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WHO News

Malaysia: Ministry of Health launched Patient Safety Council[1]

The Pacific Bridge Medical (PBM) Asian Medical eNewsletter (* Volume 4, Number 9 * December, 2004) reports:

In September 2004, the Malaysian Ministry of Health (MOH) revealed the details of the Patient Safety Council, which will go into effect within the next few months. The Council will address and resolve incidents of medical errors and help improve the overall patient safety and healthcare in Malaysia. Currently, the MOH has an incident reporting program, which monitors 30 different types of incidents at hospitals. This program examines such incidents as complications in the ICU, falls in the wards, adverse transfusion reactions and problems that occur to patients under anesthesia. However, these incidents are only monitored every six months and the program does not provide for ways to prevent and reduce these errors. The Patient Safety Council will allow for an overall evaluation and improvement of patient healthcare and safety in Malaysia.

The Council will have five functions, namely, to

- Develop a national, electronic database system for reporting and documenting medical errors in hospitals.
- Promote an open and fair system for the confidential reporting of incidents.
- Analyze these incidents and learn how to avoid them in the future.
- Devise strategies to improve safety and quality.
- Publish reports on adverse incidents and patient safety.

The Patient Safety Council is comprised of about 30 experts from across the healthcare industry. Council members include individuals from the Malaysian Ministry of Health, university hospitals, professional organizations, representatives from the private sector and the president of the Federation of Malaysian Consumers Association. These experts will focus on six main issues, specifically, data and information, consumer education, continuing education, medication safety, transfusion safety and quality of work life. The Council will take into account some of the common reasons for errors in the workplace, such as time constraints, inadequate training, understaffing, fatigue and inexperience. After determining the reasons for patient complaints and medical errors, the Council will propose strategies for resolving these issues.

Modernising medical careers – the new curriculum for the foundation years in postgraduate education and training[2]

The launch of the new UK-wide curriculum for junior doctors on 4 April 2005, as part of the Modernising Medical Careers programme, signals a groundbreaking change in postgraduate medical training.

[1]Originally published as: http://www.who.int/patientsafety/news/malaysia_council/en/ (World Health Organization 2005).
[2]Originally published as: http://www.who.int/patientsafety/news/medical_careers_uk/en/ (World Health Organization 2005).

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The world-leading programme will provide graduates with far broader exposure to medical practice and specialties than was previously provided. The result of two years of research and development, it has been produced in conjunction with the Academy of Royal Medical Colleges and the four UK health departments, with input from a wide variety of stakeholder groups.

The new curriculum recognises that the next generation of doctors will need a far broader range of skills in order to provide the best care to patients. To meet this challenge the curriculum has identified a range of competencies that it will assess, in addition to the more traditional elements of medical training. Many of these competencies have never been set before, such as communication skills, leadership, quality and safety improvements, acute care and team working.

Sir Liam Donaldson, Chief Medical Officer for England, said:

> "The Foundation Programme curriculum marks a new era in UK medicine. For the first time, doctors will have the opportunity to explore a range of career options, while ensuring that their acute clinical and professional skills are secure and robust."
>
> "This is very much a 'curriculum for patient safety', ensuring that at the end of their two years of training doctors are both confident and competent and we are delighted that the UK is leading the world in these innovations in medical education."

Congress debates legislation on patient safety[3]

The US "Patient Safety and Quality Improvement Act of 2005 – S 544" was unanimously approved by the Senate Health, Education, Labor and Pensions Committee on March 9. The bill, identical to a measure passed by the Senate in 2004 would establish a voluntary medical error reporting system that provides legal protection to caregivers and encourages safety education and information-sharing.

The legislation permits caregivers to analyze the cause of medical errors – without fear of being sued and without compromising patient's legal rights – to promote the development of interventions and solutions that ensure patient safety.

Specifically, this legislation:

- Creates a confidential, voluntary reporting system in which physicians, hospitals, and other health care providers can report information on errors to organizations known as Patient Safety Organizations (PSOs).
- Allows PSOs to collect and analyze unique "patient safety data" and then provide feedback on patient safety improvement strategies.
- Provides that "patient safety data" will be confidential and legally protected.
- Does not limit or affect the availability of any information or evidence that is currently available from sources other than the PSO and can be collected under existing law.
- Provides for appropriate penalties for unlawful disclosures.
- Recognizes and preserves the protection of confidential patient information under the Health Insurance Portability and Accountability Act of 1996.
- Does not preempt other state and federal peer review laws.

[3]Originally published as: http://www.who.int/patientsafety/news/us_congress_debate/en/ (World Health Organization 2005).