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EDITORIAL

Medical professional responsibility and clinical safety in the practice of orthopaedic surgery and traumatology☆

La responsabilidad profesional médica y la seguridad clínica en el ejercicio de la Cirugía Ortopédica y Traumatología

Concepts such as professional medical liability (PML) and medical safety (MS) are at the forefront of scientific forums on professional medical practice. The publication of ''*To err is human: Building a safer Health System*'' in 1999 suggested adverse event (AE) rates of between 2.9% and 3.4% in health care, over half of which would have been preventable.[1] Starfield later published in *JAMA* that every year 225,000 deaths took place in USA as a result of heath care and was thus the third main cause of death there, only just behind that of heart disease and cancer.[2]

Nowadays, consulting the PubMed–NCBI database with keywords such as ''malpractice claims'' or ''patient safety'' conjures up a large quantity of scientific publications treating these subjects, and the current trend is on increasing publications/per year. Current medical practice is increasingly more specialised, with high risk diagnostic and therapeutic procedures, coupled with a growing concern for medical safety. Specifically, in the case of orthopaedic and trauma surgery (OTS), in recent years, OTS services have increased their activity enormously, mainly promoting outpatient surgery and new minimally invasive surgical techniques have appeared. Moreover, OTS is not immune to the enormous healthcare pressure due to many factors, which require organisational management measures in emergency services to minimise risks. The objective of MS is to find solutions to improve healthcare in OTS, guaranteeing the quality of medical practice, with patient safety. Organisations such as the World Health Organisation (WHO) and the majority of scientific associations specialising in different areas are making good progress in creating guidelines to exercise greater safety and minimise the AE which may occur during medical practice. The concepts of the ''check list'' or medical practice guidelines have progressively advanced in clinical practice. Since 2000 progress in patient safety is palpable in the majority of primary care hospitals and centres. In 2004 the World Alliance for Patient Safety was founded, with its purpose of coordinating, disseminating and promoting improvements in patient safety throughout the world, serving as a vehicle for international coordination between member states, of the WHO itself, the patients, health professionals and the health industry.[3,4]

Several authors, both national and international also underline the MS in OTS, determining safety programmes, such as risk identification and assessment and AE, notification of AE systems, security alerts and organisational culture of medical safety.[5–7]

Paradoxically in the last five years claims from PML have increased in Spain, but without reaching levels of countries like USA, immersed in the ''malpractice crisis'', and the continual novelties and legislative reforms force the professional to be up to date with medical and legal matters. This increase has occurred within a context of highly specialised medicine, with a major scientific and technological evolution and is notably affected by socio-cultural changes. The enactment of Law 41/2002, the basic regulator of patient autonomy and of the rights and obligations regarding clinical information and documentation, greatly altered the physician–patient relationship, from the traditional paternalistic and possibly imposing role to a type of exercise based on the principle of autonomy where information was essential and the notion of the informed consent document (ICD) became essential. As prevailing legislation dictates, in its article 8.2, consent is generally verbal. However consent becomes written in the following cases: surgical

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intervention, diagnostic procedures and invasive therapies, and in general application of procedures which will lead to notable risk or inconveniences and foreseeable negative repercussions for the patient.[8] In keeping with this legislation, scientific bodies have brought themselves up to date in medical and legal matters. For example the Sociedad Española de Cirugía Ortopédica y Traumatología (SECOT) have gone to great pains to be up to date and to make surgical procedures of the ICD contemporary. The latter have for some time being the most downloaded page on the entity's website. From the beginning the ICDs have proven to be very useful for the trauma surgeons, reporting MS thanks to the endorsement of this scientific body.[9]

The OTS speciality, according to several published studies, comes high in the ranking of specialities with the greatest frequency of claims.[10,11] Analysis of claims in our area thus determine that the OTS is located first in frequency, reaching 17.3% of the total surgical procedures claimed, but despite this the financial volume of claims is not high (under €50,000), with the main reason for claim being therapeutic error during surgery.[10–12]

We consider it necessary to approach the PML area from analysis of medical or surgical procedures which are subject to claims, legal analysis and rulings in court or outside it, to determine which are risk procedures where measures need to be taken. Said analysis must contextualise to reinforce to a maximum attention to patient safety and the development of organisational and scientific actions to improve the quality of healthcare. It is of vital importance that preventative behaviour patterns of risk be established through the establishment of standards which take into account the main risks of presenting claims.

In today's context it is vital that orthopaedic and trauma surgeons recognise the medical and legal concepts which govern healthcare in their daily clinical practice. This is important both for minimising the risks for patients, and for preventing having to incur in defensive medicine. For this reason, analysis of information which is generated by the study of claims is key,[13] and knowledge produced should revert to the professionals in the form of publications of a scientific nature, and though collaboration between analysis of information generated and the specialists. The role of scientific bodies is also decisive here for helping to spread knowledge arising from claims analysis, and we therefore are grateful to the journal for the articles included in this edition on this matter, which is of the utmost interest to traumatology as a high risk speciality.[12,14]

Level of evidence

V.

References

1. Kohn KT, Corrigan JMDM. To err is human: building a safer health system. Washington: National Academy Press; 1999 [cited 30.10.15]. Available at: http://www.journals.cambridge.org/abstract_S095026880100509X
2. Starfield B. Is US health really the best in the world? JAMA. 2000;284:483–5.
3. World Health Organization patient safety: report by the secretariat. En: Fiftyninth World Health Assembly, 4 May 2006; 2012 [cited 06.04.12].
4. Ministerio de Sanidad y Consumo. Plan de Calidad del Sistema Nacional de Salud; 2012 [cited 06.04.12].
5. Grau J, Santiña M, Combalia A, Prat A, Suso S, Trilla A. Fundamentos de seguridad clínica en cirugía ortopédica y traumatología. Rev Esp Cir Ortop Traumatol. 2010;54:251–8.
6. Digiovanni CW, Kang L, Manuel J. Patient compliance in avoiding wrong-site surgery. J Bone Joint Surg Am. 2003;85A:815–9.
7. James JT. A new, evidence-based estimate of patient harms associated with hospital care. J Patient Saf. 2013;9:122–8.
8. Ley 41/2002, de 14 de noviembre, básica reguladora de la autonomía del paciente y de derechos y obligaciones en materia de información y documentación clínica. BOE número 274 de 15/11/2002, 40126–32.
9. Sociedad Española de Cirugía Ortopédica y Traumatología. Documentos. Consentimiento informado; 2015 [cited 06.10.15]. Available at: http://www.secot.es/consentimiento.php
10. Jena AB, Seabury S, Lakdawalla D, Chandra A. Malpractice risk according to physician specialty. N Engl J Med. 2011;365:629–36.
11. Arimany-Manso J, Benet-Travé J, Bruguera Cortada M., Torné-Escasany R, Klamburg-Pujol J, Gómez-Durán EL. Procedimientos quirúrgicos objeto de reclamación por presunto defecto de praxis. Med Clin (Barc). 2014;142 Suppl. 2:S47–51.
12. Cardoso-Cita B, Perea-Pérez B, Albarrán-Juan ME, Labajo-González ME, López-Durán L, Marco-Martínez F, et al. Análisis de sentencias judiciales relativas a negligencias médicas emitidas contra traumatólogos entre 1995 y 2011. Rev Esp Cir Ortop Traumatol. 2015, http://dx.doi.org/10.1016/j.recot.2015.07.001.
13. Gómez-Durán EL, Martín-Fumadó C, Arimany-Manso J. Legal medicine contributions to patient safety. From ascertainment and evaluation to research in medical liability. Int. J. Legal Med. 2013;127:1051–3.
14. Bori G, Gómez-Durán EL, Combalia A, Trilla A, Prat A, Bruguera M, et al. Seguridad Clínica y Reclamaciones por Responsabilidad Profesional en Cirugía Ortopédica y Traumatología. Rev Esp Cir Ortop Traumatol. 2015, http://dx.doi.org/10.1016/j.recot.2014.10.004.

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