

**Leadership is essential in
managing risks.**

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We must be able to trust each
other as doctors and
employers.

We must systematically approach
a "culture of safety".

**Systems dealing with safety
must not be based on
punishment but on positive
feedback.**

How shall we manage risks?

How can we change our
attitudes and establish a
learning culture?

Defensive medicine?

Let us establish a culture of safety.

Errors should be identified
Errors should be dealt with
Errors should be prevented

There should be action programs
for safety at every hospital.

Take care!

Conclusions

- Identify the risks and manage them.
Make mistakes visible.

Find and analyse errors, mistakes,
and accidents that altered the
foreseen result of treatment without
focusing on guilt.

Open minds rather than blame.

Make registration of mistakes made and "almost made" confidential and mandatory.

This information should be available to everyone on a national and international level.

Change the attitude among doctors as well as the written law from punishment towards prevention.

Organize and market knowledge about risk management.

riskmanagement
~~adverse advent~~
patient safety
Bad apple
maximum security
punishment
~~mistake~~
culture of safety
fault
~~multiple errors~~