



Attitudes regarding reporting healthcare-associated patient deaths to the police: A nationwide survey of physicians and RMs in Japanese teaching hospitals

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ABSTRACT

In Japan, healthcare professionals are required by Article 21 of the Medical Practitioner's Law to report "unnatural deaths" to the police in cases of healthcare-associated patient death. The attitudes of medical personnel at the forefront of clinical medicine regarding reporting have not been described. We investigate the attitudes of physicians and risk managers (RMs) regarding reporting to the police under different circumstances. We sent standardized questionnaires to all hospitals in Japan that participate in the National General Residency Program. We asked physicians and RMs to indicate if they would report to the police or not under scenarios including cases where medical error is present, uncertain, or absent. We also asked if they would report when medical error had occurred and the cause-of-death was directly related, possibly related, or unrelated. We found most physicians believe they would report to the police if medical error clearly caused patient death. We found most RMs believe they would advise physicians to report given the same situation. Less but still a large number of participants favor reporting even when cause-of-death is not clearly related to medical care provided. This tendency persisted even when given a scenario where the hospital director opposed the decision to report.

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1. Introduction

In Japan, physicians are currently required to report healthcare-associated patient deaths to the police under the Japanese Medical Practitioner's Law. Article 21 of the law states, "In the course of pronouncing death of any person or fetus over the age of 4 months should the physician find anything unnatural, he or she must report that death to the police within 24 h". Explanation of how Japan handles unnatural death, and how this may differ from other nations, is beyond the scope of this paper, but in Japan, the police who investigate deaths of all types, as no country-wide coroner system is established [1]. Once a healthcare-associated death is reported to the police, an investigation ensues. While these types of investigations have been reported in other countries, such as the United States and Great Britain [2,3], Japan is unique in its frequent occurrence [4]. Depending on the results of the investigation, healthcare providers may be criminally charged with "negligence leading to patient death" (Article 199.1 of the Penal Code).

The majority of clinicians were not aware that Article 21 was applicable to patient deaths occurring in the course of medical

treatment; historically, Article 21 applied to cases where patients who were found down, brought to a healthcare facility, and then died or found dead on arrival. At the time, as now, no standardized definition of "unnatural death" existed. Despite this, law enforcement began to prosecute practitioners who did not report deaths to the police, as in the famous case where a nurse mistakenly administered an antiseptic intravenously and killed a patient. That was the first case where Article 21 was applied to patient death during the course of medical treatment. In an unprecedented ruling, on April 13, 2004, the Supreme Court of Japan decided that Article 21 applies to persons who die during the course of medical treatment. The Supreme Court still failed to formally define what cases should be considered "unnatural" so as to require reporting [5].

When deaths that occur during the course of medical treatment are reported to the police, an investigation ensues and criminal prosecution of the involved medical personnel is possible. The prosecution occurs on the grounds of having caused death or injury through negligence as stated in Article 199.1 of the Penal Code. Recent research has confirmed a marked increase in the number of medical personnel reporting to police as well as the incidence of criminal prosecution [4].

While healthcare professionals are required by law to report unnatural deaths to the police, the attitudes of physicians and risk managers (RMs) concerning if they would actually report or not

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has not been previously described. Therefore, our study aims to describe if physicians and RMs would report to police when faced with various scenarios of healthcare-associated patient death.

2. Materials and methods

2.1. Subjects

Standardized questionnaires were sent on January 15th, 2009 to all hospitals in Japan that participate in the National General Residency Program. This included the 1004 non-university and 109 university-affiliated hospitals listed on the government's Residency Program information web site [6]. The study targeted the attending physician in charge of graduate medical education, as this physician would be most likely to make policy regarding reporting of medical-error-related deaths to the police in the residency program, and also the hospital's chief risk management officer. Respondents had 15 days to return the completed questionnaire.

2.2. Materials

A structured, anonymous, self-administered questionnaire presented various scenarios of patient death. The questionnaire con-

sisted of eight major sections, and this paper focuses on two sections, (1) attitudes toward reporting patient death to the police in specific clinical scenarios and (2) respondent demographics (see Table 1). Each scenario described the presence, absence, or uncertainty of medical error and the presence, absence, of uncertainty of the causal relationship of care rendered to patient death. This information was presented in a graph format for clarity (see Fig. 1). The questionnaire administered to physicians was similar in format to that administered to RMs, but the content differed: we asked in each of the situations if the physician would report the patient death to the police while we asked if the RMs would recommend that the physician report to the police.

2.3. Statistical analysis

Statistical analysis was completed using JMP 8.0 software. Chi-squared analysis was used to compare group differences between respondents who would or would not report. To determine the influence of various factors on attitudes regarding reporting, a Wilcoxon rank-sum test was used. Significance was set at an $\alpha < 0.05$. Apriori we decided to group physicians into years of experience for analysis of <20, 20–50, and >50 years experience and risk

Table 1
Characteristics of study sample.

Characteristics		% of physicians (n = 466)		% of risk managers (n = 599)		p
Sex	Male	94.8	(442)	40.9	(245)	<0.0001
	Female	4.3	(20)	58.1	(348)	
	No response	0.9	(4)	1.0	(6)	
Age	0–39	1.9	(9)	4.7	(28)	<0.0001
	40–59	74.5	(347)	85.2	(511)	
	60+	23.4	(109)	9.9	(59)	
	No response	0.2	(1)	0.2	(1)	
Years of experience	0–19	6.4	(30)	0–2	40.7	–
	20–39	85.7	(399)	3–5	29.7	
	40–59	6.0	(28)	5–6	18.2	
	No response	1.9	(9)	No response	11.4	
Hospital type	University hospital (governmental/public/private)	11.4	(53)	12.2	(73)	0.0006
	Public	55.4	(258)	55.0	(330)	
	Private	31.1	(145)	24.9	(149)	
	Others	1.9	(9)	7.2	(43)	
	No response	0.2	(1)	0.7	(4)	
Number of beds	0–199	5.4	(25)	5.3	(32)	0.9514
	200–499	60.9	(284)	61.6	(369)	
	500+	33.3	(155)	32.4	(194)	
	No response	0.4	(2)	0.7	(4)	
Autopsy facility in-house	Yes	91.5	(426)	89.8	(538)	0.6657
	No	7.9	(37)	9.5	(57)	
	No response	0.6	(3)	0.7	(4)	

For statistical analysis, the Chi-square test or Wilcoxon rank-sum test were used where appropriate.

Years of experience was defined as years in practice for physicians and years on the job for risk managers.

Scenario 1: Medical care directly related to death but uncertain whether medical error was present

Think of a scenario where medical care clearly caused a patient to die, for example massive hemorrhage leading to death during an elective laparoscopic surgery. In this scenario, medical error can be present (left), medical error can be unclear (middle), or medical error can be absent (right).



Scenario 2: Medical error is evident but ambiguous direct causal relationship between care and death

Think of a scenario where medical error clearly occurred and death occurred, for example during the treatment of a patient with a chronic terminal illness. In this scenario, the relationship of the medical error to the patient's death can be present and direct (left), the relationship can be unclear (middle), or the relationship can be absent (right).

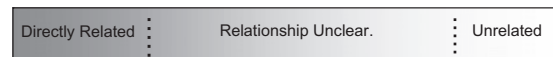


Fig. 1. Scenarios presented to respondents.

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