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Risk management.

Report from the AEMH working group.

Health Care is dangerous, more dangerous than climbing mountains. A Danish investigation has approximated that 9 % of the patients admitted to hospitals suffer from errors connected to their treatment. Some of these errors may be expected and prevented, but others may not.

To err is human. Human always makes errors, even doctors. Their patients can be protected against the consequences of errors. The purpose of risk management is to prevent errors and minimize the consequences of errors for the patients. Identification of potential errors increases the safety in healthcare. Every possible failure mode should be identified and analysed.

To accomplish this it is necessary to change the culture of blame to a culture of safety. The doctor or nurse who reports a mistake must have a positive reward to do so, not merely taking the risk of being punished. A lot of money is spent on unnecessary blood- test, x-rays and other diagnostic measures to reduce the anxiety of the medical professionals. Good risk management helps the doctor feel confident and perform only the appropriate investigations.

It is also important to change the attitude towards making errors among the doctors themselves. It should be considered just as important to report unexpected failures as successes. There should not be a risk of being punished for near misses. The admission of such a mistake should be considered the most valuable medical reporting you could do.

Today the doctor is held responsible for most errors that are made. It is the easiest way to protect the health service against costly complaints. But errors are caused by bad systems, not by bad people.

Every system of administration is perfectly designed to achieve exactly the results it gets. Some of the mistakes that hurt our patients are due to bad decisions made by people not directly involved in the treatment. There should be the possibility of reporting errors due to a bad organisation or a lack of capacity in the health service or at the hospital. There should be a way to put the blame on the board, the management or even at on political decisions.

Risk management today is large and important. It is organized differently in different professional systems. Risk management in aviation for example is organized according to international agreements from ICAO (International Civil Aviation Org). Since 1999 the airlines in Europe has a united system of reporting, designed to take advantage of the huge experience of errors and risks.

The most important part of the work towards increased security in health-service is to spread information regarding errors and how they are made and can be prevented. There must be a forum to locally register and analyse risks, which then nationwide could be presented in a pedagogic way. A regular risk analyse should be mandatory in all parts of patient care just as

there should be quality registration in each medical speciality. The medical profession can manage registration.

The Disciplinary system.

A doctor has both personal and professional responsibility of his or her actions. That responsibility is important to maintain. To establish the confidence that good risk management is dependent on, the risk management discussion must be separated from the disciplinary system, which includes patient complaints.

The chief-doctor should be a central person in the processing of complaints. She or he must be able to deal with the misunderstandings or mistakes in the wisest way. The patient frequently asks for an explanation of what happened or what went wrong. Most of the questions can be answered and thus the problem settled in a discussion between the doctor, the chief-doctor and the patient. If that is not sufficient, the chief-doctor can turn the case over to the next level where it shall be properly investigated and where disciplinary actions could be taken. Thereafter it should be possible for the accused doctor to ask for a trial in a civil court with legal assistance.

Statement

1. Identify the risks and manage them. Make errors visible.
2. Register and analyse errors and accidents that altered the foreseen result of treatment without focusing on guilt. It is important to be open-minded.
3. Organize a mandatory registration of errors and “near misses” and make that information available to everyone on a national and international level.
4. Change the attitude among doctors as well as the written law from punitive to preventative.
5. Disseminate and market knowledge about risk management.

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