COMITÉ PERMANENT DES MÉDECINS EUROPÉENS
STANDING COMMITTEE OF EUROPEAN DOCTORS

CPME/AD/Brd/210902/20/EN/fr

At its Board meeting, Brussels, September 21st, 2002, the CPME adopted the following policy : **Patient safety / Clinical risk management** (CPME 2002/087 Final EN/fr)

Patient Safety/Clinical Risk Management

A number of international investigations have now documented the need to reduce the number of adverse events in the health sector. This would lead to a significant reduction of unnecessary suffering and complications for the patients and would make it possible to realize savings in health care resources which could be channelled elsewhere in the system.

The aim is to eliminate, minimize, or block the consequences of such adverse events by introducing failsafe mechanisms in the complex systems of the health care sector. The health care sector must be designed in such a way that errors are caught and contained and that serious consequences of errors are avoided. Risk management cannot be based on individual responsibility.

The introduction of such barriers will require knowledge about epidemiology of adverse events which in turn means that these events must be brought out into the open with the help of reporting systems.

Furthermore it will be necessary to effect a change in the culture of the health care system, establishing an openness that will encourage the exchange of experience and learning. Such a cultural change can be brought about via a conscious effort by the leadership and a focus on patient safety throughout medical education and training.

Error is inevitable. Doctors also make mistakes. Regardless of how knowledgeable, conscientious, careful and industrious doctors are, they will make mistakes. This recognition and documented knowledge ought to form the basis for our efforts in the field of patient safety. Errors cannot be eliminated by threats or punishment, but the consequences of error can be minimized and blocked via a conscious and goal-directed effort.

The legal framework for medical activity is to a large extent based upon personal responsibility through the national laws governing authorization. Within these frames, however, responsibility is not assigned to ensure the exchange of experience and thereby the enhancement of learning from one's own and others' experiences.

For many years this kind of responsibility has become a essential part of the working routines of for example, airplane pilots, with legislation that requires the reporting of adverse events and near miss episodes, ensuring that it cannot afterwards be used in any legal action against the person in question.

The health care system is a high risk area, on a level with the atomic energy and airline industries. Yet the health care system lacks the security systems and security organisation and regulated risk analysis which are a well integrated part of both the atomic energy and airline industries.

The role of the CPME

The role of the Standing Committee of European Doctors in the area of patient safety and clinical risk management ought to be to function as a link between the national medical associations to make experience available on the European level.

Such experience can, for example, be used with regard to the integration of patient safety in those areas within the European Union in which attention to patient safety can make a significant difference – concerning medical equipment or the pharmaceutical area (labeling and packaging), for example as well as in the area of medical education with a view toward ensuring its quality and its inclusion of patient safety teaching.

Specific efforts by CPME

CPME should:

- work to broaden the understanding and recognition of the need to establish voluntary, confidential reporting systems;

- work towards the establishment of an internationally recognized terminology that can facilitate the carrying out of comparative analyses.

- work towards the introduction of standards for patient safety in the national accreditation systems which evaluate the overall quality of the health care system.

CPME recommendations to its members

CPME should recommend that its members:

- work toward a change of the culture of the health care system in order to achieve an open working environment wherein personnel can recognize and learn from the mistakes that are made;

- ensure that trainers educating junior doctors emphasize the importance and understanding of patient safety;
- placing patient safety on the political agenda;
- support a national study of patient records;
- arrange a conference of all stakeholders;
- ensure that patient safety becomes part of the curricula of undergraduate and postgraduate training and is included in doctors' continuing professional development
- conduct serious discussions with various patient organisations;
- establish a Patient Safety Society;
- facilitate a publication of scientific articles about patient safety in their respective national medical journals.

Bibliography

Australian Health Care Study. Wilson RM, Runciman WB, Gibberd RW, Harrison BT, Newby L, Hamilton JD. The quality in Australian health care study. Med J Aust 1995; 163:458-71.

The Danish pilot study. Forekomsten af utilsigtede hændelser på sygehuse. En retrospektiv gennemgang af journaler. Schiøler T, Lipczak H, Pedersen BL et al. Ugeskr Læger 2001;163:5370-78.

The Harvard study. Leape LL, Brennan TA, Laird N, Lawthers AG, Locatio AR, Bames BA et al. The nature of adverse events in hospitalized patients. Results of the Harvard Medical Practice Study. N Engl J Med 1991; 324:377-84.

The UK pilot study: Vincent C, Neale G, Woloshynowych M. Adverse events in British hospitals: Preliminary retrospective record review. BMJ 2001; 322: 517-519.
www.bmj.com/cgi/content/full/322/7285/517

The Utah/Colorado Study. Studdert DM, Thomas EJ, Burstin HR, Zbar Bl, Orav EJ, Brennan TA. Negligent care and malpractice claiming behaviour in Utah and Colorado. Med Care 2000; 38:250-60.