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ETHICAL ROLE OF HEALTHCARE ORGANIZATIONS IN CHANGING BEHAVIORS OF INDIVIDUAL HEALTHCARE PROFESSIONALS IN ATTEMPT TO IMPROVE PATIENT SAFETY

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Abstract

In modern society, medicine is one of the domains that have to face great challenges in many aspects. The major challenge in terms of quality in health care is the safety for patients. Besides the negative consequences caused by serious conditions of the diseases, many harmful occurrences are avoidable. The occurrence of avoidable harms sometimes deprive patients' lives or abilities, which has created great fear for patients of being at risk more than in help.

Such avoidable harms may be resulted by the healthcare professionals' knowledge, skills, or behaviors. These harms may be caused by either human errors or violations. To prevent these errors from occurring in the future, some measurements need to be enforced on organizational level. Medical errors are unavoidable in every clinical unit as medicine is practiced by human, and human beings are not free from making mistakes. Yet, it does not mean that it is impossible to remedy the issue of medical error. Confronting the mistakes made by individuals are the organizations they work within. Organizations represent their individuals and play substantial roles of not only seeking for the solutions to the incidents but also preventing such incidents from re-occurring in the future. There are two important notions- human error and violations- which thoroughly influence on the strategies of management of unintended adverse incidents.

Keywords: *Medical error, Patient safety, Organizational behavior*

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Current practical problems of medical error in health care

In both ancient and modern health care, avoidable harm caused by medical errors has been aware of, yet the issue tends not to abate even in the era of modern medical technology and science. Unlike the early time of medicine, health care is now highly effective but potentially unsafe.

about the risks and the benefits of the treatments. Physicians sometimes acknowledge the risks at lower level than their patients, so they may not be aware of the necessary warning of the risks for the patients, causing the loss of trust in patients, harm to patients, and harm to the organization.[3] Besides, patients may be at risk due to another type of error occurring when physicians suggest and proceed wrong treatment plans.

Nevertheless, such errors are much distinctive from violation in medicine in many aspects. One whose error results in harm may not know the should-be correct things to do while one who knows the right path but still engage in wrongdoing possibly due to negligence. Any healthcare staff involves medical violations is blameworthy while one who may cause harm by error.[4]

1.2. Common circumstances of occurrence of medical errors

Most medical errors which are avoidable and have caused severe damage to patients are nondiagnostic errors. Some mistakes are due to the healthcare professionals' cognition, some are due to the application of technology, some are because of transition,[5] and some are because of communication. Among these situations, insufficient cognition is likely to be improved by individual professionals without the enforcement of changes by the organizations. Reinforcing and improving professional knowledge and related information are in the healthcare professionals' capability and should be consistent and voluntary during their medical practice.[6]

On the other hand, improper application of technology often comes from inadequate routines, or sometimes the staff's negligence. This matter requires involvement of both individuals and their organizations.[7] The causes of transition and effectiveness of communications, whereas, need higher level of management- the organizations- in order to eliminate the according harms.[8]

2. The roles of organizational systems for patient safety in health care

Although individuals which are healthcare professionals in this matter, play substantial role in improving the quality of health care, many other interrelated components of the healthcare systems have cooperate with healthcare professionals in order to confront and effectively deal with, as well as prevent the future occurrence of medical errors. Nevertheless, each of them holds different responsibilities.[9]

2.1. Organizations and their roles in individual steps of dealing with medical error

In most of the incidents, medical error is caused by medical procedures or methods decided and conducted by healthcare professionals; hence, it seems that the responsibility for the occurrence is particularly of medical staff but the organizations. Nevertheless, the organization is the level at which the problem should be worked out. Individuals exhibit their own corresponding obligations and duties and cooperate with others within the organization in many steps.

Risks in health care are at various ranges of severity, additionally risks are perceived differently from people to people. Therefore, in weighing risks against benefits in a particular treatment, ultimate decisions are likely to vary. On the other hand, the perception of risks directly influences on human behavior. For instance, some people may understand risks in clinical setting as the occurrence of death, thus their best practice is any medical plan as long as it avoids cessation. Other requirements for patient safety may be disregarded or neglected. To avoid such issue, risks should not be defined by any individual healthcare professionals but alternatively by the organization in the organizational statement.[10] Another type of risks appears due to the physicians' practice. Organizations responsible for recruitment play significant roles maintaining the quality of medical practice within the organizations.[11]

During medical practice, recording the data about the features of procedures and patients, as well as particular complications is crucial and should be a routine among healthcare professionals. While collecting data can be implemented only by medical staff, how effectively the data is utilized is on account of the organizations. At organizational level, the data should be analyzed and concluded to the root causes of the problems, and applied for improvement of safety perspective. By such cooperative process, the adverse events are systematically concerned, resolved, and prevented from recurrence in the future throughout the organizations.[12]

When adverse events occur, faults or responsibilities tend to blame on individuals for the organizations are fear of losing reputation or involving in legal disputes. In fact, such way of response leads to covering up and punishing rather than addressing and learning from the problems in the systems that may have contributed to the incidents. The role of organizations is to take collective responsibility on behalf of all the individuals within the organizations, identify and understand the issues and learn from the mistakes in order to possibly comfort the involved parties and prevent the future recurrence.[13]

It is important for organizations to distinguish the difference between human error and violations since confrontation of each type requires particular courses of actions. In order to deal with error, in fact, healthcare organizations have to become error proofed. On the other hand, changes in individual or organizational behaviors may amend violations to subsequently avoid creating avoidable harm. Accordingly, upon identifying a harm caused by violations, organization can adjust the system and avoid future occurrence in a good time manner; whereas, when recognizing a harm caused by error, offering solutions to or suggestions of essential changes within the system is more complex.[14]

In management of unintended adverse incidents in medicine, solutions or corrections are substantial but, for most patients or patients' families who suffer the detriments, how the hospitals prevent the recurrence of a similar event is also great

concern. Accordingly, individual physicians are not capable of changing or renewing the system but the organizations are able to extensively work on the problems, change individual behavior, as well as develop a culture of safety within healthcare.[15]

2. 2. Organizations and their roles in creating a good communication in clinical settings

In clinical settings, relationship between patients and healthcare professionals has been always decisive factor in obtaining success in medical treatments. Yet, this relationship has been under several critical changes of the primary roles in medical history. The changes overtime have much influenced the professional behaviors among healthcare professional. In the eighteenth century, patients were dominant to the doctors since patients were normally high class in the society; doctors, even the skillful ones, must learn the art of pleasing in addition to their bedside skills so that their life would not be encumbered by their superior patients. After that, until the twentieth century, upon the coming of the era of science and technology, doctors' knowledge and skills were much assured by their improvement in integrated studies; together with the growth of hospitals, doctors were placed in higher position than their patients. During this time, the relationship between doctors and patients were commonly paternalism; patients relied on their doctors and their autonomy was not a necessary component in making medical decision. Over the time, doctors and patients currently hold the relationship of partnership in accordance with the ethical principle of respect for the autonomy of patients. The relationship requires doctors to provide relevant information to the patients and have their patients fully informed about the health conditions and treatments. On the basis of the provided information, patients make medical decisions for which doctors must respect.[16]

In contemporary medicine, patient autonomy is of significance in making medical decisions. Nonetheless, patient autonomy should be restricted at certain level rather than being totally granted for individual patients since patients are dependent on healthcare professionals for medical information and treatments as well as, in some situations, financially dependent on the third parties. Hence, decisions in health care should be drawn from a consensus among involved parties under setting policies established by the organizations.[17] Organizations play central and controlling roles with the established and clarified policies which take patients as the most priority. The policies, afterward, give guidance for particular cases, of providing and gathering necessary information to involved parties, evaluating the reliability and validity of suggestions of the parties, and making the ultimate decisions for the best interest of the patients.

The involvement of organizations also establishes a good communication which is a key factor in managing the consequences of the unintended effects and inefficiencies of the systems. A good communication is a means of maintaining trust whose immediate involved parties are healthcare professionals and patients, still organizations' policies significantly have influence on the standing of the trust. Besides, a good communication also can be an effective protection against litigation when harms occur, since patients with fully trustful information about their conditions are unlikely to take action against their doctors.[18] Whereas, poor communication would increase the chances for litigation to happen as patients or their families are already frustrating dealing with the adverse incidents.[19] However, when only healthcare professionals who have caused the tragic events handle the consequences, their explanations or suggestions may not be considered objective but more self-defensive from engaging the mistakes. Therefore, when things go wrong, healthcare organizations should represent their healthcare professionals to provide necessary information and explanation and assure that all involved parties understand the information and explanation.[20]

3. Possible improvements for patient safety by diminishing medical errors in health care

3. 1. Improvements for involved parties upon the adverse incidents

Health care is a complex system composed of interactions between those receiving the care and those delivering it.[21] As a result, dealing with the adverse incidents, an ideal way is to get the best out of involved parties, including patients and/or their families, relatives, healthcare professionals, managerial staff. In other words, each individual may contribute to reduce the resulting damages and reach the best solutions to the problems, as well as prevent the recurrence of the events. It is common that patients or their families do not acknowledge their roles in diminishing medical errors. As a matter of fact, the full engagement and involvement enable patients to ensure to receive appropriate care and understand their doctors. It is great advantageous when patients can pursue their own safety under the circumstances of millions of potential errors resulted from healthcare professionals and systems.[22]

Another party is the team of healthcare professionals who directly interact with patients and who are the main financial resources of the organizations. How effective and successful the medical treatments are decides the patients' physical and mental health and the organizations' financial health. Hence, organizations are responsible for recruiting medical staff, supporting medical practice, and directing medical staff to the right things. Nowadays, physicians are under much more pressure and exposure to more conflicts than earlier; they have to consider more perspectives when making medical decisions. Therefore, good communication among healthcare professionals and patients, or their families, friends, colleagues, and community would help resolve the existing conflicts.[23]

As financial improvement is one of priorities in healthcare organizations, the organizations commonly put the provision of effective treatment in the front row, arguing that effective treatments sufficiently represents the quality of health care in the organizations, thereby improving their patients' health is the most prior reason for their existence. However, the quality of health care should include the component of safety, entailing that healthcare organizations are responsible to provide patients with safe healthcare facilities as well as effective treatments to
those who need them. With these factors, healthcare organizations may fulfill their primary goal to improve people's health by three approaches, including the treatment of illness, the prevention of illness, and the promotion of health.[24]

In defining medical risks, the organization should emphasize on that the medical risks include not only the occurrence of death but also any kind of inappropriate health care.[25] In addition, it is necessary that all the risks and benefits should be included in informed consent so that patients can evaluate or at least be aware of the possible risks and the organizations may avoid disputes or legal issues.

3. 2. Improvements formulated from changing behaviors towards the adverse incidents

In addition to the human factors, healthcare systems also can support the provision of safe, high quality care for all who need it by changing the organizational behaviors.[26] However, the only way to make this change is to have collective changes among individuals within the organizations because the systems' attributes reflex the collective attributes of their individuals. Accordingly, primarily necessary changes in the organizations are healthcare professionals' skills and knowledge, thereby changing their behaviors about the safety for patients.[27]

The discussed points above demonstrate the interactive relationship between individuals and organizations. When organizations focus on safety, stating and clarifying in their policies, individuals who work within them tend to behave or attempt to follow accordingly, unless organizations tolerate otherwise behaviors of individuals.[28]

3. 4. Improvements made by eliminating the root causes of the adverse incidents

The fundamental steps when a medical error occurs should successively be identifying the contributing factors, identifying the incident, and identifying outcomes and consequences. The root causes of the incident should be understood properly so that the problems can be prevented from happening again in the future.[29] It is true that every healthcare system has to be error tolerant since human error is unavoidable. How involved parties confront, evaluate, analyze, and give solution or possible future prevention is prior to looking for someone who will be blamed on for the incidents. Blaming would not bring effective administration; instead, it would encourage the cover-up information of the causes and effects. Without disclosure of essential information, the root causes would never be revealed and the problems would never be remedied or eliminated.[30]

Conclusion An effective healthcare system is the one that is able to provide the real medical needs of patients and to apply technology with the most cautions of patients' safety. Although it is inevitable that healthcare professionals would not have any mistakes in their practice, they have duty to do everything at best to prevent their patients from being harmed during the medical treatment. Individual professionals must protect their patients from avoidable harms when considering any medical procedure or treatment by enhancing knowledge and skills and strictly abiding to the policies established by the organization they work for. Accordingly, organizations are responsible to set up and adjust if necessary their medical policies based upon collecting data, analyzing the incidents to the extent of the root causes. Patients and their families or relatives also play significant roles in the attempt of improving safety for patients in medicine.

End Notes

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