WHEC UPDATE

Briefings of worldwide activity of Women's Health and Education Center (WHEC)

November 2010; Vol. 5, No. 11

Accusations of negligence and the harm they do can be greatly reduced by a no-fault compensation, more realistic expectations, and an appropriate continuing education system for health professionals. The usual reaction to the term "medical negligence" is: A healthcare professional has done something wrong and I want monetary compensation for it". In practice, however, a careful interpretation is needed. Nowadays "negligence" does not turn out to be such a simple concept. It is sometimes considered to be a synonym for malpractice but in fact it has to be confined to two specific meanings: the use of outdated knowledge and skills (negligence with regard to continuing education); and not taking the safety measures that are known to be necessary (negligence with regard to standard procedures). Both definitions are complex and relative, because the rapid evolution of the health professions. Most examples of alleged negligence in the health services do not concern recent scientific developments but simple treatments and safety procedures that are long-standing common knowledge in the health sector. Public attitudes towards the health services and health professionals used to be submissive on the whole, but fortunately they have changed dramatically during the last few decades. People have become much more aware of the real danger of negligence, and indeed it sometimes seems as if the pendulum has swung from one extreme to other: from blind trust in the almost divine skills of health professionals to the feeling that if treatment or advice do not yield the desired results someone must have made a mistake, should take blame and people should be monetarily compensated.

Medical negligence exists almost in all the countries, but in most of the countries it is on such a small scale that at present there is no impact on the cost, quality and availability of healthcare. In USA it has reached at the dangerous levels. The first obvious need is to narrow the gap between public expectations and the reality of what the health system can deliver. Unfortunately, the parties on both sides of the gap are resistant to change in this direction. The public feel that their financial contribution to the health sector – whether through taxation, insurance or fees for service – entitles them to high expectations, just as they would demand value for money when they buy other services or consumer goods. In some health systems an effort is made to bridge gap, but this takes the form of a legalistic contractual presentation of every foreseeable unhappy event. Communication skills, public information, and health education can greatly help to narrow the gap, and they need more emphasis in most of today's health systems. The second thing to do is to find better ways of maintaining and updating health professionals' knowledge and skills. The most promising solution is to develop a system which will combine a compulsory minimum of further training with plenty of opportunities for the highly motivated to learn more on a voluntary basis. We are grateful to your views on the solutions of medical malpractice, recently hosted on **WomensHealthSection.com**. Keep your thoughts coming and we hope to compile the round-table discussion soon.

Narrowing The Gap Between Expectation And Reality

Rita Luthra, MD

Your Questions, Our Reply:

Is no-fault compensation system better alternative to the complexities of court-based litigation to settle medical malpractice claims?

No-fault Compensation – pros and cons: When there is an unexpected result and a patient or relative raises the question of whether it was because of negligence, the steps taken depend on the traditions, laws and insurance schemes of the country concerned. The first question is whether formal procedures exist for handling such a case. In countries where they do not, the patient's only option is to take legal action, accusing the health professional of being at fault. This can be such a time-consuming and expensive process that many people decide not to embark on it. Systems based on "fault" sometimes have the opposite disadvantage, of inciting claimants to try for excessive compensation if there seems to be a good chance of a ruling that someone was at fault. This adds to the cautiousness and defensiveness of health professionals, sometimes even to the extent that potentially beneficial interventions are avoided if the possible side-effects could incite a patient or relatives to seek legal redress.

No-fault compensation system may well be better, provided that the following factors are catered for:

- That medical accountability is still maintained through independent, adequate and reasonable reviews backed by monetary or other sanctions to ensure proper standards of performance;
- That the payment of compensation to wronged patients is adequate to their needs;
- And that the scheme is not overburdened with bureaucracy, making it difficult for patients to apply for compensation and costing State more than what it had to bear under the old system.

In our editorial board, some believe in the long run, public confidence is better maintained if the assessment of the nature and scope of the negligence is by an independent tribunal rather than an agency that is part of the department that makes the payments. An independent tribunal which is not bound by strict rules of evidence and argumentation by lawyers is a good compromise between determinations by a regular court of law and an administrative department which is obligated by law to pay the complainant. It is a good principle that one should not judge one's own cause. No such compensation scheme can run without some involvement of the State in terms of funding and personnel. That being so, there is a danger that the expense involved will prove to be excessive, and become a matter of public concern.

About NGO Association with the UN:

UN Partner on Millennium Development Goals (MDGs)
A Gateway to the UN System's Work on MDGs

OHCHR- Office of the High Commissioner for Human Rights
Right to Development

The right to development can be rooted in the provisions of the Charter of the United Nations, the Universal Declaration on Human Rights and the two International Human Rights Covenants. Through the United Nations Charter, Member States undertook to "promote social progress and better standards of life in larger freedom" and "to achieve international cooperation in solving international problems of an economic, social, cultural or humanitarian character, and in promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction as to race, sex, language or religion."
The Universal Declaration on Human Rights contains a number of elements that became central to the international community's understanding of the right to development. It attaches

importance, for example, to the promotion of social progress and better standards of life and recognizes the right to non-discrimination, the right to participate in public affairs and the right to an adequate standard of living. It also contains everyone's entitlement to a social and international order in which the rights and freedoms set forth in the Declaration can be fully realized.

In its resolution 4 (XXXIII) of 21 February 1977, the UN Commission on Human Rights decided to pay special attention to consideration of the obstacles impeding the full realization of economic, social and cultural rights, particularly in developing countries, and of national and international action to secure the enjoyment of those rights. Recognizing the right to development as a human right, the Commission requested the UN Secretary-General to undertake a study on "the international dimensions of the right to development as a human right in relation with other human rights based on international cooperation, including the right to peace, taking into account the requirements of the New International Economic Order and fundamental human needs." The study was submitted and considered by the Commission on Human Rights at its thirty-fifth session in 1979. The Commission subsequently, by its resolution 36 (XXXVII) of 11 March 1981, established a working group of 15 governmental experts to study the scope and contents of the right to development and the most effective means to ensure the realization, in all countries, of the economic, social and cultural rights enshrined in various international instruments, paying particular attention to the obstacles encountered by developing countries in their efforts to secure the enjoyment of human rights. It also requested the Working Group to submit a report with concrete proposals for implementation of the right to development and for a draft international instrument on this subject. The right to development was proclaimed by the United Nations in 1986 in the "Declaration on the Right to Development" which was adopted by the United Nations General Assembly resolution 41/128.

Collaboration with World Health Organization (WHO):

Selected bibliography supporting the ten essential objectives for safe surgery:

Surgical care is complex and involves dozens of steps that must be optimized for individual patients. In order to effectively minimize unnecessary loss of life and serious complications, operative teams have ten basic and essential objectives in any surgical case, which the WHO Safe Surgery Guidelines aim to support:

1. The team will operate on the correct patient at the correct site;
2. The team will use methods known to prevent harm from anesthetic administration, while protecting the patient from pain;
3. The team will recognize and effectively prepare for life-threatening loss of airway or respiratory function;
4. The team will recognize and effectively prepare for risk of high blood loss;
5. The team will avoid inducing any allergic or adverse drug reaction known to be a significant risk for the patient;
6. The team will consistently use methods known to minimize risk of surgical site infection;
7. The team will prevent inadvertent retention of instruments or sponges in surgical wounds;
8. The team will secure and accurately identify all surgical specimens;
9. The team will effectively communicate and exchange critical patient information for the safe conduct of the operation;
10. Hospitals and public health systems will establish routine surveillance of surgical capacity, volume, and results.

Details: Background to Safe Surgery Saves Lives:
http://www.who.int/patientsafety/safesurgery/issue/en/index.html

Bulletin of the World Health Organization; Volume 88, Number 11, November 2010, 797–876 Table of contents

Collaboration with UN University (UNU):

A Model of Destructive Entrepreneurship

The current research on entrepreneurship as an economic phenomenon often assumes its desirability as a driver of economic development and growth. However, entrepreneurial talent can be allocated among productive, unproductive, and destructive activities. This process is theorized as driven by institutions. Although the tradeoff between productive and unproductive entrepreneurship has been examined, destructive entrepreneurship has been largely ignored. We build from existing theory and define destructive entrepreneurship as wealth-destroying. We propose three assumptions to develop a model of destructive entrepreneurship that presents the mechanisms through which entrepreneurial talent behaves in this manner. We present four key propositions on the nature and behavior of destructive entrepreneurship. We conclude by identifying policy and research streams that emerge from our model.

Attempts to shed light on the dynamics of entrepreneurial talent have come overwhelmingly from empirical perspectives, while its theoretical foundations have remained largely unexplored. Empirical approaches tend to assume that entrepreneurship should be encouraged—i.e., that its positive effects on job creation, wealth creation, and innovation are universal across contexts. Such approaches focus on key relationships, i.e., between banking and new firm formation, with the underlying assumption motivation of understanding and identifying channels to strengthen entrepreneurship. However, entrepreneurial activity is not universally “good” because entrepreneurs act in creative ways simply to increase their wealth, power, and prestige—and without active consideration of externalities or societal effects. Entrepreneurial talent is allocated to activities with the highest private returns, which may not generate the highest social returns. If activities are chosen based on perceived profit, it is not implicit that they will have positive effects and can include activities with questionable or undesirable societal outcomes. Therefore, entrepreneurial talent can be allocated among a range of selections with varying effects.

There is no conceptual framework for destructive entrepreneurship and the topic is noticeably absent from the literature. The current understanding of entrepreneurship is fundamentally incomplete, rendering applications of existing knowledge inadequate or worse, inaccurate. This is particularly the case for public policies and economic development. For example, most models of entrepreneurship assume occupational choice: individuals can choose between entrepreneurship and wage employment. Murphy, Shleifer, and Vishny note that “when they are free to do so, people choose occupations that offer them the highest returns on their abilities”. However, very real constraints exist on individual occupational choice and thus, entrepreneurial choices particularly in developing countries. In addition, existing models of entrepreneurship may be appropriate for high growth and high technology sectors, but simply do not fit many, if not most, activities in poor, underdeveloped, and conflict countries.

Publisher: UNU-WIDER; Authors: Sameeksha Desai, Zoltan Acs, and Utz Weitzel; WIDER Working Paper; Sponsor: UNU-WIDER gratefully acknowledges the financial contributions to the project by the Finnish Ministry for Foreign Affairs, and the financial contributions to the research program by the governments of Denmark (Royal Ministry of Foreign Affairs), Finland (Finnish Ministry for Foreign Affairs), Sweden (Swedish International Development Cooperation Agency—Sida) and the United Kingdom (Department for International Development).

(Details of the paper can be accessed from the link of UNU-WIDER on CME Page of WomensHealthSection.com)

Constitution Of The World Health Organization:

(Continued)

CHAPTER IX – CONFERENCES

Article 41
The Health Assembly or the Board may convene local, general, technical or other special conferences to consider any matter within the competence of the Organization and may provide for the representation at such conferences of international organizations and, with the consent of the Government concerned, of national organizations, governmental or nongovernmental. The manner of such representation shall be determined by the Health Assembly or the Board.

Article 42
The Board may provide for representation of the Organization at conferences in which the Board considers that the Organization has an interest.

CHAPTER X – HEADQUARTERS

Article 43
The location of the headquarters of the Organization shall be determined by the Health Assembly after consultation with the United Nations.

To be continued…..

Top Two Articles Accessed in October 2010:

1. Medical Negligence: A Return To Trust;
   http://www.womenshealthsection.com/content/heal/heal005.php3
   World Health Forum; WHO publication. Published with permission from World Health Organization (WHO).
   Special thanks to the editors for compiling the discussion and review. The worldwide forum on Medical Liability and Risk Management on ***WomensHealthSection.com*** is going well. We hope to compile the review and publish by March 2011. Thanks to the experts from around the world for contributions on the topic.

2. Overview of Obstetric Anesthesia Professional Liability;
   http://www.womenshealthsection.com/content/obspm/obspm009.php3
   WHEC Publications. Special thanks to Dr. Bhavani Shankar Kodali, Associate Professor, Harvard Medical School, Attending Anesthesiologist at Brigham and Women's Hospital, Boston, MA (USA) for the assistance in preparing the review and bulletin.

From Editor's Desk:

WHO Patient Safety: Curriculum Guide for Medical Schools

Medicine has changed greatly over the last century. Our knowledge of the physiology, biochemistry and genetics of human life has improved, as has our understanding of the diseases that affect health. As the technical ability to treat disease has grown, the complexity of medical practice has increased significantly. The same drugs and surgeries that can save lives have the potential to cause harm. Modern health care is delivered in teams, not by individuals. Modern clinicians rely on the support of intricate health-care systems to enable them to carry out their task. Errors can occur at each stage in any of these processes. There is a constant threat of accidental harm, which cannot easily be removed. High risk organizations, such as the airline industry, meticulously apply layers of protection to their routine work to reduce risk to acceptable

levels. Systems are built so that human error – which is to some extent inevitable – does not cause catastrophe. Flying has now become very safe.

In recent years, a science of patient safety has developed. Harm to patients is not inevitable and can be avoided. To achieve this, clinicians and institutions must learn from past errors, and learn how to prevent future errors. We need to adapt our ways of working to make safe health care a robust and achievable goal. Traditionally, curricula for doctors and medical students have focused on pure clinical skills: diagnosis of illness, treatment of disease, after-care and follow-up. However, team working, quality improvement and risk management have been overlooked. These skills are fundamental to patient safety. It is therefore fitting that the WHO Patient Safety has developed this curriculum which will enable and encourage medical schools to include patient safety in their courses. Reducing harm caused by health care is a global priority. Incorporating the knowledge of how to do this into the medical student curriculum is an urgent necessity. This Curriculum Guide is only a start. A plan is underway to adapt it for use by other health-care professionals including nurses and pharmacists. It is only one strand of what we need to build safer health-care systems. However, there is no doubt that engaging clinicians from the earliest stages of their training is crucial.

Why do medical students need patient safety education?
Health care outcomes have significantly improved with the scientific discoveries of modern medicine. However, studies from a multitude of countries show that with these benefits come significant risks to patient safety. We have learnt that hospitalized patients are at risk of suffering an adverse event, and patients on medication have the risk of medication errors and adverse reactions. A major consequence of this knowledge has been the development of patient safety as a specialized discipline. Clinicians, managers, health-care organizations, governments (worldwide) and consumers must become familiar with patient safety concepts and principles. Everyone is affected. The tasks ahead of health care are immense and require all those involved care to understand the extent of harm to patients and why health care must move to adopt a safety culture. Patient safety education and training is only beginning to occur at all levels. Medical students, as future doctors and health-care leaders, must also be prepared to practice safe health care. Though medical curricula are continually changing to accommodate the latest discoveries and new knowledge, patient safety knowledge is different from other because it applies to all areas of practice.

Details: http://whqlibdoc.who.int/publications/2009/9789241598316_eng.pdf

Words *of* Wisdom:

Employ your time in improving yourself by other man's writings, so that you shall gain easily what others have labored hard for.

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Monthly newsletter of WHEC designed to keep you informed on the latest UN and NGO activities