

AEMH VIEW ON TODAY'S' POLICY IN EUROPEAN HOSPITALS

I - Europe today

General:

- Different countries
- Different healthcare systems
- Different hospital models
- Different problems

- **Financial problems**
- **Crisis**

Specific:

- Privatization of hospitals
- High technology
- Expensive treatments
- Hospitals always a good target for cost saving measures

But the focus should always be

II - Patients safety and quality care

How to reach this ?

1. Risk management

The key to patient safety is to reduce or eliminate harm to patients. There is a longstanding tradition to focus on individuals the responsibility for the unsafe acts, whose targets are: doctors, nurses, pharmacists. This “naming and blaming” culture tends to view people as agents capable of choosing between safe or unsafe procedures.

Uncouple a person's act from institutional responsibility at short term is financially and legally more convenient but it leads to the repetition of errors and the problem remains unsolved.

Efforts that try to eliminate only the personal mistakes will fail.

“Health accidents” are, most of the times, a result of a chain of events involving both individual and system failures.

Violation procedures, mistakes, unprofessional conduct, lapses are different forms of personal misbehavior that all should try to reduce.

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

An adverse event usually occurs when individual and system failures combine at the same time and place.

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

In this context the involvement of managers, physicians, nurses and other stakeholders is essential to guarantee quality and patients safety:

- Accident prevention has not been a primary focus of hospital medicine. Hospital systems are not designed to prevent errors: they just react and are not proactive.
- Hospital leaders must avoid the reflexive response of viewing the problem as exclusively clinical and become open to the need for more fundamental organizational changes.
- **Changes in multiple organizational components**
 - Use of information technology to reduce errors.
 - Use of a check control system to analyze medical equipment's and maintain them up-dated.
 - Create a reporting culture in a non-punishing environment where practitioners feel psychologically safe about discussing adverse events.
- **Developing quality measures**
 - Promote quality control evaluation of health departments.
 - Involve local groups in measuring, monitoring and improving quality.
- **Reducing high-hazard risks**
 - Create a reporting system notifying adverse events, no harm incidents, near misses, open to all levels of assistance, typically non-punitive, confidential and anonymous.
 - Subsequently identify changes that need to be made and implement them.

2- Pre and postgraduate medical training

Pre-graduate training

Bologna process

Harmonization

6 years or 5500 hours

Postgraduate training

Difficult to harmonize

Programs

Training periods

36 medical specialities that are official in at least two member states.

Other 14 were recognized in all Member States.

3- CPD (Continuous Professional Development)

CPD can be defined as the educational means by which doctors ensure that they maintain and improve their medical competence and clinical performance.

- It is an ethical and professional responsibility of every practicing doctor to ensure that the medical care they provide for patients is safe and based on valid scientific evidence. In order to achieve this, every doctor must engage actively in CPD appropriate to his or her medical practice.
- Doctors are very familiar with learning, but learn in individual ways; recognition must be given to this. Doctors should be supported in being able to use the learning methods that they prefer, based on an assessment of their learning needs, and educational opportunities must be sufficiently varied to provide for this.
- Continuous professional development (CPD) is a huge concern for medical profession, an ethical obligation and fundamental to maintain up-dated doctors and high-level performances. CME (Continuing medical education) credit points is an insufficient instrument to measure quality, is only an indicator of time spent. Also recertification or revalidation showed no value in detection of incompetent / underperforming doctors (AEMH declaration of Athens).
- **Health professionals education and training**

- Improve quality of training and working conditions of junior doctors
- Encourage European hospital doctors to plan for CPD actions implemented in the framework of the organization.
- National Medical Associations should claim for medical careers with a peer evaluation based on technical performances and Continuous Professional Development.
- Training of hospital staff should be a priority in quality management. Exquisite qualification programs for junior doctors, a well-educated nurse workforce will bring less risk in hospital performances.

4- Working conditions of hospital doctors and other hospital staff

- Labour conditions of hospital doctors play a crucial role in patients' safety. 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.
- Poorly paid work, non-specialized doctors doing specialized tasks, cheap manpower in health services, quantity instead of quality indicators only leads to an increasing risk for patients' safety.
- **Improvement of working conditions of hospital doctors**
 - Provide health care workers with optimized working conditions.
 - Limited working hours with obligatory rest time period.
 - Stimulate teamwork training throughout each health care provider's career.

5- Task shifting / shortage of doctors

In health care, the term "Task Shifting" is used to describe a situation where a task normally performed by a certain type of health professional is transferred to a health professional with a different or lower level of education and training, or to a person specifically trained to perform a limited task only, without having a formal health education. Task shifting occurs both in countries facing shortages of physicians and those not facing shortages. It carries with it significant risks.

It should never be a cost saving strategy.

Task shifting in poor countries may be used to justify a policy shift in rich countries.

Shortage of doctors and more expensive manpower should never justify task shifting.

It should not and must not be associated with second-rate services.

“The RCP is concerned by the mounting evidence of poor care delivered to patients in hospital out of hours and at weekends”

There is a consistent pattern of increased mortality rates in patients admitted to hospital outside normal working hours

2 important reasons:

Reduced senior and junior medical staffing

Reduced nurse and technical staffing

More Medical/ Nursing staff is the key to patient safety because services need to be 7/7 for maximum efficiency.

6- Hospitals evolving into centers of excellence

Centers of Excellence and Centers of Reference are institutions, which have demonstrated the highest degree or level of standards along the areas of health care, research, education and training. They provide institutional leadership in all aspects of development in specific disciplines to ensure the development in their respective service areas.

To achieve this purpose it's crucial for hospitals to accomplish some criteria in order to reach those goals:

• **The citizen on the health system** – centers of excellence must be a service to the community.

1- Satisfaction, participation and rights

2- Accessibility and continuity of care

3- Improvement of doctor-patient relationships on a trusty basis

• **Organization of the activity** – to promote, plan and co-operate with other Centers of Excellence and other institutions.

• **Professionals** - effective, sustained, high quality professional development.

• **Structure** - to serve as "state-of-the-art" centers in a specific area related to the improvement of health care.

• **Results** - The process by which it is noted and recognized that the way we pay attention to citizens in health, responds to a model of quality, always with the aim to promote and encourage the continued improvement of our institutions.

In conclusion promotion of continuous quality improvement, high-qualified staff and international partnerships should create a Centers of Excellence network within the European health structure with integrated care.

7- Patients' rights in cross-border health care

How can we contribute to achieve these goals –

III - Hospital management based on quality and safety

Doctors' involvement in hospital management

- Decisions involving individual clinical judgment, decisions involving larger organization-wide resource allocation and patients' safety are highly interrelated. The nature of physicians' involvement in management must be understood within this context.
- **Larger involvement of doctors in hospital management**
 - Support doctor's involvement in hospital management and strategic decisions.
 - Implement doctors' post-graduate education in management of health care units.