

*Regional Workshop: "Radiation Protection Culture in  
Medicine"*

# *The Patient Voice*

*PATIENTS FOR PATIENT SAFETY **PFPS**  
WHO PATIENT SAFETY PROGRAMME*

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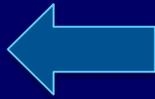
*CHICAGO 2007 Patient Safety Workshop*

*“It may be part of human nature to err, but is also part of human nature to create solutions, find better alternatives and meet the challenges ahead.”*

*“First Do No Harm.”*

Hippocrates  
4th Century A.D.

# Patients for Patient Safety



Patients for Patient Safety  
Partnerships for Safer Health Care

World Health Organization



## PFPS Network

- Strengthen capacity, communication, advocacy

## Policy-makers

- Collaborate with WHO, national, international organizations

## Academic institutions

- Create and share knowledge through research, education and training

## Health-care providers

- Facilitate patient engagement at hospitals and health-care facilities

## Civil society, NGOs

- Collaborate with NGOs and professional organizations

# Patients for Patient Safety



## Partnerships for safer care

A global network



A WHO programme

Telling “stories” to catalyse improvements and organizational learning.

Encourage partnership, empowerment and inspire action on patient safety worldwide.

Aims to incorporate the patient voice in all levels of health care.

Empowers and facilitates patients and their families to advocate for change collaboratively.

# How patients are engaged?

- As advocates and *catalyst* for change: - Telling stories - put a human face behind patient safety statistics
- As advisors- on professional, accreditation and regulatory committees and boards and contribute to policy development
- As educators to students and health professionals



Margaret Murphy (Ireland)

- Lead Advisor to WHO on patient engagement
- Chair of the PFPS Strategy Group
- Member of the WHO Patient Safety Curriculum Guides committee
- Recently reappointed as a lay member of the Irish Medical Council (regulatory body) for the 2013-2018 period



Johanna Trimble (Canada) - On committee developing continuing physician education on use of medication for the elderly



Maryann Murray (Canada) - Provided input to help change legislation after the ADE (her 21 year old daughter died of heart failure after taking contra-indicated medication)

# *Patient Voice*

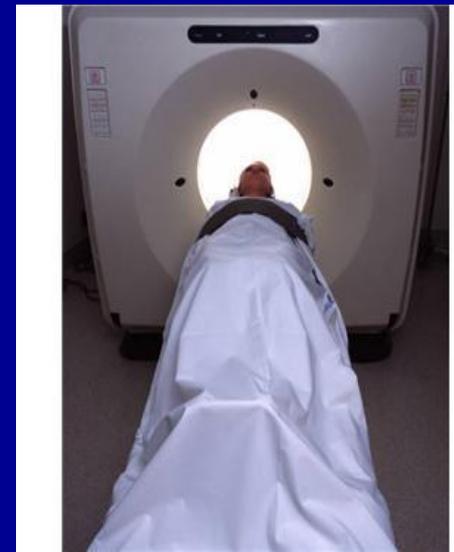
## *PFPS*

- 1. Patients who know what to expect during treatment can help identify potential incidents before they occur.**
- 2. Telling a story is a way to enable reflections that do not jump from the pages of statistical reports.**

*Errors =*

*NOT ALL THE COST CAN BE DIRECTLY  
MEASURED*

- *Loss of trust in the system by patients*
- *Longer hospital stay or disability produce physical and psychological discomfort*
- *Health care professionals: loss of morale and frustration*



*WHO COMMITMENTS IN PATIENT SAFETY:*

***PFPS  
TRAINING  
THE NEXT GENERATION***



# *Knowledge, skills and attitudes needed for 21<sup>st</sup> century care*

- *Accept patients as partners*
- *Realise that the “experience of care” needs to be improved*
- *Understand the importance of data collection, error analysis and feedback in a just culture in driving improvement*

# *Critical Success Factors*

- *Creation of an organization of “safety culture” instead of “blame culture”*
- *Patient safety as “the” top priority, not “a” priority*
- *Leadership by engagement ...and model*

# *Patient Voice*

## *PFPS – Recommendations / Solutions*

### *Learning objective for next generations:*

Understand the ways in which patients and carers can be involved as partners in health care both in preventing harm and learning and healing from an adverse event



# *Patient Voice*

## *PFPS – Recommendations / Solutions*

### *Performance requirements for next generations*

- *actively encourages patients and carers to share information*
- *shows empathy, honesty and respect for patients and carers*
- *communicates effectively*
- *obtaining informed consent*
- *shows respect for each patient's differences, religious and cultural beliefs, and individual needs*
- *describes and understands the basic steps in an open disclosure process*
- *apply patient engagement thinking in all clinical activities*
- *demonstrates ability to recognize the place of patient and carer engagement in good clinical management*

# *Patient Voice*

## *PFPS – Recommendations / Solutions*

### *Performance requirements for next generations*

- 0 **S**harpen listening skills
- 0 **P**ay attention to patient perceptions
- 0 **I**nvoke the patient to discuss details
- 0 **K**now the facts
- 0 **E**xplore emotions and deliver empathy
- 0 **S**trategize next steps with patient or family



# *Patient Voice*

## *PFPS – Recommendations / Solutions*

*Share: experiences- strengths- limitations*

*help*

*individuals and organizations learn how*

*improve activities*

# *Patient Voice*

## *PFPS - Challenge*

- Many individual Champions are performing an excellent job and proposals
- The impact analysis produce recommendations of how to translate awareness into evidence-based interventions to reduce patient harm

# Radiation safety issues seen from the patient perspective

**WHO**  
**PFPS**

- 1. Lack of access to appropriate diagnostics and treatment**
- 2. Delayed diagnostic imaging resulting in delayed treatment**
- 3. Misinterpretations and resulting misdiagnosis**
- 4. Unnecessary tests and ineffective treatment**
- 5. Errors in administering diagnostic tests and treatment**
- 6. Unacceptable effects of treatment**

# THE CURRENT REALITY

- Existence of a low level of patient understanding
- The need for an effective method of communicating risks and benefits
- Knowledge gaps which prevent patients from assessing options
- Patients and the wider public unaware of the risks associated with imaging

# THE SOLUTION

- Patient education which would facilitate meaningful interaction between patient and provider
- Addressing the deficit in easily accessible information
- Implementing a consultation process at policy making level which includes patient representation and values the patient perspective.

# Prevention of medical radiation incidents

## ■ What needs to be done

- Implement and support voluntary educational safety reporting systems
- Harmonize taxonomy in relation to medical radiation incidents and accidents

## ■ What WHO can do

- Engage change leaders in finding ways to teach patients to speak up when something seems "wrong"
- Help qualify patient safety reporting systems
- Help define taxonomy that could be meaningful in patients' incident reports

# *Patient Voice*

## *PFPS - Challenge*

- How demonstrate that patient care is safer because of patient engagement  
and
- how the effect of PFPS is perceived by Health-Care Providers

**are measures difficult to make visibles**

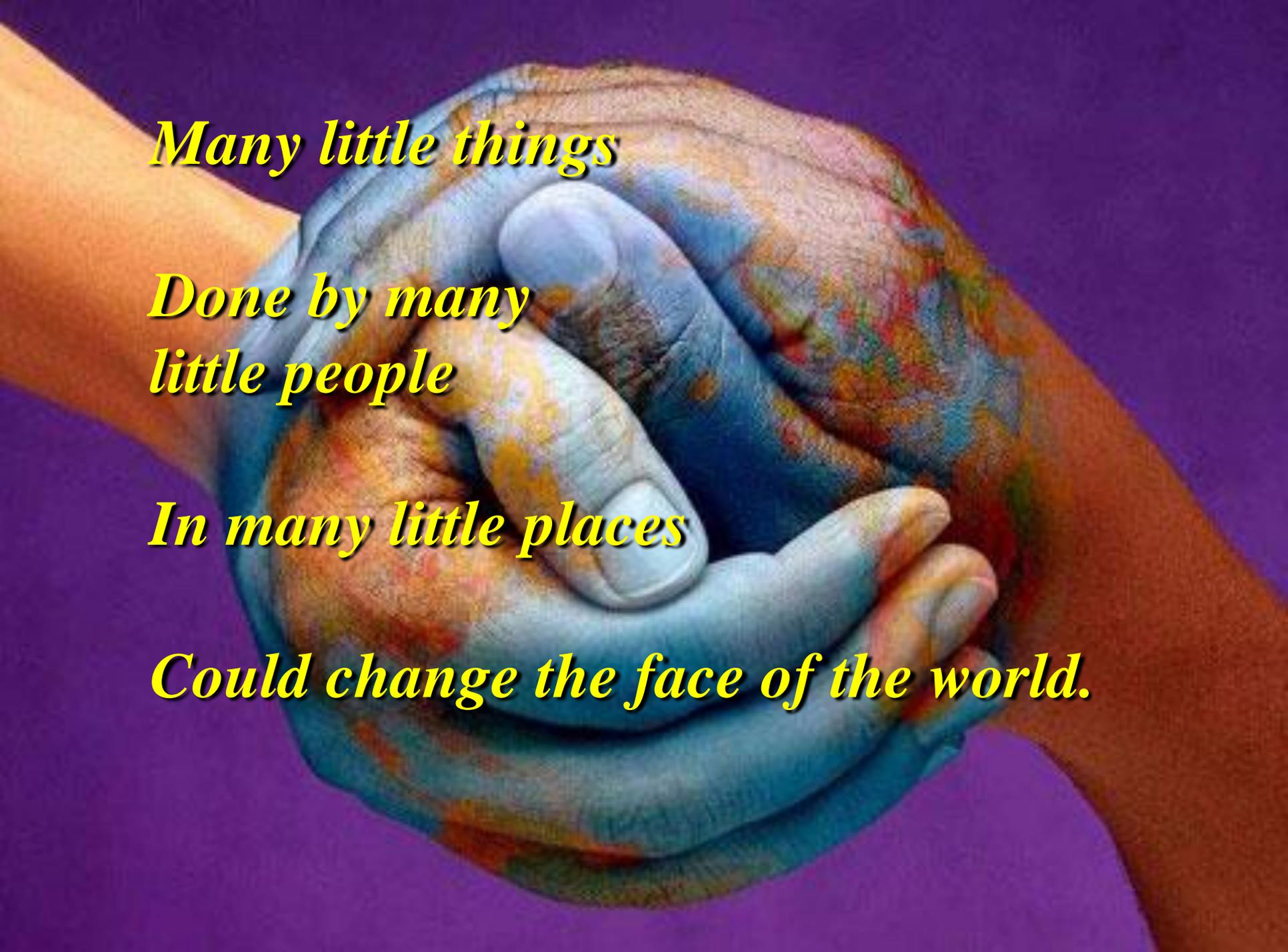
**but**

**should be our goal**



Working  
together  
for health



A close-up photograph of two hands clasped together. The hand on the left is light-skinned, and the hand on the right is dark-skinned. Both hands are covered in colorful, abstract paint splatters in shades of blue, green, red, and yellow. The background is a solid, deep purple color. The text is overlaid on the left side of the image in a yellow, italicized font.

*Many little things*

*Done by many  
little people*

*In many little places*

*Could change the face of the world.*