Medical Success Leads to Medical Error: How Health Professionals Accept Responsibility for Safety

Plenary Session, Thursday 19 March, 2009

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„Times, they are a‘ changing…“

• Medicine is a story of success!
  
  e. g.  HIV,

  Diabetes,

  Anaesthesia,

  pediatric oncology,

  Minimally invasive surgery

  …
„Times, they are a´ changing…“

Open to „High-Risk-Group-Patients“:

multimorbid and demanding

older patients

Multimorbidity

very low birth weight infants

very demanding patients
Capability of Medicine

Cor pulmonale NYHA III
„Times, they are a‘ changing…“

• General Conditions:

  lack of money
  lack of ressources
  lack of leadership
  lack of political support
  pressure on Health Care Systems!!
No change:

- **Principles of organisation!**
  
  „assembly-line“
  
  no common responsibility
  
  competing interests
  
  „buck-stop-principle“
  
  no real leadership
  
  „just try harder“

„Why are doctors so unhappy?“ Richard Smith, BMJ May 5th 2001
Patient Care has become a challenging and risky issue:

= = ⇒ “Quality and SAFETY”
„Patient safety is about avoiding damage and harm caused involuntarily by healthcare – it is about how to become wise not only after, but possibly before the potential harm is done.”

(Mierzewski/ Pennanen 2007:1)
What is needed: Transparency and Trust

• No more taboos - speak out!

• No dramatizing or scandalizing

• No more abuse of Patient Safety

• promote joint action

• multidisciplinary approach
What did we do?

We did not start with frightening statistics.

We started with the everyday experience of everyone who is engaged in Patient Care.

Ask anyone about his experiences and he/she will tell you enough stories to start to take action.

Any action according to Patient Safety has to keep all human beings in mind, patients and professionals!
Key messages:

There is a problem!

There are solutions!

It’s our common agenda!
Options of action

- Better **knowledge** about errors in medicine

  **System failure, problems with communication rather than failure of individuals**
  ➔ Asking **“Why”** instead of **“Who”** is to blame

- **Tools and Instruments** concerning prevention of errors
  - Critical Incident Reporting Systems,
  - Root cause analyses
  - A wide spread of learning activities (CPD, Simulation Training, **“non-technical”** skills)
  - Management know how, tools und techniques (Quality Management, Risk Management, importance of role models and leadership in medical work etc)
What did we do?

1995 first attempt to implement Risk Management and Root-Cause-Analysis into the arbitration boards of the German Federal Chambers of Physicians

„Why“ not „who is to blame and to pay“. 
What did we do?


2002 „Berliner Gesundheitspreis“ for Innovations in Health Care (BCP and AOK, Statutory Health Insurance Company)

Public agenda
What did we do?

2004 Scientific Congress on Patient Safety
(Society for Quality Management in Health Care GQMG) **Scientific agenda**

2004 Workshop of AOK and BCP

Network is needed!
2005:
„Year of Patient Safety in Germany"

Foundation of GCPS

Congress of the German Society of Surgeons

108. German Medical Assembly
(Parliament of Doctors in Germany)
2005- Resolution of the The German Medical Assembly

„medical ethics and social responsibility of doctors in Germany are the foundation to take action on Patient Safety“
2005- Resolution of the German Medical Assembly

- There are challenges and solutions in Patient Safety
- Action for patient safety is based on trust.
- A holistic approach which focuses on the improvement of the organization of health care
- Apart from the system approach, the individual responsibility of the health care professionals is untouched.
- Prevent scandalization.
- Support the building of a network organization.
Aims

Action for Patient Safety leads to

- Better confidence in health care
- Higher quality
- Less harm, pain and grief
- Lower costs

„win-win-win-situation“
AIMS- II

• Better cooperation based on common sense and trust

• Evidence based health care

• Understanding of a better organization

• End of „passing the buck“

• More job satisfaction
Promote acceptance

Patient Safety is as old as medicine itself

⇒ „Don’t panic!“

It is not just a problem, it is a chance and invitation to take action

⇒ „Good news!“

80% of all harms are due to bad organization

⇒ „Be honest but don’t feel guilty!“

Various institutions and people are there to help you acting on Patient Safety

⇒ „You are not alone!“
Unanimous vote for Patient Safety Resolution

„...getting to the hearts of the doctors...“

Colin Feek, MinHealth NZ, 2006

Internat. Forum on Quality and Safety in Health Care, Plenary Session, Thursday 19 March, 2009
Start of GCPS (2004-5)

→ Building a network organisation

Five meetings in preparation for the German Coalition for Patient Safety, invited by Prof. Matthias Schrappe, hosted by the Chamber of Physicians of North Rhine

Including - from the beginning - all relevant players of the German health care system:
Patients, health care professionals, ministry, health insurances, hospitals…
The German Coalition for Patient Safety

GCPS

AKTIONSBÜNDNIS
PATIENTENSICHERHEIT

http://www.german-coalition-for-patient-safety.org/

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GCPS

• Common Sense,
• Common Aims,
• Common Responsibility
• Top Down – Bottom Up
• Network Organization
• Open Workshops and Working Groups

„Umbrella“
„Leadership“
GCPS- Characteristics

• Based on voluntary, honorary engagement and enthusiasm of members, activists and their organizations

• The persons and parties involved are of full integrity, recognized and competent

• Credibility based on independence

• Bundling of Know how

• Multidisciplinary networking

• Based on experience and science

➢ Providing: trust, knowledge, tools, cooperations
Actual number of members: 240

Individuals and Institutions:
Health Professional Organizations, Health Care Institutions (e.g. hospitals), Patients Organizations, Health Insurance Companies, Scientific Organizations,…

→ Working Groups are open for everyone, not only for members!

Participation!!!
Political and financial support from the Ministry

„Patient Safety sometimes gets abused. Mrs Minister, you have never done that!“

Prof. Hoppe, President German Medical Association, 111. Deutscher Ärztetag 2008
Financing and support

Year 2005-2008:

- Funding by the German Ministry of Health
- Membership fees (~ 100T € per year)

Up to 2009:

- Fundraising
- In part funding by the Ministry of Health
- **Donations** and Membership fees (~ 500T € per year)
GCPS- Fields of Action


• From 2009: The first Institut for Patient Safety in Germany, University of Bonn
GCPS- Fields of Action

Research fields:

- Patient Safety Culture
- Patient Safety Indicators
- Implementation and Evaluation
- Epidemiology/ Assessment
GCPS- Fields of Action
Working Groups and Recommendations

• Wrong Site Surgery
• Patient Identification
• Medication Safety
• Patients Involvement
• Implementation of Critical Incident Reporting Systems (CIRS)
• Basic Data Set for Medical Error Reporting Systems (MERS)
• Training Center, focussing on „non-technical skills“
• Forgotten objects
• Training courses
• etc....
Recommendations – one example:
Wrong site surgery

Cooperation with the

• German Society of Surgeons and
• German Hospital Association (~2300 Hospitals)
GCPS- Fields of Action/Cooperations and Projects
„Clean your Hands“- the German Version

„Aktion Saubere Hände“
www.aktion-saubere-haende.de

Cooperation with the

• Society for Quality Management in Healthcare/ Germany (GOMG)

• the National Reference Centre for HAI

By now: 492 hospitals take part
Cooperation

- Ministry of Health
- Drug Commission of the German Medical Association

Implementation of 49 specific actions
Engagement of GCPS – international Level

**High 5s: CMWF**

Joint Commission on Accreditation of Healthcare Organizations (JCAHCO) und Joint Commission International (JCI) (WHO Collaborating Centre on Patient Safety)

*Operating Agency in Germany:*

www.aqumed.de

**EUNeTPaS**

*Operating Agency in Germany:*

⇒ Berlin Chamber of Physicians

www.eunetpas.eu
Continuing Education Concept

Patient Safety

1. Foreword ................................................................. 3
2. The Continuing Education Concept “Patient Safety” .............................................. 4
  2.1 Goals of the CME “Patient Safety” ........................................................................ 5
    2.1.1 Substantive Goals of the CME “Patient Safety” ........................................... 5
    2.1.2 Methodological Goals of the Concept ............................................................ 5
  2.2 Target Groups of the CME “Patient Safety” ............................................................. 5
  2.3 Instructions/Recommendations for the Design of the CME Program ......................... 6
    2.3.1 Participants ....................................................................................................... 6
    2.3.2 Didactics .......................................................................................................... 6
  2.4 Stepwise Structure of the CME “Patient Safety” ...................................................... 6
  3. Areas of Instruction/Modules of the CME “Patient Safety” ........................................ 8
    A Fundamentals ......................................................................................................... 8
    B Error Research/The Psychology of Safety .............................................................. 9
    C Communication/Teamwork .................................................................................. 10
    D Instruments/Realization into Practice/Disseminating Information ............................ 12
  4. Modular Content and Model Syllabus ....................................................................... 14
    4.1 Modules for the Third Level (Additional Qualification) ....................................... 14
    4.2. Communication and Teamwork ......................................................................... 15
      4.2.1 Goals: ............................................................................................................. 15
      4.2.2 Methods ........................................................................................................ 15
      4.2.3 Content ........................................................................................................ 15
    4.3. Human Factors .................................................................................................. 17
      4.3.1 Goals ............................................................................................................. 17
      4.3.2 Methods ........................................................................................................ 17
      4.3.3 Content ........................................................................................................ 17

Appendix: Glossary Patient Safety .................................................................................. 19
Literature ....................................................................................................................... 21
References ..................................................................................................................... 22
Many activities besides GCPS

About 1000 Patient Safety projects in 400 hospitals organized by risk insurance companies.

Two nationwide open CI RS projects
www.cirsmedical.de
www.jeder-fehler-zaehlt.de

Self made CI RS in about one third of all German hospitals.

First four scientific medical societies have initiated their own CI RS.
Psychology of the Health Care System!

„they are socialized to strive for error-free practice. There is a powerful emphasis on perfection. Physicians are expected to function without error, an expectation that physicians translate into the need to be infallible“

Prof. Lucian Leape, JAMA, Dec 21 1994, 272 No 23
"I do not tend to be insecure, but after 4 hrs of listening to a representative of the ’Emergency Group of Harmed Patients’ I felt quite uneasy."

Prof. Dr. Siebert
General Secretary of the German Society of Traumasurgeons
Head of WG ’Forgotten objects’
March 11th 2009
Safety culture: Going Public

Booklet 2008
„Learning from errors“
My mistake!

Cooperation with AOK, Health Insurance Company

Personal Reports from 17 doctors, nurses, therapists

• Analyses of causes of errors
• Personal lessons to learn
• Add on: Information about reporting and learning systems

[Quelle: www.aps-ev.de]
"In a safety culture, the telling of stories is viewed as having greater importance than mere data collection, because it is in the story where the knowledge and the emotion lies, not in the numbers."

University of Michigan Hospitals and Health Centers 2002

[Quelle: www.aps-ev.de]
“These are the most courageous doctors in Germany”.

BILD 28. 2. 2008

Safety Culture on Top Level
Success factors for Networking in Germany

- Bad issue but „good news“!!
- Taking action is possible
- Participation, honesty, appreciation, support, friendliness, cooperation, confidence
- Free access and share ware of know how and products/ materials (recommendations, scientific results, reports, informations…)

Leadership (not duties and bureaucracy)
„Re-discovery of primary - not only doctor’s - virtues on systematic ground“

GJ
Joint Action is Needed!

NEJM 354; 21 May 25th 2006

„...we have also talked with families who have experienced errors in their care, and it has become clear to us that if we are to find a fair and equitable solution to this complex problem, all parties - physicians, hospitals, insurers, and patients - must work together“.

Hillary Rodham Clinton and Barack Obama

„Making Patient Safety the Centerpiece of Medical Liability Reform“