the inferences made are clear. However, including ‘staff attitudes’ in the typology raises the possibility of a staff attitudes literature review that might, if similarly analysed, show ‘neglect’ as a consequence (e.g. failings in care, harm etc. as in Figure 2).

A similar case can be made with antecedents cited in the model (e.g. looking at the literature on high workload/ staff shortage for failings in care which may arise). Hurst (2005) again does not mention neglect but draws connections between nursing workload (proximal causal factors in Figure 2) and care quality.

This is not an insurmountable problem. The dialectic between inductive and deductive reasoning in analysis is well known and is recognised by the authors in the section on conceptualizing patient neglect where they say that ‘In reviewing the data captured within the research studies, it became apparent that further reflection was required on the meaning of patient neglect’. However, I think the relationship between the model and the systematic treatment of neglect (just 14 papers analysed) needs to be made clearer.

1. Discretionary revision: Perhaps it could be stressed here that the basic model
is generated from analysis of the literature from the systematic search but that some of its descriptive aspects are informed by the authors’ more general awareness of the types of antecedents, behaviours and outcomes that occur when healthcare systems do not function optimally (see for example papers they cite in discussion).

Conceptual model (Figure 2)

Figure 2 contains a number of categories of interest.

Error/failure and abuse

The distinction made is between ‘unintended errors or failures in the caring of patients that occur due to factors such as workload, system design, or training/competence’ versus ‘Deliberate attempts to harm patients through withholding care (e.g. due to a breakdown in staff-patient relationships)’.

Abuse (knowingly acting against the best interests of the patient) is straightforward enough is that it fits with the somewhat wider concept of a rule-violation (a deliberate choice of an individual to deviate from rules; Goodman et al., 2011).

It is difficult to do justice to the large literature on human error in a model like this, but I am not sure the denoted ‘unintended errors’ is helpful. WHO (2009 p16) are clear that ‘Errors are, by definition, unintentional’. However, it can be argued that whilst outcomes may be unintended errors are better classified in behavioural terms rather than by their effects.

Some errors (principally modal ones) involve intended behaviours that for one reason or another (e.g. acting on misinformation) have unintended consequences. Here, the course followed is wrongly believed to be correct at the time (contrast with attentional lapses or physical errors of perception).

2. Discretionary revision: The authors are familiar with taxonomies of error; perhaps the error/failure box might include some short description which makes clear that intended behaviour might have unintended consequence.

3. Discretionary revision: Also, I would not tend to ‘couple’ the errors in the top ‘box’ with their causes/ antecedents. The model does this already via distal and proximal antecedent boxes and I think it is conceptually more elegant without defining errors in terms of their antecedents.

Outcome neglect

Finally I wonder if ‘outcome neglect’ is the clearest possible term for falling short of ‘objective and observable standards’ (Figure 2). The final three boxes of the model, whilst termed ‘impact’, read like patient outcomes, which is a well known concept around harmful impacts on patients including ‘psychological trauma’ (Ausserhauffer et al., In Press).

4. Discretionary revision: I wonder if outcomes could be exclusive to the right hand side of the model and the types of neglect distinction redrawn around the
perceptive/subjective versus ‘objective’ distinction which the authors make; Material neglect? - just an idea.

Conclusion
I think the paper is methodologically clear (Figure 1) and it is easy to read. The conclusions in Figure 2 are supported in part by the data in Table 1. However, the conceptual model of neglect introduces terms that are themselves meaningful but are not included in the search syntax.

5. Discretionary revision: This opens up the possibility that there is a wider literature (examples given here are staff attitudes and workload) that could feed into an antecedent- neglect- impact model. My recommendation is that this is made explicit. Then, as well as the future directions mentioned in the paper, work could explore the different areas of the neglect model to examine further whether it is substantially robust.

References


Online available at

Level of interest: An article of importance in its field

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:
'I declare that I have no competing interests'