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EUROPÄISCHE VEREINIGUNG DER LEITENDEN KRANKENHAUSÄRZTE
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DEN EUROPÆISKE OVERLÆGEFORENING
ΕΥΡΩΠΑΪΚΟΣ ΣΥΛΛΟΓΟΣ ΝΟΣΟΚΟΜΕΙΑΚΩΝ ΙΑΤΡΩΝ ΔΙΕΥΘΥΝΤΩΝ
ASSOCIAZIONE EUROPEA DEI MEDICI OSPEDALIERI
DEN EUROPEISKE OVERLEGEFORENING
ASSOCIAÇAO EUROPEIA DOS MÉDICOS HOSPITALARES
ASOCIACIÓN EUROPEA DE MÉDICOS DE HOSPITALES
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AEMH ACTIVITY REPORT
CPME Meeting, Gothenburg 11-12 November 2004

1. **AEMH – Meetings**
2. **Symposium**
3. **Statement**
4. **External Meetings**
5. **Organisational Matters**

1. AEMH-meetings

Board : The AEMH Board met three times in 2004, in January in Brussels, in April in Madrid prior to the Plenary meeting and in October in Varese. The next Board meeting is scheduled 28 January 2005 in Brussels.

Plenary : The 57th Plenary meeting took place in April 2004 in Madrid. This was the start of the new calendar of meeting, placing the annual meeting in Spring. The important decisions were

- The AEMH will become a mono-lingual organisation as from 2009;
- Decision on a rapprochement with FEMS;
- Adoption of a statement on Quality Assurance and Quality Control;
- Adoption of a report from the working group on Risk Management;
- Election of new Board members : Dr Zilling/ Sweden as 2nd Vice-President, Dr De Deus/ Portugal as 3rd Vice-President.

2. Symposium on Clinical Risk Management

The Spanish Medical Chamber and the AEMH have organized a symposium on clinical risk management, which took place in April 2004 in Madrid. It was meant to raise awareness that a National and International Registration System on adverse events is needed. Standards for risk management and patient safety must be incorporated in the national accreditation systems. Attached to this report is the statement of the AEMH working group, which conclusions are :

- Identify the risks and manage them. Make mistakes visible.
- Find and analyse errors, mistakes, and accidents that altered the foreseen result of treatment without focusing on guilt. Open minds rather than blame.

- Make registration of mistakes made and "almost made" mandatory. This information should be made available to everyone on a national and international level.
- Change the attitude among doctors as well as the written law from punishment towards prevention.
- Organize and market knowledge about risk management.

Preparation of the Symposium 2005
In 2005 the AEMH Symposium will take place prior to the Plenary Meeting in Athens on the topic "Quality Assurance and Quality Control in the process of professional development".

3. Statement on Quality Assurance

The AEMH working group on CME/CPD resumed their two years' survey in a statement on Quality Assurance and Quality Control in the process of professional development of doctors. The continuity of the work is the implementation of the principles laid down in the statement, which is here attached.

4. External Meetings

Open Health Forum
The AEMH received for the first time an invitation to participate in the Open Health Forum organized by the European Commission's DG Health and Consumer Protection.

MCC Hospital World 2004
During the two-day congress MCC hospital world 2004 provided a comprehensive overview of national and international issues effecting hospitals. The AEMH-President was part of the speakers' panel.

The AEMH, represented by its Secretary General, attended numerous meetings in Brussels on invitation of the **European Commission, NGOs and think-tanks**

5. Organisational Matters

Nomination of a Secretary General
The AEMH Plenary assembly in 2003 decided to increase its participation in European policy affairs. The Secretary Brigitte Jencik laid the basis for contacts to the European institutions and other stakeholders of the health sector. This new dimension and permanent representation has been affirmed by her nomination as Secretary General.

-The World Market Research Centre

The WMRC offered AEMH a one page advertising in their edition ”European PharmacoTherapy” and editorial space of 3 pages, which we shared with EFPIA on the subject “Cross-border healthcare – Inequitable Access to Medicines in Europe”.

Statement on the organization of the European Medical Organisations

Following to some integration models, the AEMH has issued an own view of the future of collaboration, which is based on the model of the European institutions and advocates Co-ordination, Coherence, Complementarity, and Consolidation of offices. The AEMH is in favour of a common Domus Medica uniting all European Medical Organisations under one roof.

Joint Meeting with FEMS

Following the decision of the plenary assembly the AEMH and FEMS called a joint meeting on executive level, which took place 2 october 2004 in Varese.
The important decision of this meeting were

- Mutual exchange of information;
- Coordinate strategies;
- Common working groups;
- Joint Permanent Secretariat.

AEMH statement on Quality Assurance and Quality Control in the process of professional development

1. Quality assurance is a way for the individual doctor to demonstrate to the general public that the medical competence is up-dated in a proper way.

2. Quality Assurance should be an integrated part in the CPD process (CPD=Continuing Professional Development). CPD follows after formal qualifications have been obtained. The methodology for acquiring knowledge is based on the educational principles characteristic of adult learning, including self controlled learning, problem orientated learning, teamwork and on the job learning.

3. The process of Quality Assurance should be target orientated. All medical specialists should plan for CPD in dialogue with superiors and keep logbooks for planned and completed education.

4. Quality Assurance in the process of personal development can best be visualized through personal development plans which are drawn up, implemented and followed within the framework of the organisation.

5. CME-credit points is an insufficient instrument to measure Quality Assurance and Quality Control (CME=Continuing Medical Education). A high score in the meaning of many CME-points carries the risk of giving the false impression of high quality. The score usually indicates the extent of education in hours, and is therefore only a measure of time spent.

6. The definition Quality Assurance should be kept apart from Quality of current practice. The later focus more on how National Authorities organize medical care to guarantee a sufficient patient volume to create a learning environment and guarantee adequate experience within the organisation.

7. AEMH believes that if the medical profession focus on a well functioning CPD-process combined with Quality Assurance, Quality Control will not be necessary. Quality Control and its variety of obligation or recertification is expensive for the society and calls for heavy bureaucracy.

8. There is today no evidence that recertification or revalidation methods are helpful in the early detection of incompetent / underperforming doctors. That problem must be dealt with within the organisation.

Dr. Sanchez-Garcia
Spain

Dr. Moreira da Silva
Portugal

Dr. Zilling
Sweden

Report from the AEMH Working group on Patient Safety.

Patient safety was declared the main topic of WMA last year. The CPME gave all its organizations a task to focus on Patient safety. The goal was to produce a main political platform.
The CPME Recommendation on patient safety from 2003 has been approved by many organizations such as UEMO, UEMS and PWG. The AEMH working group on patient safety strongly agree to the statements and suggestions of the CPME recommendations and we want to recommend AEMH to endorse the paper at the plenary session tomorrow. We want however to focus on some points that we, out of a hospital doctors view, think closely relates to the Risk management / Patient Safety discussion.

Comments to the CPME strategy on patient safety:

We understand that a common European view on Patient-safety and Risk-management is necessary as the mobility increases among the European patients but also among the European health-personal. We must all be sure that we are working with the same rules towards the same goal and that our mistakes and complaints are accepted and dealt with in a similar manor wherever we get our treatment and wherever we go to work. We can't have big differences in the codes and routines. We will need comparable quality-measurements if we are going to trust each other as good doctors and good employers.

The change of attitudes and the establishment of a learning culture.
In the work of defining an European policy of quality is it most important to establish a change of attitudes towards the "non guilt approach".
Is then really an voluntary, confidential reporting system for adverse events as it spelled out in the CPME paper really the right way to go? Would it not be better if you as an individual doctor or nurse dared to make your report in your own name and be sure of getting positive credit for doing so? You should preferably, as you report a mistake, on the internet, get immediate access to the local and nationally collected experience of that kind of mistake with suggestions of routines that others have had good experience from. Then you could instantly learn as well as your mistake could come to the benefit by others. That would create an individual interest of reporting and also help spreading the aura of a learning culture. By a non- anonymous reporting system is it also, no doubt easier, to analyze the factors of the incident and come to the right risk management conclusion.

The experience and suggestions of the patients is also very important to collect and learn from. There is also a "big healing" effect in risk management routines showing respect for the feelings and wishes of the disappointed patient. Therefore the patients should also receive feedback on what happened with their complaint? Was someone listening? Did anyone bother?

National Quality Registration and International Quality Measurements
An important step towards a learning culture is focusing on quality-work and quality-control. Acknowledged, good, evidenced based indicators are essential to accomplish a trustworthy, systematic, registration of quality, to be used for quality improvement and accountability all over.

Adoption of guidelines
Some resistance still exists, from part of the hospitals doctors, towards guidelines. In a learning culture, it is important to consider and appreciate an evidence based selection of adequate alternatives of treatment based on valid research and the experience of many professional colleagues. All which can be contained in guidelines.

Continuing medical education and continuing professional Development CME/CPD
Prevention of errors and risk management is dependent on the knowledge and the skill of doctors. The CME/CPD responsibility rests primarily with the individual doctor but employers and other health care funding bodies also have a responsibility by creating economic and organisational conditions for high quality CME/CPD. This should be a process based on the educational principles characteristic of adult learning, including self controlled learning, problem based learning, teamwork and on the job learning. The process should include a quality control of current practice.

Satisfactory working conditions.
It is necessary, according to the European council to protect the health of the workers, not because they work in particular fields or carry out a particular activity, but for the fact that they are workers. Doctors are in several European countries excluded from the directive. Physical hard work can increase the risk of professional errors and the frequency of adverse events. The criteria of the European Council Directive 93/104/EC1 must therefore be valid for hospital doctors too.
Consideration must also be given to the sentence of the European court (SIMAP and Jaeger) that the period spent on call at the hospital is considered working time.

Disqualification and mobbing
Disqualification and mobbing reflects on the doctor who is the victim and thus increase the risks for his patients. The effects of mobbing are those of depression or psychosomatic disease and will interfere on the quality of the work, above all in terms of attention. Other symptoms are: insecurity and fear to take initiatives, withdrawal from internal information, arrest of the professional development and limitation to function especially in emergency situations.It is therefore indispensable that risk management routines includes efficient ways of preventing, identifying and dealing with the phenomenon of mobbing.

<u>Insurance coverage</u>

The demands for monetary compensation for damages due to medical mistakes will rise in the future. This will increase the insurance costs for the hospitals and/or for the doctors themselves. Therefore risk management and prevention of errors will be essential also from a economical view. Legal rules of responsibility will, for the same reasons, be increasingly important.

Conclusions

Identify the risks and manage them. Make mistakes visible.

Find and analyse errors, mistakes, and accidents that altered the foreseen result of treatment without focusing on guilt. Open minds rather than blame.

Make registration of mistakes made and "almost made" mandatory. This information should be made available to everyone on a national and international level.

Change the attitude among doctors as well as the written law from punishment towards prevention.

Organize and market knowledge about risk management.

For AEMH to discuss:

After AEMH have endorsed the CPME Paper the next important question is how AEMH should participate in the adoption of the document. Should we concentrate on providing support for the process initiated by CPME or should we also act on this topic in a more active way?

The CPME paper contains a number of recommendations for the further work on patient safety both for the CPME and for the national medical associations. The document presents a need for establishment of contact and cooperation at the European level between the health professionals´ European organizations. There is also stated a need of description and recommendation of risk management routines as part of the quality assessment systems in the health sectors.

The suggestion from our working group is to send out a questionnaire charting to what extent governments, health care organizations and other suppliers of health care services in specialized/hospital medicine have taken action in the matter of patient safety. To our knowledge, such information has not been provided by the CPME members.

Dr Eikvar Norway
Dr Reginato Italy
Dr Wedin Sweden