

Distinctive Feature of Risk in Health Care Organizations

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Abstract

Risk is present in all types of organizations and is perceived as one of the main features of human daily life, as there is no single outcome that is absolutely certain. Risk management has become a crucial part of any effective management system. However, risk in Health Care Organizations (HCOs) has some distinctive attributes that make it unique and an indispensable obligation. This descriptive study, which is based on examining, elaborating, illustrating, and tackling related researches and literature in risk in healthcare and uses a systematic literature review technique, aimed at discussing and addressing the main characteristics and traits that distinguish risk in the healthcare sector and HCOs from risk in other sectors and organizations. As a result, the study highlighted seven distinctive features of risk that relate closely to the healthcare sector and HCOs.

Key Words: Risk, Healthcare, Health Care Organizations, Distinctive Features of Risk

Introduction:

Although healthcare is intended to help in healing and to relieve pain, the healthcare sector is usually described as a risky sector that is surrounded by various types, forms, and sources of risk. Managing risk in healthcare and HCOs effectively requires identifying potential risks and recognizing their features for setting strategies to control them or at least to mitigate their adverse impact. Risk identification and controlling is a crucial instrument for measuring the quality of healthcare delivery. This descriptive paper is intended to tackle and address the key features of risk in the healthcare sector and HCOs.

The Main Input of HCOs: Human

Unlike most other sectors, the main input of the health sector and HCOs is human and human welfare. Therefore, any hurt or potential risk may affect the quality of human life in way that, in many instances, is difficult to compensate for. In many sectors, such as the economic sector, most damages, if something goes wrong, would be financial losses that could be remunerated. Consequently, tolerance of risk in HCOs is very narrow as human welfare and health are viewed as redlines that are difficult to be cross (Mohanna & Chambers, 2018). The dominance of the human element as the main input of HCOs has two related dimensions: patients' expectations and those of patients' families.

When it comes to health and medical care, patients' expectations usually tend to be positive. They switch between hopes and optimism and the reality of their health status.

Overstatement of positive expectations is by itself a source of risk that may affect the health condition and general mood of the patient if outcomes come below expectations. In this regard, patients should recognize, and should be informed as well, that medical care may cause harm as it sets out to heal.

Expectation has a crucial role in patients' satisfaction. Patients assess medical services and healthcare quality, whether it is good or bad, with regard to their expectations (and in many instances their hopes) of results and outcomes. Regardless of what efforts and procedures are carried out, and despite the fact that there are many other factors other than medical care itself that might affect results, patients' perspectives closely follow their expectations (Hill & Alexander, 2017). In addition, patients' families, in many cases, could be the significant. Their expectations, opinions, and judgement are part of patients' opinions, and, in many instances, are more significant. This is particularly the case when the patient is a child or an unconscious person. This includes expectations from medical staff (physicians), nurses and other health practitioners, administrative services, room cleaners, and all other related services.

A good deal of research has highlighted the robust relationship between patients and their families' perception and expectations and their satisfaction (e.g., Lorusso et al., 2016). Furthermore, Berhane and Enquesselassie (2016) found that patients' expectations are significant in patients' satisfaction, and that they are vital in patients' responses to treatment, medical staff's instructions, and the therapy process.

In this regard, risk could come from two sources: the level of expectations and factors that determine this level. Overstatement and a high level of expectations of patients and their families without considering potential risk or side effects of medical interventions could affect the treatment, satisfaction, and involvement in the therapy process by both patients and their families. Secondly, the diverse and number of stakeholders in the medical care process, including patients and their families, plays a role. Unlike other sectors and organizations, stakeholders in HCOs are varied. It is a difficult process to identify them precisely, thus to recognize their expectations and identifying their satisfaction-related variables these steps require extensive efforts. In terms of perception and expectation, every case is unique and has inimitable conditions as people are different in their manner, knowledge, and culture, and thus in the way they perceive potential risks. This makes from this process a very complicated one (Cole et al., 2017).

Risk from the Human Key Role in Healthcare Delivery

Healthcare delivery and quality of health services are a product of collaboration between patients and healthcare providers. The effectiveness of this relationship is influenced by personal factors for both parties: healthcare providers and patients, whether their traits, culture and background, education or characteristics. This makes this cooperative environment subject to many personal variables that make it complicated and critical.

On the other hand, the importance of the human element in healthcare delivery is more notable than most other sectors. Even when using medical equipment, a significant part of their efficiency in producing desired outputs depends on the human element. In other sectors, equipment in general are self-operated, where human intervention, in most instances, is low. In addition, those who operate those equipment and tools still have key roles in taking all possible

safety procedures and steps to make sure that risk is under control or at a minimum level (Hignett et al., 2018).

Risk related to the Decision-Making Process

Patients, in other words the key customers of HCOs, insist in many instances on being a part of the decision-making process, if not the only decision-maker regarding medical interventions in their health and medical status. Moreover, doctors and caregivers themselves encourage patients to participate in decisions regarding their health status and the treatment process, or even to take their decisions alone.

Some scholars claim that medical practitioners and health authorities intend, by informing patients and involving them in the decision-making process, to liberate themselves from any sort of responsibility of relative risks if things do not go as expected. Others see it as an ethical procedure to make sure that it is a part of patients' rights to share in decisions and to give them an opportunity of taking their own decisions regarding their medical concerns. This, also, may make them more satisfied. Providing patients with adequate information about their health status, and other related variables, is a significant step for increasing the awareness of patients, as well as empowering them to make rational health decisions (Han et al., 2012). However, three concerns may arise of special importance here:

- Decisions are more likely to be subjective as individuals have different perceptions regarding what is considered a risk, or the severity of each risk. People are different in their risk perception and behavior; what is viewed as risk by a person is not necessarily viewed in the same way by another. Therefore, judgements by patients are more likely to be personal and mood-based rather than systematic and objective (Ting et al., 2016).
- The extent to which medical staff actually give, and should give, information to patients to help them to make the right decision in terms of accepting or rejecting medical intervention. Indeed, not all information should be given to the patient, even though it belongs to his or her medical status (Stiggelbout et al., 2015). Moreover, in some instances it is unethical to release or share all information with patients although they are the main targeted person of treatment. Some information, although it is completely true, may represent a source of risk as it may lead to adverse impact on the patient's mood and status.
- The ethical responsibility of medical staff (even though the patient takes the decision): Most patients lack enough health-related information and medical background to enable them to make the right decision or to carry responsibility alone. Medical practitioners should still hold accountability. While research has highlighted the positive consequences of involving patients in their own care and medical intervention as this may support them and may improve outcomes of the treatment (e.g., Stiggelbout et al., 2015), it is unacceptable to completely consider patients as individuals who are independently able to analyze and assess their medical situations and needs. Inadequate recognition and lack of sufficient health knowledge and background are sources of risk that affect the risk management process negatively. Unless they came from medical background, like being medical practitioners themselves, patients should partially be involved in the decision-making process not to be only decision-makers. Therefore, medical staff could be a subject to legal risks even though patients were informed about their health status.

Risk in HCOs is Various

HCOs are described as high-risk organizations. Types of risk in HCOs, and in the healthcare sector in general, are varied and diverse, take different forms, and come from various sources. It may come from patients and their families; medical errors; deficiency in equipment; medication itself; malpractice; managerial errors; environmental factors; infection; and/or deficiencies in the healthcare system. McCaffrey and Hagg-Rickert (2009), in this regard, categorized risk in healthcare into the following five groups: patient care-related; medical staff-related; employee-related; property-related; and financial risks. Mohammed (2010) added three more groups to this category; these are system-related; medication-related; and equipment-related risks. Among these types of risk, the most familiar ones are residual risk and medical errors (as will be discussed below).

An essential and crucial part of controlling risk in HCOs is to identify its types, as well as its potential sources and forms. Listing all types, sources and forms of risk in HCOs is not an easy task. Consequently, setting a plan for controlling these risks requires extra efforts and extensive attention, whether in postulating strategies to cover potential risks or in identifying and classifying these risks. Indeed, controlling risk in healthcare requires participatory efforts from all stakeholders for a comprehensive list of potential risk; otherwise, some types and sources may be missed. The significant point here is that risk, among other issues, is a matter of perception (Mohammed, 2010). Therefore, if people who are involved in the risk management process do not recognize some types and sources of risk, then they would not be able to identify, name and list them. Neglecting any type or potential source of risk may lead to hurt people when exist, and risk that is unseen or seems small and minor today may become major and serious tomorrow.

Residual Risk

Residual risk, as identified by Monhan (2008), is the risk that remains after taking all necessary actions and applying all risk control-related procedures and efforts to identify and manage it. Medical interventions, x-ray, and medications all include a sort of risk that is neither possible nor expected to be eliminated. Patients have no choice but to accept and adapt to it. Even worse, this undesired impact may cause other complications and may have severe impact on health (Myoni et al., 2019).

While this is very familiar, mainly unavoidable, and a part of medication itself, authorities in HCOs are required not only to identify residual risk but also to control it; it is viewed an ethical issue (Runciman et al., 2017). Thus, health and medical staff, in many cases, find themselves responsible for finding techniques and tools to mitigate residual risk's adverse impact, even though the possibility of progress to eliminate it or to mitigate its adverse impact, in many instances, is very small or nil.

Medical Errors: Dire Phenomena and High Costs

Despite the remarkable development and advances in technologies in healthcare and HCOs, the human element is still viewed as the key element to efficient delivery and provision of health services. This role becomes more crucial when it relates to the risk management process, as this process mainly relies on people and those who deal with and are responsible for

managing risk. Therefore, healthcare staff, as much as they are supposed to control risk, could be a serious source of risk, including medical errors.

A medical error, as identified by Banning (2016) is “any preventable event that may cause or lead to inappropriate medication use or patient harm” (Banning, 2006, p. 27). In HCOs and healthcare, medical errors are very familiar and have become a serious problem that is dramatically increasing, even while although developments in the medical care system are gradually improving the situation. Day after day, statistics show horrible figures. According to Makary and Daniel (2016), there were approximately 94000 deaths from medical errors in the USA in 1990. This number reached 142,000 in 2013, then 213,000 deaths in 2016. Another alarm is a research that has been carried out by Proctor et al. (2003), which found that, “Medical error occurs in more than one half of hospital admissions on a general pediatric surgery service and contributes to a substantial number of adverse outcomes” (p.1365). This put medical errors in the third place as a cause of death after heart disease and cancer in USA (Laposata, 2018).

Economically, this is also terrible. Additional costs which relate to malpractice and medical errors, whether direct costs such as costs of fixing the medical error by another medical intervention (i.e., another surgery) and extra in-hospital days or in direct costs and expenses such as statutory compensations and other legal expenses, are huge. It also involves and produces other forms and types of risk, such as the financial risk and the negative reputation risk. Andel et al. (2012) found that, “In 2008, medical errors cost the United States \$19.5 billion ... [whereas] the economic impact is much higher, perhaps nearly \$1 trillion annually when quality-adjusted life years are applied to those that die” (p.1).

The Individualistic Aspect of Incidents in HCOs

To exemplify what the individualistic aspect of risk in HCOs means, the aviation industry would be an obvious example and a good comparison base. When a Boeing 737 plane that was operated by Ethiopian Airlines crashed, most airlines stopped operating this type of plane, whether temporary or permanently. The total number of deaths was approximately 150, the national flag was at half-mast, and commiseration letters from governments have been sent to show empathy with the Ethiopian government and people. Later, many airlines decided not to fly the Boeing 737. Boeing management, immediately after the accident, sent experts, investigators, and technicians to the place where the plane crashed, and many safety procedures have been implemented. Many countries (i.e.; the United States, Kenya, Canada, etc.) sent experts to help in the investigation (New York Times, 12-03-2019). In this regard, Kapur et al. (2016) noted that, “Despite the number of worldwide flight hours doubling over the past 20 years (from approximately 25 million in 1993 to 54 million in 2013), the number of fatalities has fallen from approximately 450 to 250 per year. This stands in comparison to healthcare, where in the USA alone there are an estimated 200,000 preventable medical deaths every year ... if such a level of fatalities was to happen in aviation, airlines would stop flying [and] airports would close” (p.1).

What happens in the health sector and HCOs is remarkably and regrettably different. Despite more than 200,000 preventable medical deaths every year in the USA alone, the humble efforts and preventable procedures are below expectations or, at least, do not reflect the size of crisis. Even worse, despite the above horrible figures of deaths from medical errors, Makary and Daniel (2016) highlighted that medical errors are not included on death certificates or among classifications of cause of death in the USA; this may negatively affect the awareness of it.

Helmreich (2000) referred to this negligence or underestimation to the individualistic nature of incidents in healthcare. Comparing it with aviation incidents, Helmreich stated that, “in contrast [to the aviation sector], medical adverse events happen to individual patients and seldom receive national publicity. More importantly, there is no standardized method of investigation, documentation, and dissemination” (2000, p. 1).

Conclusion:

This paper outlined seven common distinctive features of risk in healthcare and HCOs. It did not, and was not intended to, offer solutions or strategies to deal with these risks. However, putting the spotlight on these features may increase awareness of health authorities and other stakeholders with these common features of risk when setting mechanisms and plans for dealing and controlling risk in healthcare and HCOs.

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