ÄRZTEKAMMER BERLIN


[Foto: Stefanie Seuffert]

Patient Safety? The German Story

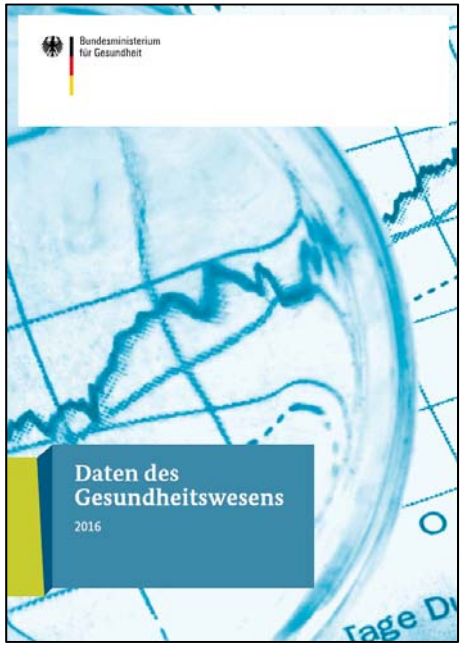
Clinical Audit Masterclass Meeting,
St. Vincents Healthcare Group,
5 October 2017, Dublin

Dr. med. Günther Jonitz, President of the Berlin Chamber of Physicians

Germany – some data

- **Population** ca **81 Mio**
- Number of **doctors**
  (without dentists) ca **365.000**
- Inhabitants/doctor ca **216**
- Hospitals ca **1.980**
- **Hospital beds**: ca **500.680**
- **Expenditures**/ health care ca. **300.000 Mio €**
- **Federal Budget Germany** ca. **329.000 Mio €**

(Quelle: www.nationalflaggen.de)

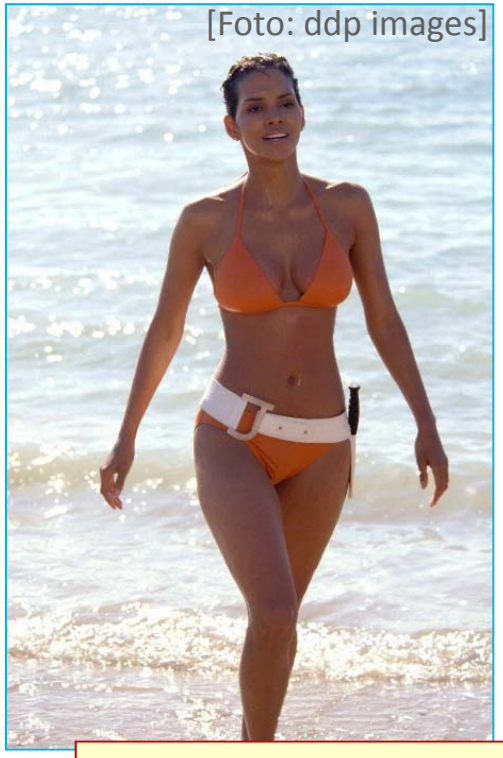


[https://www.bundesgesundheitsministerium.de/fileadmin/Dateien/5_Publikationen/Gesundheit/Broschueren/161019_BMG_DdGW.pdf]

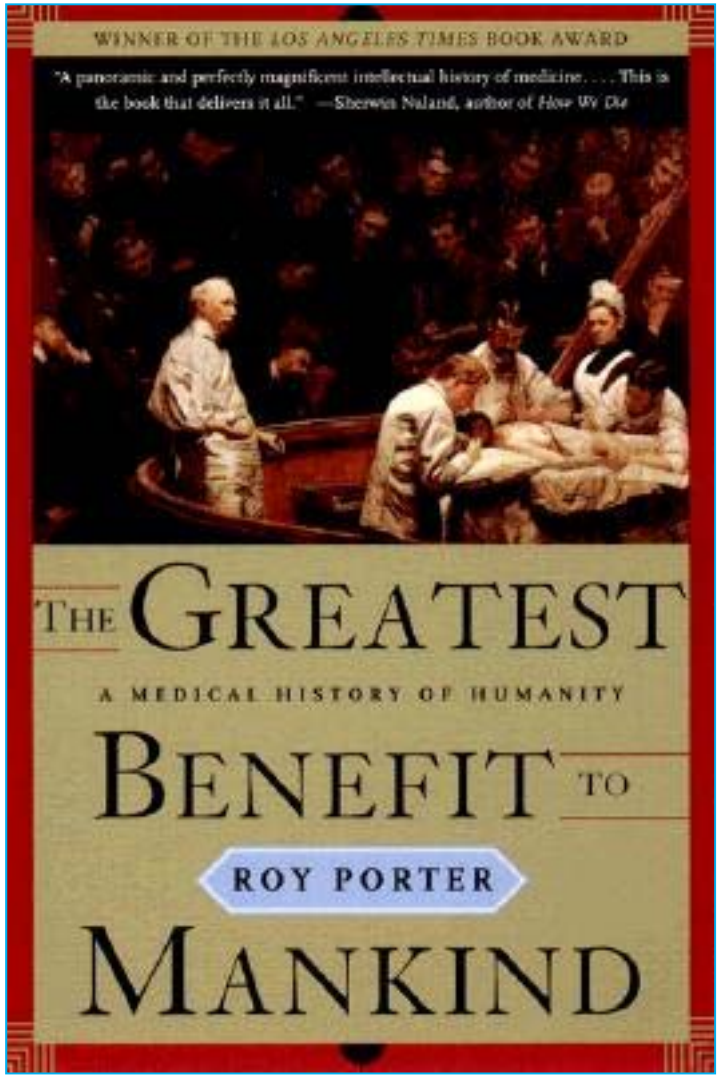
Medicine is a story of success!

e. g.

- ✓ HIV
- ✓ Diabetes
- ✓ Anaesthesia
- ✓ Pediatric oncology,
- ✓ Minimally invasive surgery
- ✓ Accident and emergency medicine
- ✓ Obstetrics
- ✓ „High Risk“ Groups (elderly, multimorbidity, infants…) …



Diabetes mellitus Typ I


WINNER OF THE LOS ANGELES TIMES BOOK AWARD
"A panoramic and perfectly magnificent intellectual history of medicine. . . . This is the book that delivers it all." —Sherwin Nuland, author of How We Die
THE GREATEST
A MEDICAL HISTORY OF HUMANITY
BENEFIT TO
ROY PORTER
MANKIND

„Times, they are a‘ changing…“, Bob Dylan 1964

- **Medicine** Successful and complex
- **Patients** Multimorbid and demanding
- **Economics** Decreased funding and trust, bad working conditions
- **Lack of Staff** *„Why are doctors so unhappy?“*

(BMJ May 2001)

Need for action!

Patients!?!?

„An estimated 8 – 12% of patients admitted

to hospital in the EU

suffer from adverse events

whilst receiving healthcare.“

(Source: EU-Recommendation Patient Safety 2009)

„Times, they are a‘ changing…“, Bob Dylan 1964,

but…**not here!**

Traditional Culture in Health Care Systems:

- „Assembly-line“
- No common responsibility
- Competing interests
- No real leadership
- „Just try harder“
- „Blame and shame“

Obstacle: Expectations

„... 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

Double need for action!

Many possibilities for action!

Change of culture:

Promote action and acceptance I

„Salus aegroti suprema lex“

= Quality

„Primum nil nocere“

= Patient Safety

Patient Safety is as old as medicine itself!

Change of culture:

Promote action and acceptance II

It is not just a problem, it is a chance

and invitation to take action for patient safety

➔ „bad issue, but glad news!“

80% of all harms are due to bad organization

➔ „Be honest but don‘t feel guilty!“

Various institutions, stake holders and people are there

to support you on promoting the patient safety issue

➔ „You are not alone!“

Options for Action I

Knowledge about dealing with incidents

„WHY“ not „WHO“

Patient Safety

can be learned !

Options for Action II

New **procedures and tools** for prevention of incidents

- ✓ **Critical Incident Reporting and Learning Systems**
- ✓ **Root cause analyses**
- ✓ **Professional Training, CPD, Simulation Training, „nontechnical“ skills**
- ✓ **Certification, Procedures, Management know how,**

  (Quality Mangement, Risk Management,
  *importance of role models and **leadership** in medical work …)*

„Don‘t stand there- do something“!

Goals

- ✓ **Better confidence in health care**
- ✓ **Higher quality**
- ✓ **Less harm, pain and grief** *(patients, families and „second victims“)*
- ✓ **Lower costs**
- ✓ **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**

„win-win-win-situation“

What did we do?

Since 1975

Chambers of Physicians: Arbitration boards/ „Gutachterkommissionen/ Schlichtungsstellen“

2002

„Berliner Gesundheitspreis“ Award for Innovations in Health Care

(Berlin Chamber of Physicians/ BCP and AOK, Statutory Health Insurance Company)

→ **Public agenda**

2004

Scientific Congress on Patient Safety

(Society for Quality Management in Health Care GQMG)

→ **Scientific agenda**

2004

Workshop of AOK (insurance) and BCP

→ **Stepwise forward procedure, including people and organisations**

2005 → political agenda ⟶ **Network !!**

Berlin Award for Health Care 2002

2005 – „Year of Patient Safety in Germany“

Amendment of the German Medical Assembly

108. German Medical Assembly
(Parliament of Doctors in Germany)

Unanimous vote for

Patient Safety Resolution

2005: Amendment of the German Medical Assembly

- ✓ 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!! - No blame and shame!
- ✓ Support the building of a network organization!

~~„To err is human,~~
~~to cover up is unforgivable,~~
~~but to fail to learn is~~
~~inexcusable!“~~

To my opinion (GJ):

This promotes „blame culture“!

The German Coalition for Patient Safety (GCPS)

Umbrella Organisation

AKTIONSBÜNDNIS
PATIENTENSICHERHEIT

http://www.aktionsbuendnis-patientensicherheit.de/

➔ **Building a network organisation**

➔ **Including - from the beginning – <u>all relevant players</u> of the German health care system**

GCPS-Characteristics

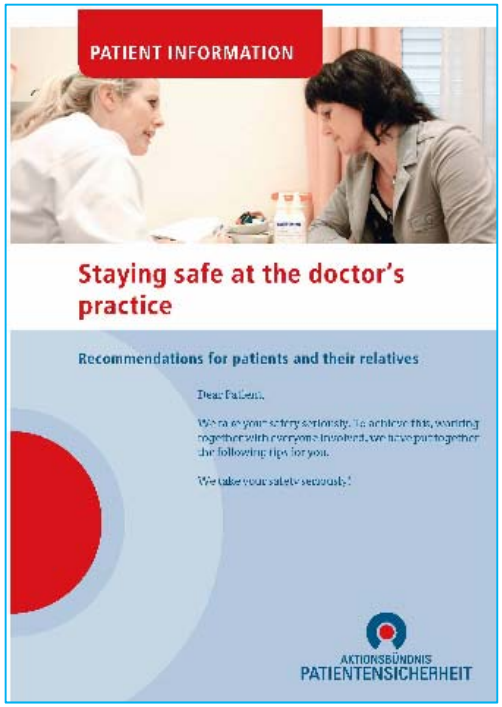
- ✓ Based on voluntary, honorary engagement and enthusiasm of members, activists and their organizations
- ✓ The persons and parties involved are of full integrity, recognized and competent
- ✓ Credibility based on indepence
- ✓ Bundling of Know how
- ✓ Multidisciplinary networking
- ✓ Based on experience „from practice for better practice“
- ✓ Providing: trust, knowledge, tools, cooperations
- ✓ Common responsibility!! No „King of Patient Safety“

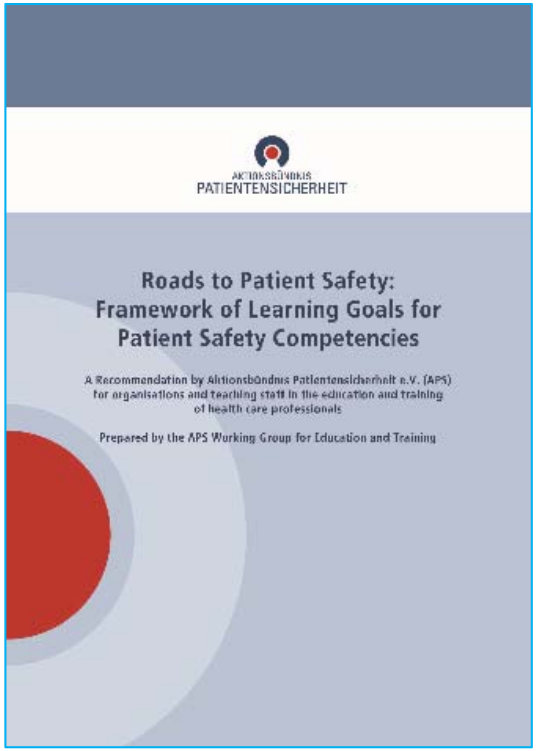
GCPS-Recommandations

- **WG Registry for Medical Errors**
- **WG Critical Incident Reporting Systems** (work completed)
- **WG Wrong Site Surgery** (work completed)
- **WG Patient Identification**
- **WG Forgotten Foreign Bodies after Surgery**
- **WG Patients for Patient Safety** (information-advice-decision)
- **WG Medical Devices**
- **WG Drug Safety**
- **WG Education and Training**
- **WG Communication after Adverse Event** ("Reden ist Gold")
- **WG Patient Safety and Senior Citizens**
- *…etc*

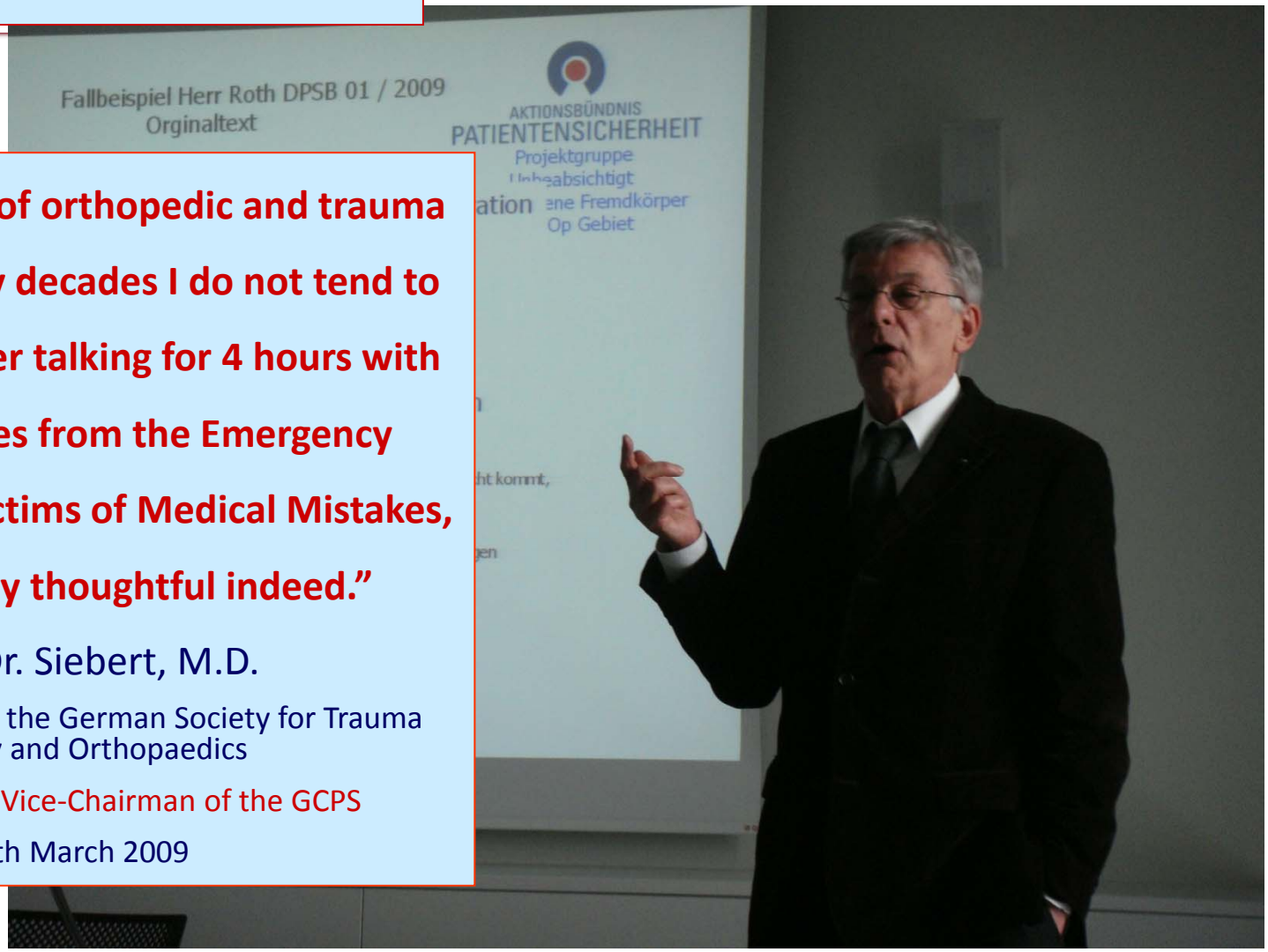
You can take action !

http://www.aps-ev.de/recommendations-in-english/





Great encounters!!



"As a consultant of orthopedic and trauma surgery for many decades I do not tend to hesitate, but after talking for 4 hours with representatives from the Emergency Association of Victims of Medical Mistakes, I became very thoughtful indeed."

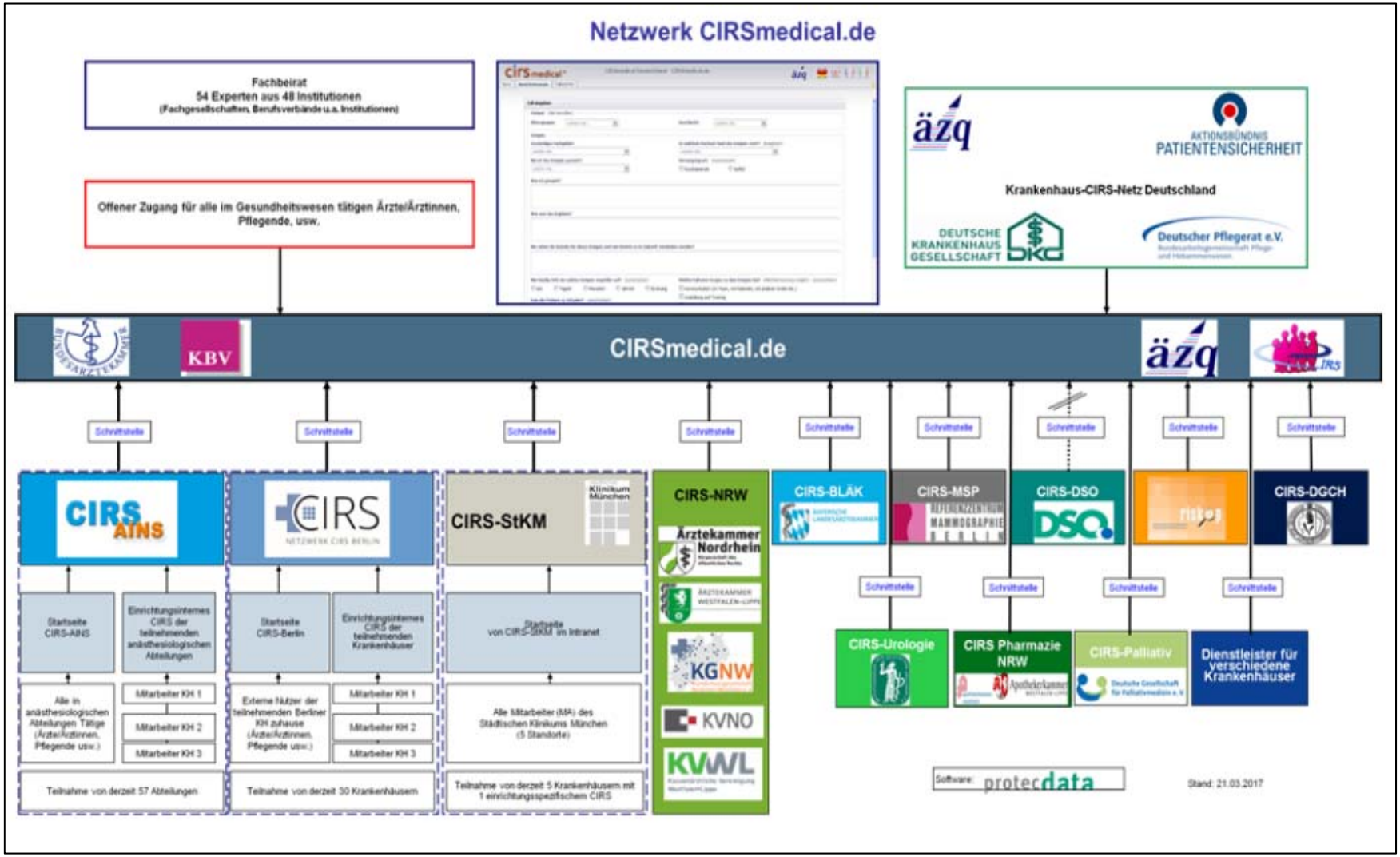
Prof. Dr. Siebert, M.D.

General Secretary of the German Society for Trauma Surgery and Orthopaedics

Now re-elected Vice-Chairman of the GCPS

11th March 2009

Nationwide CIRS



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[Quelle: http://patientensicherheit-online.de/cirs/netzwerk-cirsmedical.de, abgerufen am 4.8.2017]

Safety Culture: Going Public

GCPS-Booklet 2008

„Learning from errors“

My mistake!

- ✓Cooperation with AOK
- ✓Personal Reports from 17 doctors, nurses, therapists
- ✓Analyses of causes of errors
- ✓Personal lessons to learn
- ✓Add on: Infomation about reporting and learning systems

„These are the most courageous doctors in Germany“.

BILD 28. 2. 2008

Safety Culture on Top Level

Success factors of the German strategy

- ✓ **Leadership by professionals and leading institutions!**
- ✓ **Bad issue but „good news“!!** (Positive framing)
- ✓ **Taking action!** (No more suffering as a victim – help yourself AND your patients)
- ✓ **Participation, honesty, appreciation, support, friendliness, cooperation, confidence, common responsibility!**
- ✓ **Free access and share ware** of know how and products/ materials (recommendations, scientific results, reports, informations…)
- ✓ **Involvement of leading stakeholders up to the minister!** (Top-down-revolution)

win-win-win-situation

1. Patient Safety Global Summit 9.-10.11.2016 in London

German MinoH Hermann Gröhe, Don Berwick, Victor Dzau, Prof. Lord Darzi u. a.

At the „Ministerial Patient Safety Global Action Summit“ for the first time ministers and experts and stakeholders (including victims) came together to talk about actions.

The German way - cooperation, solutions, friendliness – is acknowledged.

2nd Min PSGAS March 2017 in Bonn

http://www.who.int/patientsafety/policies/ministerial-summits/en/

3rd MinPSGAS April 2018 in Tokyo

Don Berwick:

„We have good people in bad systems.

And good people in bad systems will fail.“

„You can choose between ‚fear‘ or ‚safety‘.“

First Ministerial Summit on Patient Safety

London, March 2016

Emotions !!!

“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

It‘s all about culture!!

Culture eats strategy for breakfast

Measurement normally is seen as a threat

Patient safety – be positive!

„Learning from Excellence“

Birmingham Children‘s Hospital

“Safety in healthcare has traditionally focused on avoiding harm by learning from error. This approach may miss opportunities to learn from excellent practice. Excellence in healthcare is highly prevalent, but there is no formal system to capture it. We tend to regard excellence as something to gratefully accept, rather than something to study and understand. Our preoccupation with avoiding error and harm in healthcare has resulted in the rise of rules and rigidity, which in turn has cultivated a culture of fear and stifled innovation. It is time to redress the balance.”

http://learningfromexcellence.com/

Birmingham Children’s Hospital, Warwick Business School et al

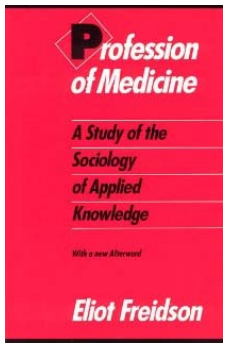
Thanks to Adrian Plunkett MD

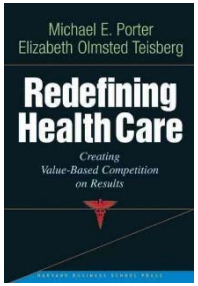
New political strategy: **Optimising** Health Care instead of **decimating costs?!?**

- **1919 Autistic-undisciplined thinking in medicine and how to overcome it, Eugen Bleuler**
- **1970 The Profession of Medicine, Eliot Freidson**

  ("clinical mentality", "placebo-reactor")
- **1999 choosing wisely,** ABIM,
  - http://www.choosingwisely.org/
- **2002 "too much medicine" BMJ**
- **2004 value-based health care, Sir John Muir Gray,** www.bettervaluehealthcare.net
- **2007 Re-Defining Healthcare,** Porter, Teisberg
  - = vale-based healthcare, *us-american version*
- **2012 Preventing Overdiagnosis.** BMJ et al
- **2016 "realistic medicine", Scot NHS,**
  - CMO Catherine Calderwood MD PhD
- **2017 "right care" The Lancet,**

  http://www.thelancet.com/series/right-care





PREVENTING OVERDIAGNOSIS
Winding back the harms of too much medicine

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“

THANK YOU!

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