

患者の声を医療政策決定プロセスに反映させるための政策提言

行政への提言

- 患者・市民が参加する医療政策の基本問題を議論する場をつくる
- 審議会委員の人選、任命についてのルール確立
- パブリックコメントの実施方法の改善
 - ・医療制度改革全体に対するコメントの実施
 - ・意見の違いを概観できるパブリックコメントの実施
- 審議会の運営方法の改善
 - ・患者・市民の声を把握するプランニング
 - ・インターネットによる審議会の公開

患者の声を医療政策決定プロセスに反映させるための政策提言(2)

患者会への提言

- 患者会支援機能を担う組織をつくろう
 - ・医療に関する政策動向や審議会等の開催状況を患者団体に知らせる
 - ・医療政策について患者団体間での勉強や意見交換
 - ・政策立案者と患者団体との橋渡し
- 政策形成のため外部の協力者との連携を強化しよう

今後の取り組みの方向

- 医療基本法の制定の検討
 - ・昭和47年医療基本法の国会提出
 - ・数次にわたる医療法の改正
 - ・小泉政権以降の医療政策
 - ・患者の権利法
 - ・医療政策の基本について
 - ・英国におけるPPIの取り組み
(Patient and Public Involvement)

いま一番重要な検討課題は何か

- わが国の医療政策の基本理念の再確認と具体的な制度設計
- 皆保険制度を基盤とした国民の助け合いの仕組みを重視した制度かアメリカのような自己責任の国を目指すのか
- 患者、市民が参加した国民的な議論
- 患者団体に共通の問題は何か
- 医療基本法の制定が必要

(4)

米国医療にみるパートナーシップ

Partnership in the U.S. Medicine

赤津 晴子

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これまでの幾つかのご発表とは少し違った視点から、医療の安全、そして、広義な意味での医療におけるパートナーシップという問題提起をさせていただきます。

昨日、一昨日の学会、そして今日のフォーラムのテーマであります「医療の安全」という本題に入ります前に、我々にとって非常に身近な「車社会における安全」、ということをもまず一緒に考えてみたいと思います。

車社会の安全を高めるためには、二つのやり方があります。一つは安全な運転の仕方をきっちり学び実行する、というやり方。もう一つは事故が万が一起こってしまった場合の、事故の対処法を考える、というやり方です。安全運転の仕方といえますのは、言うまでもなくシートベルトを締めるとか、カーブ前にはスピードを落とす、車間距離を十分にとるといったことであります。一方事故の対処法といえますのは、けが人をまず助ける、警察に通報する、ということでもあります。

1点目の安全運転の仕方とは、まさに運転能力にかかわることで、その能力をいかに高めるか。それも一人、あるいは一握りの運転手の能力を高めるのではなく、社会全体として、全ての運転手の運転能力をいかに高めるかによって、車社会の安全を守る、という考え方です。一方、事故の対処法とは文字通り、事故対策で、万が一事故が起こってしまった場合、その被害をどうやって最低限に食い止めるか、又その事故から何を学べるのか、ニアミスをどうやって防ぐか、といったことを考えることであります。事故対策にとって大事なものは、対策本部とか安全委員会のあり方です。一方、安全運転を普及させるために大事なものは、教習所での教育、免許書き換えの際の再教育や視力検査であります。

さて本題であります医療における安全ということを考えてみました場合に、この車の安全と同じように、大きく分けて二つのアプローチの仕方があるのではないかと思います。

1つ目は、まず安全な医療を推進する、という方法。2つ目は万が一事故が起こってしまった場合の対策をきちんととる、という方法です。

2つ目の医療事故対処法は、車の事故対策とあまり変わりません。けが人と申しますか、医療事故に巻き込まれてしまわれた方の危害を最低限に防ぐ、そして起きてしまった事故から学び、二度と同じ間違いを犯さないように努める、というやり方です。リスクマネジメント、あるいは安全対策室といった病院の部門から今日もお見えの方がいらっしゃると思いますが、まさにそのような部門が中心となって行われる医療安全推進です。

一方、一つ目の安全な医療を推進する、という観点に立って推進される医療の安全とは、

医学教育の在り方、生涯教育の在り方、あるいはEBMと略して呼ばれるエビデンス・ベースト・メディスンの在り方、といった広い要素を含む分野です。例えば、ベッドサイドで問診、身体所見をきちんと行い、患者さんのデータを正確に取得する、といった臨床医療の基本は、その後の検査、治療方針を決定する基盤となる大切なものであります。もしその患者さんのベッドサイドのデータ取得ががいい加減なものであれば、その後のケアすべてががいい加減なものとなり、安全ではない医療につながります。別の例として、抗生物質を選択する例を挙げることができます。目の前の患者さんにとって1番適切な抗生物質を選択することは、その患者さんの為のみならず、耐性を持つ菌を社会としてつくり出さない為にも、大変重要です。このように、抗生物質の選択の一つ、一つも、まさに患者さん、そして医療の安全を直接的に脅かすことにつながる臨床行為です。更に別の例では、このような例もあります。少し専門的になってしまい申し訳ありませんが、例えば甲状腺低下と副腎皮質低下、両方を同時に呈する患者さんがおられたとします。そういう場合には必ず副腎皮質低下をまず治療して、その後で甲状腺の治療に移らないと命取りになりかねません。これは、まさに臨床知識が直接的に医療の安全を脅かすという例の一つです。これらの例からおわかりいただけますように、運転能力が直接的に交通安全につながるのと同じように、医療提供側である、一人一人の医師の臨床能力の高さが、直接的に医療の安全につながります。そして医療における安全を社会に対して守る、あるいはその安全を提供し続けるためには、事故対策も大事ですが、まずは、医師全ての臨床能力をシステムとして高める必要があるのではないか、と私は思います。

では、臨床能力を高めるためには、具体的にどのようなことが必要なのでしょう。一つは、先程も申しましたように、まずベッドサイドで医師が患者さんのデータをきちんと入手できる臨床能力が必要です。次ぎに、そのデータを統合、整理し、全体を見通せる臨床能力。そして、最新の臨床医学知識の幅と深さという意味の臨床能力も不可欠です。

仮に今、頭痛を訴えて来院された患者さんがおられたとします。頭痛なので脳内出血や腫瘍がないことをまず確認しなくてはいけない、ということで頭部のCTをとった。CTで異常が何もなかったので、「取りあえず家に帰って様子をみていただこう」ということにしたとします。しかし、実はこの患者さん大変デプレストされて、うつ病であられたとします。頭痛ということをお口に、心の病気で医療機関に助けを求めてこられた方であったのです。きちんとベッドサイドでまず患者さんから良く話を聞いていれば、そのことはわかったはずですが、にも関わらず、我々医療提供側が正しい診断をつけられず、頭部CTだけ取り、適切なケアを何もできないまま返してしまえば、その患者さんは病院を出られた足で自殺されてしまうかも知れません。これはベッドサイドで患者さんのデータをきちんと取得できなかった臨床能力不足が患者さんの安全を脅かした例であります。

前半の車の例で、免許の書き換えの際の視力検査、という例をださせていただきました。同様に、我々医師は、常に視力検査が必要です。医師にとっての視力検査とは、臨床能力検査です。臨床能力の重要な要素の一つは、日進月歩で進歩している臨床医学知識に、ど

れだけついていけるか、という能力です。解剖学や生化学といった基礎医学の知識は変わりませんが、臨床に必要な臨床能力、知識というものは世界中で週、月単位でどんどん進歩、書き換えられております。従って、残念ながら医学部で学んだ臨床知識の大方は卒業後数年で使えなくなってしまうという厳しい現実です。そうしますと、それぞれの医師がどれだけ最先端の臨床医学知識を把握しているかが、直接的に患者さんの安全にひびくわけであります。

では、どのようにすればさまざまな複雑な要素を含む臨床能力を、我々医療提供側は向上させていくことができるのでしょうか。一つの答えはチーム医療ではないかと思えます。一人では出来ない事も、チームの皆で力をあわせれば可能になります。ここで言うチーム医療には二つの意味があると思えます。一つは職業分化が細分化している、という意味のチーム医療、もう一つはピアレビュー、同じ医師であってもさまざまな医師が一人の患者さんを診るという意味でのチーム医療です。

職業分化の細分化ということは、アメリカでは非常に進んでおります。例えば医師を中心としてフィジシャン・アシスタント、ナース・プラクティショナー、看護師、薬剤師、ソーシャルワーカー、理学療法士等々、さまざまな職種の間が一人の患者さんのケアをしております。非常に複雑化した 21 世紀の医療にあって、全人的に患者さんをケアするためには、様々な職種のスペシャリストが患者さんのケアにあたる必要がある、という認識に立ったものです。一方、ピアレビューという意味でのチーム医療では、一人の患者さんに様々な医師がチームを組み、ケアにあたる、というやり方です。日本でも VIP 患者さんのケアは医師団と呼ばれるチームで行われるのと同じです。

このようなチーム医療の利点は何かということを考えてみますと、職業分化の細分化に関しましては、まず我々、どの職業を持っておりましても本業に専念することができるため、疲労困憊を防止でき、それが突き詰めるところ、事故防止、効率向上、そしてアウトカム、臨床能力を高めることにつながる点です。ピアレビューに関しましては、風通しのいい透明性のある医療をベッドサイドで行うために、やはり医療ミスを防げる、そしてアウトカムを向上できるという利点があります。その透明性のある医療の裏にはエビデンス・ベースト・メディスン、それから患者さんのカルテがデータバンクとして機能するドキュメンテーションの存在が不可欠ですが、本日は時間の関係上それらの点に関しては割愛させていただきます。

こうして、一人の医師で全てのケアを行おうとしますと、患者さんの提示される本当の問題を見落としてしまったり、臨床知識の欠乏のために間違った臨床上の選択をおこなってしまう危険性もありますが、チームでケアを行うことによって、そのような穴をお互いにカバーしあうことができます。そして、結果として、それが医療従事者側の臨床能力アップ、ベッドサイドで行われる臨床レベルの高まりにつながり、つきつめるところ、医療の安全性を高めることにつながるのではないのでしょうか。

まとめますと、安全な医療を提供する為には、事故の対処法ということはもちろん大事

ですが、それ以前に、我々医療提供側が臨床能力を高めることが不可欠ではないか。そして臨床能力を社会として高く維持するためには、広義の意味でのパートナーシップ、チーム医療ということが一つの回答になるのではないか、という問題提起をさせていただきました。ご清聴ありがとうございました。

パネル討論
 パートナーシップに基づく
 新しい医療のかたちを創るために

米国医療にみるパートナーシップ
 ~狭義と広義~

赤津晴子
 ピッツバーグ大学

車の運転における安全




車の運転における安全

安全運転の仕方	事故の対処法
	

車の運転における安全

安全運転の仕方	事故の対処法
シートベルトを締める	
カーブ前にはスピードを落とす	
車間距離を十分とる	
	けが人を助ける
	警察に通報する
	Never say "I am sorry!"

車の運転における安全

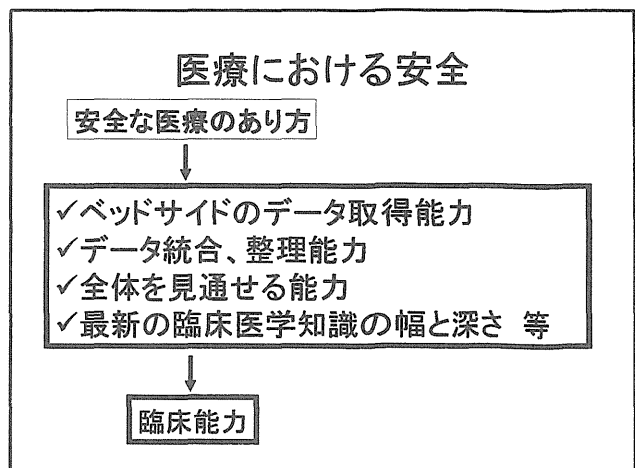
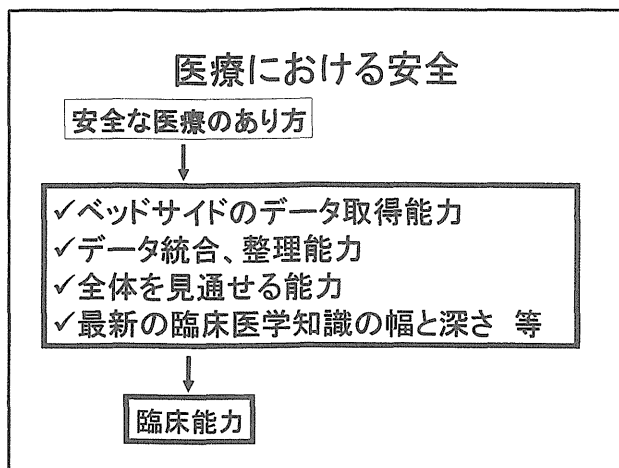
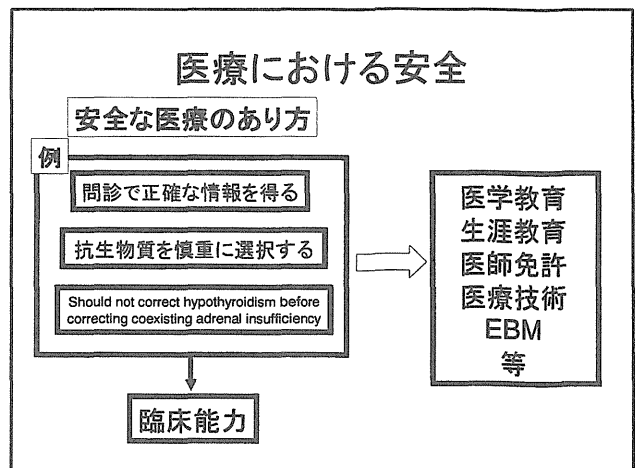
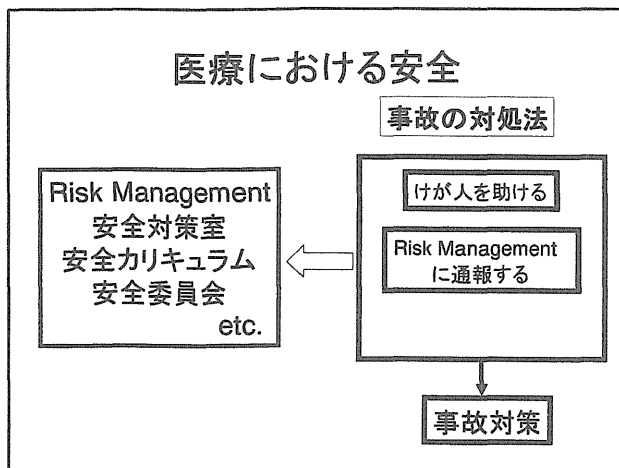
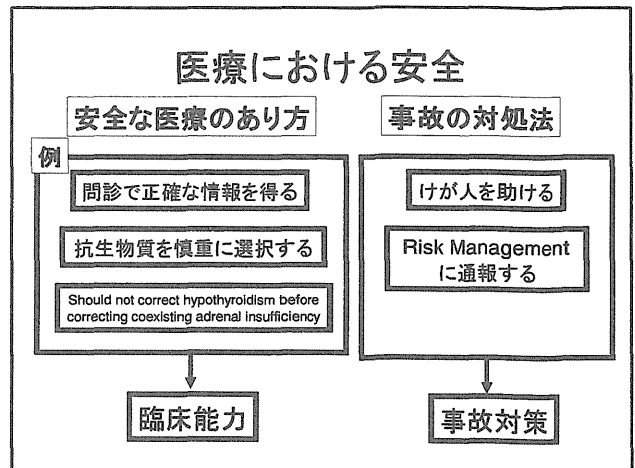
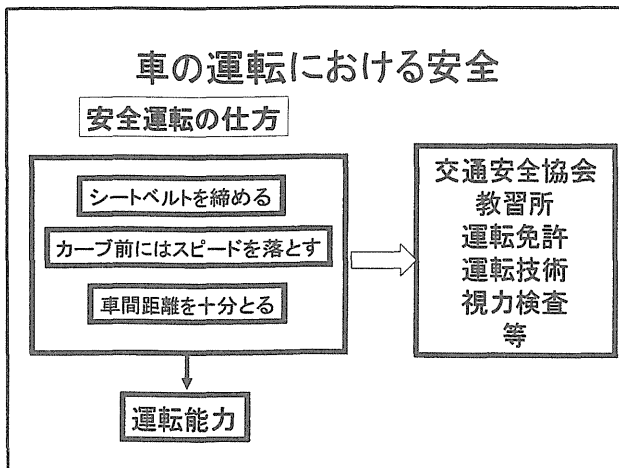
安全運転の仕方	事故の対処法
シートベルトを締める	
カーブ前にはスピードを落とす	
車間距離を十分とる	
	けが人を助ける
	警察に通報する
	Never say "I am sorry!"
↓	↓
運転能力	事故対策

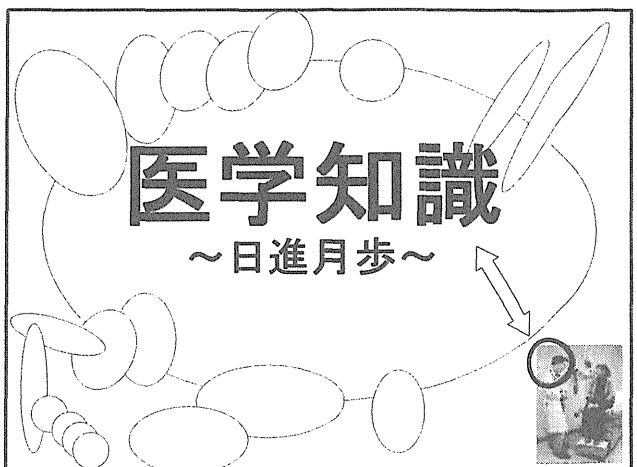
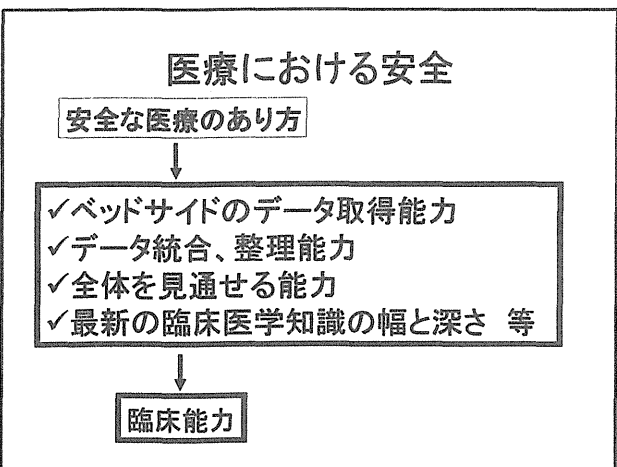
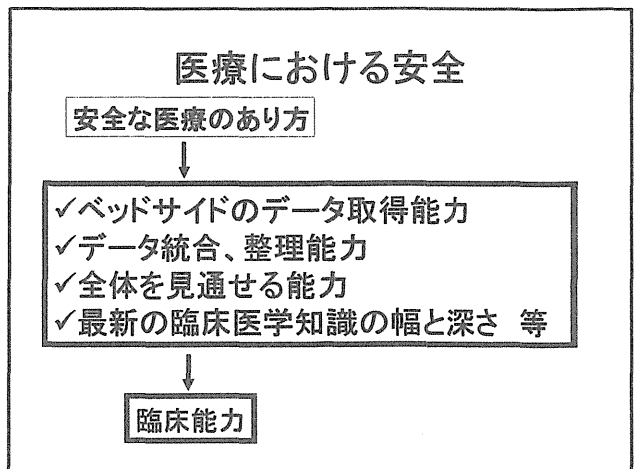
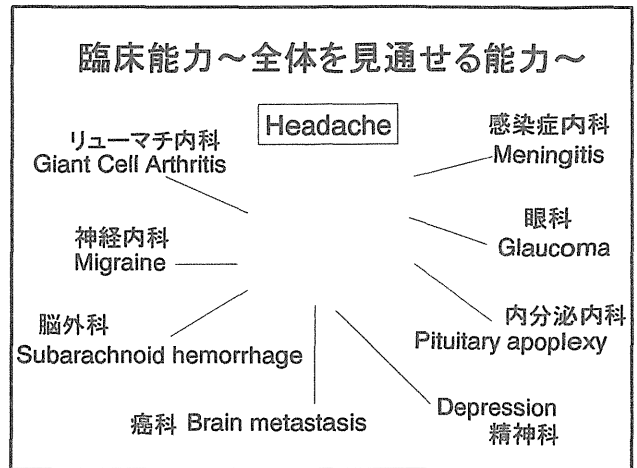
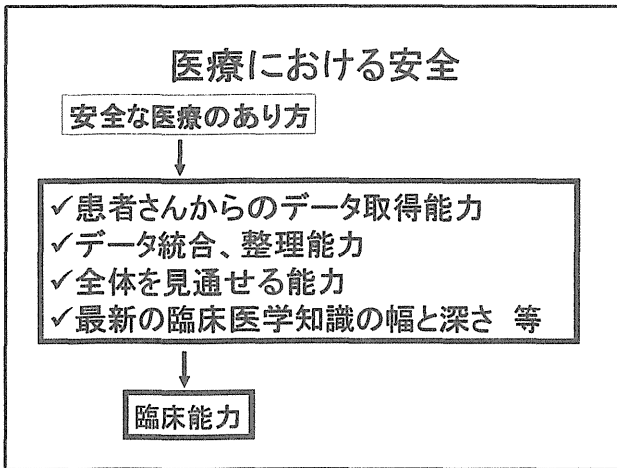
車の運転における安全

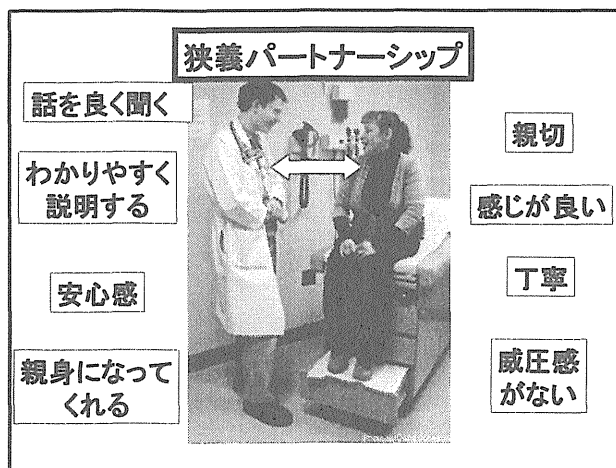
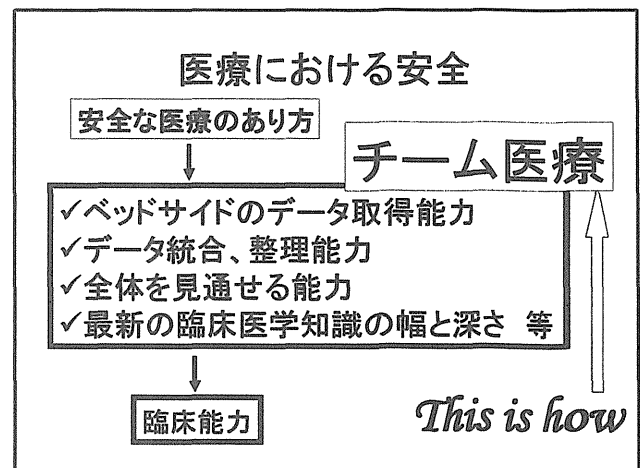
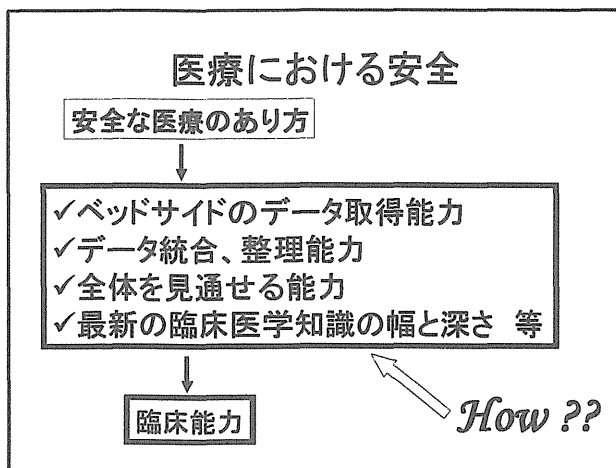
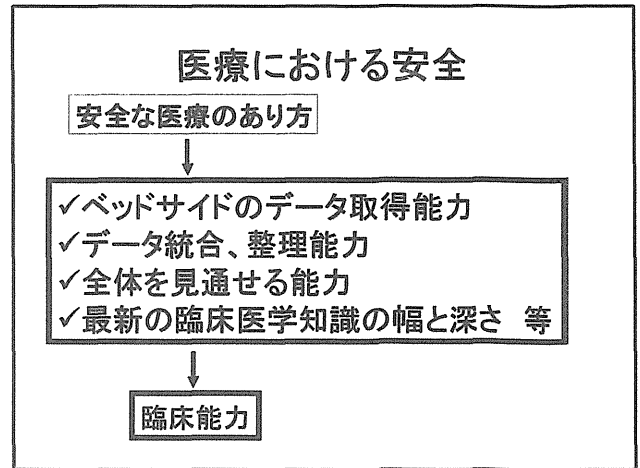
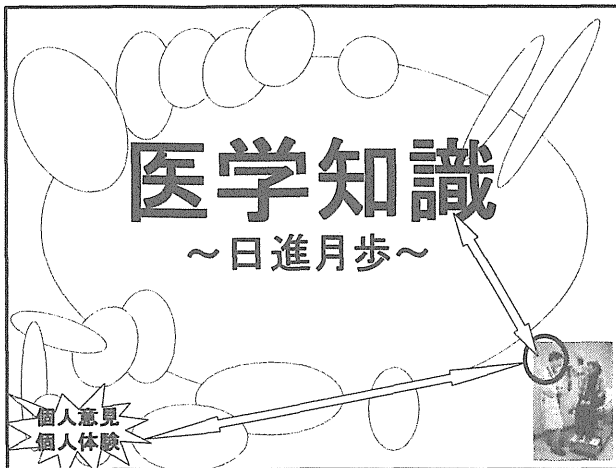
事故の対処法
けが人を助ける
警察に通報する
Never say "I am sorry!"
↓
事故対策

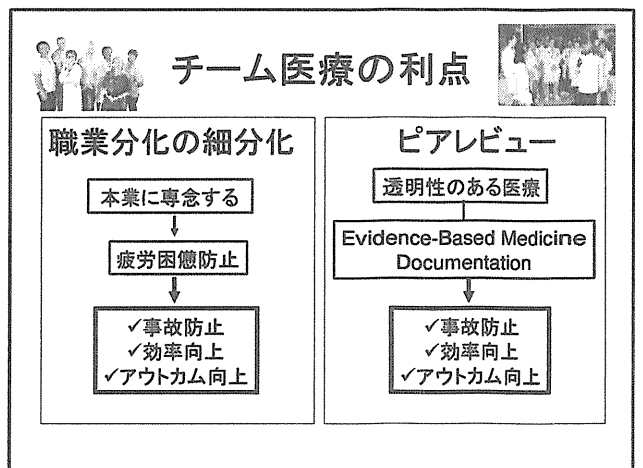
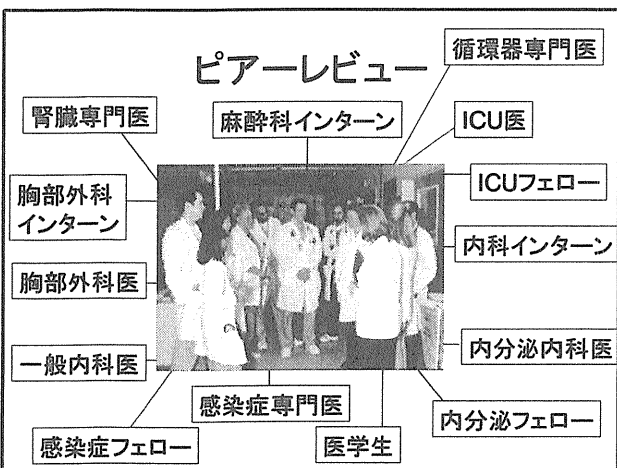
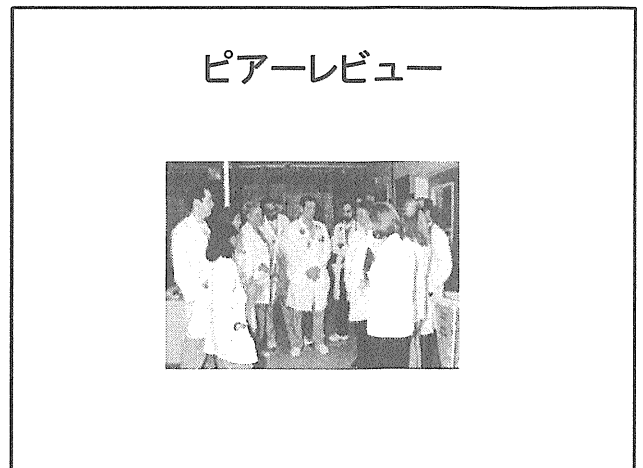
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 安全委員会
 交通安全協会
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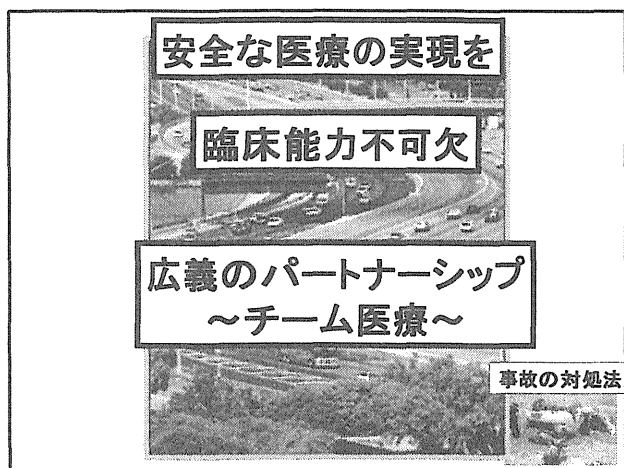
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「医療の質・安全を確保する新しい医療システムを実現するための戦略に関する研究」

(主任研究者 上原鳴夫／東北大学大学院医学系研究科国際保健学分野)

研究報告書資料

(米国における医療安全の取組みの現状)

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**Message by Donald Berwick, MD, MPP
CEO and President Institute for Healthcare Improvement**

Hello! My name is Dr. Donald Berwick. I'm a pediatrician by training and I'm President and Chief Executive Officer of the Institute for Healthcare Improvement – IHI. IHI is a non-profit organization, headquartered in Cambridge, Massachusetts, in the United States, with the mission of helping to accelerate the improvement of healthcare systems around the world. I'm also a clinical professor of pediatrics and healthcare policy at the Harvard Medical School and professor of health policy and management at the Harvard School of Public Health. I've had the opportunity to visit in Japan, a couple of times in the past decade, more recently with my good friend, Dr. Naruo Weihara, who invited me to share thoughts with you through this video tape. I very much wish that I could be with you in Japan, at this enormously interesting and important and exciting time, as you open the first annual congress of the Japanese Society for Quality and Safety in Healthcare. I wish I could be with you; unfortunately I could not at this time. Perhaps some time soon, I'll be able to visit with you personally in your lovely country. Let me express my thanks to Dr. Weihara, not just for allowing me to join you this way, but for many years now, of cordial friendship and collegueship in the effort you are now continuing in this important meeting.

Quality and safety in healthcare is now a global issue. For many, many years, only a few scientists who studied healthcare processes and outcomes knew how hazardous and sometimes damaging healthcare really is. No one doubts, who understands the situation, the good intention or the hard work of the healthcare workforce: doctors, nurses, pharmacists, therapists are trying every single day to do the right thing for their patients. But what we also know now is that healthcare is an immensely complex enterprise, involving many interfaces and interchanges, transfers, a growing and overwhelming body of knowledge. Techniques, like machines and procedures, that have hazards built into them. Very ambitious, audacious undertakings to try to do well by our patients. This is a complex system and we understand as students of safety and quality that complexity lead to error and injury in all too many environments.

In many industries, like aviation or nuclear power or defense, where complexity is part of the situation and hazards abound, there are decades of excellent work to minimize hazards and injuries and to assure extreme reliability in safety and performance. We know a lot about quality and safety. Indeed, for production systems, like manufacturing of consumer products and in many service industries, it is your country, Japan, that led the way in the 1950s and 60s and 70s to teaching the entire world about how to make systems perform at the level they can, with quality and safety, and to continually improve those systems in a never-ending journey. My country, the United States, learnt a tremendous amount from yours in the latter part of the 20th century, about how to take scientific forms of improvement into complex production systems. But somehow, medicine, healthcare, medical care stayed outside that trend in both our countries. I think maybe because healthcare is proud. Because it's generous. Because we know we come to work every day to help, we somehow escape the self-scrutiny to study the rates in which

we fail to help, sometimes even do harm. That's started to change in the late 1990s. An important study was done at Harvard – the Harvard Medical Practice Study – that looked at injury rates at hospitals in one state of the United States – New York – and later on in Colorado and Utah, and discovered an enormous amount of injuries to patients because of failures and unreliability in care systems. Not through the intentions of doctors and nurses, but because of the complexity of those systems. Indeed, in the United States, we came to learn that something between 44 thousand and 98 thousand Americans each year die in hospitals from their care, instead of from their disease. That would place healthcare as the 4th or 8th, depending on which number you choose, most significant public health problem in my country!

At the turn of the 20th and 21st century, our national academy of sciences, the Institute of Medicine, took this problem under advisement and held several long series of committee discussions and meetings, to produce two reports, which established for my country, an agenda for the improvement of healthcare. The first report was called 'To err is human' and it was about injuries to patients in care from errors and flaws. The second report was called 'Crossing the Quality Chasm' and it laid out an agenda of six improvements badly needed in American healthcare. Those improvements were called Safety (don't harm people), Effectiveness (be reliable in use of science), Patient-Centeredness (put the patient at the center and give them power and dignity; honor their choices), Timeliness (avoid waiting when it's unnecessary, and it often is), Efficiency (don't waste money) and Equity (make sure that we're not denying people what they need because of race or gender or ethnicity or wealth). Safety, Effectiveness, Patient-Centeredness, Timeliness, Efficiency and Equity. That became the American agenda for the improvement of care. My organization – the Institution for Healthcare Improvement – had been involved for many years in trying to make improvements along those dimensions and these reports led to an increasing surge of activity in the United States for the improvement of care. That improvement is intended to be scientific. It is intended to be guided by knowledge – not assumption, not habit and certainly not by blame. We now know that blaming the individuals involved in problems in care is the worst possible solution; it has nothing to do with systems thinking. We've learnt to bring systems science to the job of improving care, just as we brought systems science to the job of making better consumer products in other service industries.

Sometimes doctors and nurses and others get offended when we use analogies to other industries and apply them to healthcare, but I assure you the analogy holds. Our work is different, the care of a human being, the sick, is not the same as the production of a product, but many of the same principles, of systems science, measurement, participative management and a focus on reliability, can help with healthcare even more than they've helped in other industries that have begun to use modern methods for the management and improvement of quality and safety.

There is science behind this and crossing the quality chasm requires a research agenda as well as a teaching and change agenda. We have a lot to learn yet about how to construct technical systems of care that flow smoothly, are highly reliable and very, very safe. We have a lot to learn about teamwork – how to build inter-disciplinary work and inter-

dependency as the hallmark for better work, rather than sub-optimizing individual professions and separating people, who really need to be working together as teams. We need to learn from the field of high reliability organizations, HRO – high reliability organization theory is well developed; it applies in healthcare, in many of our environments; we just don't use it. We need to learn more about simulation – how we can put people in safe environments to learn and practice skills and to grow those skills without having patients pay the tuition of injury. And we need to learn about learning – we need to make healthcare organizations, hospitals, clinics and the entire continuum of care, in essence, a learning organization that can, every day, get better at what it does. Not just technically, not just through the invention of new drugs or new techniques, but through better and better systems.

I think the hallmark of this kind of work is that it is inter-disciplinary, multi-professional and involves collaboration and cooperation across many boundaries that we've taken a long time to build up in healthcare. It's time to tear those boundaries down and embrace the challenge of synergy, toward achieving goals for our patients. I know and expect that the Japanese Society for Quality, Safety and Healthcare will strengthen the idea of synergy and inter-dependency and involvement and pursuit of the goal of safety and quality for patients. I also hope that by the establishment of your society, we're going to speed more exchanges between our countries in this field. We've made a lot of progress in the United States toward improvement – my own organization – the Institute for Healthcare Improvement – over the past 2 years – has run a campaign over the entire nation called the hundred thousand lives campaign, whose goal was to save one hundred thousand people from dying in hospitals, whose lives could be saved by improving their processes of care, by avoiding errors and decreasing hazards. That campaign was immensely successful, involved over 3000 hospitals and may provide some examples for you in Japan to build on as you build collaborative efforts as a nation. Equally, I'm absolutely sure that we can learn from you, through the work that you're undertaking, as the Japanese Society for Quality, Safety and Healthcare, you will be engaging in experiments, and learning opportunities and change processes that we need to hear about and learn from, because in the end, we are in the same undertaking here and that is to improve care for both of our populations.

I want to acknowledge that in the other fields, Japan has been an international leader – many would say THE international leader in teaching us how to make complex things better – I know, that in the field of healthcare, if you attend to the issue of transparency, if you are honest about the problems – as I know you will be, if you confront them from the leadership levels, if you decide to be safer and better for your patients, that you too will merge into the lead in an international level in tackling this enormously important global problem of making healthcare what it can and should be for patients and in a never-ending search to make it better every single day.

I want to thank you again for your willingness to let me join you this way – thank Dr. Weihara for his generosity and his friendship and I look forward to staying in very close touch with your efforts, as your new society finds its direction and begins to lead the world, as I know it will. Thank you very, very much.

Keeping Patients Safe: Transforming the Work Environment of Healthcare Workers

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Introduction

The magnitude of the patient safety problem facing hospitals and other health care organizations was documented in the Institute of Medicine (IOM) report, "To Err is Human (2000)." The report described how thousands of people die each year in hospitals from medical errors. Although there may be a tendency to blame individuals for medical errors (e.g., doctors and nurses), the problem lies with the failure of healthcare organizations to develop and implement high reliability systems that can prevent errors from occurring, and when errors do occur, prevent them from reaching the patient.

In 2004 the IOM released a follow-up report, "Keeping Patients Safe: Transforming the Work Environment of Nurses (2004)." The goal of the report was to identify what is known about creating and managing high reliability organizations (safety sensitive) and to assess the relevance of the evidence for hospitals, nursing homes, and other healthcare organizations. The committee found extensive scientific evidence from industries outside of health care, including manufacturing, airlines, and the military, as well as more recent research from healthcare organizations. Based on the evidence, the committee concluded that healthcare organizations can and should immediately take steps to become high reliability organizations. The specific steps are embodied in the report's review of evidence and the recommendations made by the committee. The following summarizes the committee's findings and key recommendations.

Magnitude of the Challenge for Healthcare Organizations

The experiences of organizations that have transformed themselves to achieve the goal of high reliability (safety) provide models that can be adapted to health care organizations. In becoming high reliability, organizations have transformed themselves through leadership and management, changes in organizational culture, and have actively involved workers in making decisions and in the design of work and work environments. Generally it has taken years of leadership and management commitment to achieve the goal of high reliability. The IOM committee concluded that healthcare organizations can achieve high reliability but this will not be easy. It will require leadership that can achieve transformational change in the organization, its culture, and the involvement of healthcare workers in making decisions about work processes and the design of work environments.

The IOM committee organized its report into four major areas, providing a blueprint for healthcare organizations to become high reliability organizations. Hospitals and other health care organizations will require leadership that can transform the organization, its management, and how patient safety is valued. Specifically, healthcare organizations have to adopt a culture of safety, where patient safety becomes as important, or more important, than production efficiency. The workforce will need to have the capacity to support safe practices, including appropriate training, adequate staffing levels, and effective teamwork. Work processes will need to be redesigned to ensure safety (reliability). Redesign of the work environments should remove impediments to patient safety and support new work processes. The challenge for health care organizations is

great, but the cost of failure is greater. If the frequency of medical errors continues to increase, more human lives will be lost and more patients will suffer needless injuries from the medical care that is supposed to benefit them. Increasingly at risk is the essential trust of patients in their doctors, nurses and hospitals as places of healing that will do their best to return the patient to good health. The committee detailed the essential steps each healthcare organization must undertake to be able to provide a safe environment for patients.

Transformational Leadership and Evidence-based Management

Leadership that can transform an organization differs from the leadership of many organizations that effectively manages by making incremental changes over time to improve performance and respond to changing circumstances. Truly transformational leadership has to have the capacity to change the beliefs and attitudes of management and the workforce and fundamentally change work processes and redesign work environments. This type of leadership is less common yet essential. Transformational leaders are often described as “elevating” and “inspirational.” They have the capacity to communicate a new vision for an organization. In doing this, they involve managers and healthcare workers at all levels of the organization. The result is a set of shared organizational goals that are pursued jointly by managers and workers through a continuing two-way communication.

While the committee’s recommendations are based on scientific evidence, it may be less common to think of management practices being based on evidence. The concept of “evidence-based” management is relatively new. As with evidence-based medicine, it involves the application of scientific evidence in everyday practice. The committee identified the bodies of management evidence that should guide organizational changes to improve patient safety within healthcare organizations. These include the critical role of leadership in initiating and sustaining change and in creating a culture of trust. Skills are needed by managers at all levels to actively manage the change process and to involve workers in making decisions about work processes and work environment. The goal is to create a “learning organization” that continually creates and applies knowledge to change what it is doing and do it better.

Balancing Production Efficiency and Reliability

Health care organizations have to deal with financial pressures and the needs for greater efficiency. Leadership must balance these pressures against the resource requirements needed to improve reliability and patient safety. Specifically, high reliability organizations incorporate equipment and personnel redundancy to ensure safety if one component fails. Redundancy that is essential for patient safety may be seen inefficient. At the same time medical errors and the treatment of resulting adverse medical events can be very costly, as well as posing substantial risks to life and causing patient suffering. The value placed by the healthcare organizations on patient safety cannot be dependent solely on economic valuation and must recognize the core values of medicine and the mission of the healthcare organization. Leadership is pivotal in