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EUROPÄISCHE VEREINIGUNG DER LEITENDEN KRANKENHAUSÄRZTE  
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ASSOCIAZIONE EUROPEA DEI MEDICI OSPEDALIERI  
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ΕΒΡΟΠΕΪΣΚΑ ΑΣΟΪΑΪΑΪΑ ΝΑ ΣΤΑΡΣΗΤΕ ΒΟΛΝΗΪΝΗ ΛΕΚΑΡΗ  
ASOCIATIA EUROPEANA A MEDICILOR DIN SPITALE**

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**AEMH - Motion to support Portuguese Doctors and their request for reporting adopted unanimously at the 67th AEMH Plenary Meeting 30-31 May 2014**

The AEMH - European Association of Senior Hospital Physicians has been alerted on the recent proposal of the Ministry of Health in Portugal not allowing health professionals, particularly physicians, to expose deficiencies or malfunctions in their workplaces.

For AEMH patients safety is a major concern and that includes a thorough job of risk management.

Deficient equipment, untrustworthy alarms, inadequate construction, impracticable procedures are latent conditions that results on “diseases” of the system. Research has shown that system improvements can reduce the error rates and improve the quality of health care.

Excessive working time, poor or no rest after a long period of work, understaffing teams, overwork, inadequate or outdated equipment, similar names, packages and storage of drugs, creates an accident opportunity.

To change this framework is crucial to establish a reporting culture with detailed analysis of events and make the necessary changes to reduce potential accidents.

Health accidents are the eighth cause of death in the United States and we know that 58% of them can be prevented.

So, reports should be made of adverse reactions, near misses, no harm incidents and open to all different levels of assistance.

Efforts to improve quality in health care system must be carried out to improve patients’ safety: use of information technology to reduce errors, use of a check control system to analyze medical equipments and maintain them up-dated, create a reporting culture in a non punishing environment where practitioners feel psychologically safe about discussing adverse events.

Subsequently identify changes that need to be made and implement them.

Identifying patient safety incidents and ensuring they are reported and analyzed is at the heart of reducing risk in healthcare. National organizations should use the data and review the tools, guidance and support available to them. This will ensure patient safety incidents continue to be reported and learned from, strengthening the patient safety culture across all levels of the National Health Service.

If the detected problems are not quickly solved within the framework of the institution then they must be reported outside.

Because the key to patient safety is to reduce or eliminate harm to patients we appeal and we trust that the Ministry of Health in Portugal will open wide consultation with the professional medical organizations in order to achieve together goals to ensure safety healthcare and allowing physicians to report all system malfunctions.