Risk Management in Hospitals

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Introduction

News relating to medical errors frequently appears in newspapers and on TV. Medical accidents happen in various ways and are an unwelcome event not only for the general public, but also for health providers. There is a pressing need for strengthening risk management in hospitals to prevent these accidents. Risk management in hospitals should be based firstly on the collection and analysis of information concerning medical accidents. The second step should be to develop specific prevention system against accidents based on the analysis outcome, and the outcome should be fed back to the clinical field. Thus, the system is expected to shape a better framework for medical provision by improving the awareness of health providers toward medical accidents.

Definition of Medical Accident

There is currently no commonly acceptable definition of the term “medical accident.” The Ministry of Health, Labour and Welfare of Japan defined this term in the “Guidelines for Medical Safety in National Hospitals and Sanatoriums” in 2003, stating that: “Medical accidents contain all kinds of events causing injury or death of a person that may occur at any point during the entire process of health care provision, including cases such as where the victim is a health care worker and a person who has a fall in a corridor of a medical institution.” However, this description does not provide a clear definition of medical accidents, as it only means “all kinds of events causing injury or death of a person,” without clarifying what is specifically meant to be an accident. Under this interpretation, even predictable complications could be classified as a medical accident. This could result in postoperative complications being claimed to be medical accident.

The term “medical accident” is often misunderstood as malpractice. The term “malpractice” should be used carefully, because it implies negligence on the part of medical institutions and health care workers. Medical accidents should be divided into two types; “no-fault medical accidents” and “at-fault medical accidents.”

Fault or negligence mentioned in the context of malpractice means that a health care provider fails to exercise duty of care, which results in the injury of a patient or delay in their health recovery. Evidence of fault or negligence is sometimes difficult to evaluate at the time of the accident and this requires full inspection. The medical standard for the duty of care that should be exercised by the health care provider varies according to the medical standard at the time when the accident happens, and it is important to note that the standard judgment of fault may change according to the times.

The Scale of Medical Institutions and the Frequency of Malpractice

Let us consider the relationship between the occurrence of malpractice and the scale of hospitals. We assume an extreme case in which a single physician performs all medical services in a hospital and this physician makes an error, such...
as in drug administration, at the frequency of once every 100 years. In this hypothetical case, the possible frequency of malpractice by the physician would be one or none during his or her lifetime. On another assumption, if 100 health care workers are involved in medical practice such as drug prescription and drug administration and each of them makes an error at the same frequency of once every 100 years as above, this hospital would experience an error once a year. Therefore, the larger the number of health care workers in a hospital, the higher the occurrence of malpractice in the hospital.

If we want to eliminate malpractice in a hospital with 1,000 health care workers, the frequency of an error made by each worker must be 1,000 times lower than once every 100 years, i.e., once every 100,000 years. To attain this frequency, total and fundamental improvement of the awareness of the health care workers toward medical errors is required. Compared with the safety awareness level in airlines, railways, and construction sites, the level of safety awareness among individual health workers is still far from sufficient.

**Nationwide Efforts to Prevent Medical Accidents in Japan**

Nationwide efforts are being undertaken to prevent medical accidents by sharing related information among hospitals in Japan. One is a system of mandatory reports to the Japan Council for Quality Health Care, which started in October 2004. In this system, hospitals are required to submit reports to the Council about cases which are considered useful as an educational example, whether at fault or not, and whether the incident produced serious results or not. And the first report was released in April 2005. In national university hospitals efforts have also been made in performing mutual checking to ensure safety, and releasing information on medical accidents. In this way, efforts to promote the public disclosure of information concerning medical accidents are being made to prevent the occurrence and repetition of medical accidents.

**Liability and Prevention of Malpractice**

Health care providers involved in malpractice are asked to take certain responsibilities and are subject to certain penalties. These include civil liabilities which may include demands for damages and demands for apology, criminal liabilities which may include accusations of professional negligence causing injury and death, administrative penalties that may require suspension of license and practice, and social and moral penalties in which they may be reported in and criticized by the media.

Medical negligence which is totally inexcusable, and may cause most serious results would be mismatched blood transfusion, wrong medication, foreign objects left in the body, and wrong-site surgery. These four types of malpractice must not be committed at all. However, the unfortunate situation is that these cases occupy the highest percentage of reported cases.

The issues related to risk management in hospitals are diverse, ranging from individual to organizational levels. From the standpoint of prevention of malpractice, the most important is “to ensure thorough checking just before each medical act.” Even given the existence of a complicated system and numerous health care workers involved in medical practice, it is essential for each worker to ask and confirm for himself/herself whether or not it is correct procedure before starting a medical act.

**Conclusion**

It is essential to recognize that “to err is human,” and abandon the idea that you alone will never commit an error. This kind of recognition by health care workers is a basic element in the effort to substantially promote and improve medical safety and risk management in hospitals.