COMITÉ PERMANENT DES MÉDECINS EUROPÉENS
STANDING COMMITTEE OF EUROPEAN DOCTORS

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At the CPME Board Meeting in Brussels on 16 September 2009, The Executive Committee adopted the following document: **"Response by CPME to the Commission proposal for a Council recommendation on Patient safety" (referring to CPME 2009/108).**

The CPME welcomes the proposal.

The proposal recognizes the urgency of the patient safety issue.

A number of scientific studies, from within the European Union, from the US, Canada and Australia documents that approximately 10 percent of patients in hospital suffer harm as a result of the treatment or care they are given. Annually this equals close to 4 million people in the EU.
Clearly this is a serious public health issue that must be addressed locally, by Member States and by the EU wherever appropriate.

The CPME agrees with the European Commission, that added value by action at the European level, will help patients by:

- Adding political weight and visibility
- Assisting Member States in sharing data and best practices
- Assisting Member States in sharing remedies
- Funding research

The CPME is acutely aware, that incidents causing harm to patients are common, often well known and systematic in their nature. These incidents occur, not in spite of the way hospital health care in Europe is delivered, but rather as a result thereof. Every system is perfectly designed to achieve exactly the results it achieves!

Medical culture bears its part of the blame. For many years it has supported the myth of the infallible doctor. Thus, if the patient came to harm, negligence was to be suspected and disciplinary action the answer. The truth is that all people, in all professions, make errors from time to time. In aviation, this is a recognized fact, and the industry has worked systematically with this knowledge in mind, to prevent *the result of inevitable human error, causing harm to passengers.* This has led to a high level of safety, in an industry with a high inherent level of risk. It is high time that health care learns, and takes the same course.

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The medical profession is aware of the task laid on its shoulders by the European Commission proposal. The activities Member States are recommended to undertake in order to promote patient safety, can only lead to a successful outcome, if carried out by health professionals, patients and authorities in close cooperation.

The CPME welcomes the recommendation that Member States establish reporting systems that are fair, open and non punitive. For too long, knowledge of what goes wrong in patient care, has been driven into the dark, by obsession with punishment and liability. Now it is time for change. The EU should seek improvement rather than scapegoats.

Medical error takes place in a context. Doctors cannot be trained never to make errors, but the way health care is organized, can help to prevent human error from harming patients, and well designed healthcare systems can help doctors to make fewer errors.

This does not mean that negligence by doctors should be ignored. The CPME requires the highest ethical standard of its members. But only a small part of harm to patients can be attributed to unethical behavior. If we really want to improve patient safety, our focus must be changed towards system thinking.

The European Commission's attention is drawn to the fact that its role in promoting patient safety is not over, once this recommendation has been adopted. The CPME expects the European Commission to take the initiatives pointed out in its Communication.

Consideration should be given to the future organization of EU patient safety work.

The European Center for Disease Control plays an important role in combating infectious diseases, including HACI's.

As a future perspective the CPME asks the European Commission to consider a European Center for Patient Safety.