risk matters in healthcare

communicating, explaining and managing risk

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Foreword

Risk is a topic that is currently being discussed by a wide range of groups – professional, public and political. Doctors are no exception and general practice has its own range of issues in relation to risk. This book is described by the authors as a book in two halves, and to stretch the football analogy further there is an excellent review of definitions, strategy and tactics followed by a practical session on the field of play. A particularly interesting section is the one on comments by doctors on their thoughts on communicating risk. These feedback responses are both illuminating and full of educational messages. They set the context for much of the rest of the book.

For many years attempts have been made to create a 'risk scale', which would be of value to patients, the public and professionals alike. This book reviews a number of such scales and outlines their positive and negative features. The authors propose a 'risk ready reckoner', which chooses a series of clinical problems from breast cancer, amniocentesis and oral contraceptives to other medical interventions, and links them to risk estimates, a verbal description of the risk and a comparative. This is a most useful chart and will provide a helpful source of advice for doctors and other health professionals.

The second part of the book is about changing the culture and improving the management of clinical risk. There is an interesting discussion on common areas of risk in general practice. Two particularly good examples of personal and practice development plans in the area of clinical risk are stimulating to read and to learn from.

In conclusion, reverting to the football analogy, this book not only sets out some rules and provides general coaching, but is linked with 'on-the-pitch' experiences. It shows how to avoid penalties and how to score goals, all for the benefit of patients and the community. I enjoyed reading it very much.

Kenneth C Calman
October 2000

Preface

Like a football match, this book is in two halves. In Part One, we concentrate on defining risk and the factors influencing individuals as they make decisions about risk. Part Two deals with clinical teams making decisions about organisational matters and the working environment.

To effectively guide patients as they make decisions involving risk, we need to be aware of the risks posed by clinical and organisational situations, and also how best to communicate that to patients and colleagues for effective risk management. Health professionals 'have a responsibility to make a much greater effort to ... help the public by putting the levels of risk into context and ... enable people to judge ... significant levels of risk'.[1] This book demonstrates how those in the NHS can improve how they help patients share in decision making about their treatments from an informed standpoint.

Some patients want better information so that they can take more responsibility for their own care and make informed judgements about relative risks. Some doctors and nurses are trying to inform patients so that they can understand more about their illnesses, share in decision making about treatment and management options, and take more responsibility for their own health and wellbeing. Current resources for patient information/education/communication and understanding of risks is of variable quality or non-existent. People are calling for input into local and national decision making in the NHS. The book considers how this can happen in a meaningful way.

The emphasis is on practical aspects of how to explain risks to patients, what health professionals can actually do themselves to provide good-quality information and to understand the extent to which individual patients and the public need to be involved before they can make meaningful and informed decisions. We have tried to summarise some of the everyday information on risks that might be needed for discussions with patients and suggest ways in which that information might be conveyed, in response to our conversations with colleagues.

Risk management is an essential component of clinical governance. Risk assessment, risk reduction and risk management are all covered with respect to the practice organisation and working environment.

Kay Mohanna
Ruth Chambers
October 2000

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1 Lomer G (1998) Risk assessment. *The Times*. 15 Sept (letter).

About the authors

Kay Mohanna has been a general practitioner for seven years, and is a lecturer in medical education at Staffordshire University. Kay teaches undergraduate epidemiology and medical ethics to medical and dental students. Her initial interest in how people evaluate risk and then use that information to make decisions was sparked during research considering a proposal for a compulsory community mental health treatment order. This was the basis of her Masters degree in medical ethics. Since then she has looked at how an understanding of risk affects the consent process as it involves pregnant women being asked to participate in clinical trials.

She has watched with interest the way the general public has been informed by the lay press about everyday risks involving diet, medicines and lifestyle. As a doctor, she is used to trying to translate scientific risk into meaningful discussions with patients and helping them to personalise that risk for themselves and their situations. She is interested in the question 'So what would that mean if it happened to me?' as well as 'How likely is that to happen?'

Ruth Chambers has been a general practitioner for 20 years and is currently the Professor of Primary Care Development at the School of Health, Staffordshire University. She became interested in involving patients and the public in decision making about the planning and delivery of NHS services while Chair of the Staffordshire Medical Audit Advisory Group and, later, author of her district's primary healthcare strategy. Personal experience of caring for a terminally ill child has given her an insight into how distressing it is for parents to be excluded by doctors, nurses and others in authority from involvement in important management decisions that involve risks in an individual's management.

Ruth has initiated and run all types of educational initiatives and activities. She has run workshops to teach GPs, hospital consultants, nurses, therapists and non-clinical staff about clinical governance. The experiences of the workshops and how the participants put their learning about clinical governance into action inform the second part of this book.

Acknowledgements

Much of our initial thinking about communicating risks originated from the published works of, and later conversations with, Professor Sir Kenneth Calman, Dr Peter Bennett and Dr Geoffrey Royston. We were able to consolidate and test much of our thinking at the Royal College of General Practitioners' millennium Spring Meeting at Crieff, where one of the themes was 'risk'.

The basis of the integration of risk management into a clinical governance culture that is central to the second part of this book was developed in a previous publication and through associated workshops for doctors and other health professionals with Dr Gill Wakley.[1]

We should like to acknowledge the contribution of all these experts in the field and the health professionals who have told us how they manage and communicate risk in their everyday practice. We should also like to thank the several taxi drivers and other members of the public who knowingly entered into conversations about risk to inform this book.

Finally, we hope that the risks we took with our relationships with families and friends by closeting ourselves away writing this book are at least equal to the benefits to you, as readers, in helping to increase your understanding of risk and risk management.

1 Chambers R and Wakley G (2000) *Making Clinical Governance Work for You.* Radcliffe Medical Press, Oxford.

PART ONE

Understanding and talking about risk

CHAPTER ONE

Risk: what's that all about then?

When it comes to risk management – everyone is an expert.[1]

We all automatically, maybe even subconsciously, make decisions in our daily lives that take into account the anticipated effect of likely outcomes. Often we are confident that we can predict the result of our actions and what it will mean to us if it does happen. Depending on our personality and our perception of risks and benefits, we will each make decisions that suit us and fit with the way we look at the world.

However, as Ulrich Beck acknowledged, risks can be 'changed, magnified, dramatised or minimised within knowledge and to that extent they are particularly open to social definition and construction'.[2] This subjectivity accounts for why there is such a wide variation in what we each consider to be 'risky' behaviour. Similarly, the results of previous 'gambles' – whether we survive or get our fingers burnt by our choices – will colour our judgement about the level of risk we perceive for a given situation.

So is it possible to produce one definition of risk that we would all recognise? We can say that:

risk is the probability that a hazard will give rise to harm.

Both the extent to which we judge that the harmful outcome is likely to occur and that to which we judge the likely outcome to be harmful, are subjective.

On the whole we tend to be overoptimistic about the risks we face. Most smokers acknowledge the connection between smoking and disease – although some, for a variety of reasons, deny it – but the extent to which they feel that risk applies to them is generally underestimated. Similarly, individuals tend to feel that advice about healthy eating and lifestyle applies to others. If asked to estimate the risk we feel that we face from heart disease, for example, or being involved in a car accident, there will be a bias towards optimism. Outcomes with a high probability tend to be underestimated. Interestingly, the risk we consider ourselves to be under from rare events, such as nuclear accidents, HIV, AIDS or bovine spongiform encephalopathy, tends to be overestimated.

So a misperception exists: a tendency towards the illusion of relative invulnerability, even complacency, where more common risks exist and one towards unnecessary concern

for the less likely, but more newsworthy, events. Since perception of risk is a prerequisite for changes in behaviour, misplaced optimism may result in a barrier to preventative action. It is also true that the second type of error of perception can be a barrier to change. If we feel an increased sense of risk, especially when combined with low expectations for being able to deal with that risk, a 'helplessness reaction' may be provoked and obstruct intentions to adapt or modify behaviour. This has implications for the way doctors talk to patients about risk in an attempt to modify unhealthy behaviour.

In a similar way, some personality types will affect the way in which risk is allowed to influence our behaviour. Some people have a tendency to optimism despite the evidence. For pessimistic people, risks are assumed to be greater than they are, maybe as a self-protection mechanism.

All activity carries with it some level of risk; there is no such thing as absolute safety. Even so, our understanding and perception of the risk is influenced by our values and our experience. The value we place on our independence might colour how risky we feel it is to travel alone on the London Underground at night for instance, especially if 'everyone I know does it and has never come to any harm'.

Even though it is clear that our values colour our thinking about risk, this cannot fully explain how it is that certain outcomes are less acceptable to the extent that we will take action to avoid them, even if very unlikely, or not take other actions that would result in clear benefits. An additional complication is that focusing on values is not in keeping with the usual situation where we are often asked to *choose* between alternatives rather than *propose* our ideal alternative for any course of action. Proponents of value-focused thinking, however, encourage us to consider *values*, not *alternatives*, in decision making as a starting place to understand difference.[3] Our patients may tell us that although we may have all the statistics about risks of medical interventions, we don't know how it applies to them in their circumstances. (In fact they may be wrong about doctors' understanding of the statistics as well! More about that in Chapter 2.)

Consider a proposal to reduce fatalities in car accidents. Setting a speed limit of 20 miles per hour would reduce the number of crashes relative to a speed of 60 miles per hour. Such proposals, being put forward for inner cities, meet with strong opposition because they involve conflicting values – only one of which is reducing the number of deaths. Others have to do with convenience, saving time, cost and lost opportunities to do other things with the time that would be spent on the road. Since we almost certainly do not all hold identical value systems, this can result in decision making that others find difficult to comprehend. Proposals to decrease the speed limit on seemingly safe roads may infuriate those who drive for a living, such as lorry drivers and sales representatives. So in healthcare, just as in any other field, anticipated costs as well as benefits are taken into account by patients and interpreted in the light of what that outcome would mean to them, as they consider their options.

The extent to which we will tolerate the suspicion of risk then, is influenced by our preconceptions and beliefs, and our awareness of possible outcomes. We are influenced by what we see and hear. If a plane falls out of the sky, it will be reported on the news. The millions of successful flights each year go unmarked. A skewed or distorted image of