The Quest for Quality Improvement:
GOING FOR GOLD THROUGH MEDICAL EDUCATION

APRIL 20 – 23, 2013
QUEBEC CITY, QC

WELCOME
Medical Education and Patient Safety: A Patient-Doctor Dialogue

Maeve O’Beirne
Vincent Dumez
1. Review the definition and scope of patient safety:
   – Including challenges in community based practice and aging patients
2. Discuss the roles of patients and doctors in patient safety:
   – Including partnerships in care
3. Gain new perspectives on the role of Canadian medical education:
   – Why and how should we develop patient safety curriculum
Format

• For each section:
  – Doctor perspective (in English)
  – Patient perspective (in French)
  – Questions from the audience (in French or English)
Disclosure Statement

☑️ I have no actual or potential conflict of interest in relation to this presentation.
What is Patient Safety?

A method of reporting, analyzing, and preventing medical events that can lead to adverse healthcare events
What is Quality Improvement?

A method of evaluating and improving processes of patient care that focuses not on individuals, but on systems of patient care.
Why is Patient Safety & Quality Improvement Important?

Health care systems should be:

• Safe
• Effective
• Patient-centered
• Timely
• Efficient

IOM 2001
To Err Is Human, Institute of Medicine, 2000
"Harm" is an outcome with a negative effect on a patient's health or quality of life, or both

What is an Incident?

• An incident is an event or process which could have resulted, or did result, in unnecessary harm to a patient. ¹

• An incident is something in your practice that made you think: “I don’t want it to happen again”

---

## Types of Incidents Reported in Family Medicine

<table>
<thead>
<tr>
<th>Incident Type</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation</td>
<td>Missing mammogram from previous year</td>
</tr>
<tr>
<td>Medication</td>
<td>Prescribed Synthroid 75mcg instead of 100mcg</td>
</tr>
<tr>
<td>Clinical Admin.</td>
<td>Patient referred to pediatrician instead of podiatrist</td>
</tr>
<tr>
<td>Clinical Process</td>
<td>Doing biopsy, didn’t have container in room, specimen fell on floor</td>
</tr>
</tbody>
</table>
Why do Incidents Happen?

Humans make errors:

“Man, a creature made at the end of the week when God was tired.”

Mark Twain
Why do Incidents Happen?

• Humans make 2 mistakes an hour when they are not stressed
• Under stress, this number increases
James Reason

Two Conceptual Models
– Person Model
– System Model
The Person Model

- Sees errors as the product of wayward mental processes: forgetfulness, inattention, distraction, carelessness, etc.
- Remedial measures directed primarily at the “sharp end” error-maker: naming, blaming, shaming, retraining, fear appeals, writing another procedure, etc.
- But this isolates errors from their context and has little or no remedial value

The System Model

- Fallibility is part of the human condition
- Adverse events are the product of latent pathogens within the system
- “Sharp enders” are more likely to be the inheritors than the instigators
- Remedial efforts directed at improving defenses and removing error traps

The ‘Swiss cheese’ model of accident causation

Some holes due to active failures

Harm

Other holes due to system factors

Successive layers of defenses, barriers, & safeguards

Hazards
Effective Systems

Error stopped, no accident occurs

Develop systems and processes to prevent errors/accidents from happening and that can manage them when/if they occur.
Vincent Dumez, Directeur
Bureau facultaire de l’expertise patient partenaire
Disclosure Statement

☑️ I have no actual or potential conflict of interest in relation to this presentation.
1. REVIEW THE DEFINITION AND SCOPE OF PATIENT SAFETY, INCLUDING CHALLENGES IN COMMUNITY-BASED PRACTICE AND IN COMPLEX AND AGING PATIENTS
**PATIENT PARTNERSHIP HISTORICAL TREND**

**PATIENT SAFETY MANAGEMENT EVOLUTION**

**1945-1970**
- Welfare states
- Scientific progress
- Biomedical model

**1970-1980**
- Patient’s groups growth
- Patient training programs development
- Peer-to-peer training

**1980-1990**
- CRISIS
- Contaminated Blood affair
- AIDS
- Creutzfeldt-jakob

**1990-2000**
- Patient’s rights
- Patient education
- Care Legalization

**2000-...**
- Shared Decision Making
- Self management
- Patients experts
- Co-building approach

---

**ONE WAY SAFETY MANAGEMENT**
- Paternalism approach

**QUESTIONING PERIOD**
- Patient centered care

**LEGALIZATION TREND**
- Patient partnership

**SHARING RISK CULTURE ?**
- Patient centered care
of the North American population suffers from a chronic disease: Patient profile radical change (aging, long time survivor, …)

of these patients often fail to adhere to medication directives

Major safety and risk issue

of internet users search for health-related information online: Patient knowledge revolution
Discuss the roles of patients and doctors in patient safety:

Including partnerships in care
Adverse Event Causation

Accident Causation

Technical Factors

Human Factors

Safety Culture + Operator Behaviour

(20-30%)

(70-80%)
Human Factors...

...refers to environmental, organisational and job factors, and human and individual characteristics which influence behaviour at work.
Error Producing Conditions

What sort of things make us more prone to making mistakes?
Error Producing Conditions

- Stress/fatigue
- Time pressures
- Frequent distractions/interruptions
- Fragmentation and multitasking
- Communication
- Poor design / interface / IT systems
Physician’s Role

• Recognise error producing conditions

• Take steps to mitigate/change conditions to support the infallible human
Physician’s Role

• Recognise that error is inevitable
• Report incidents
• Analyse underlying causes of incidents
• Change systems
Physician’s Role

• Disclose unanticipated medical outcomes to patients
• Support colleagues involved in incidents
• Change culture away from “blame and shame”
Physician’s Role

• Include patients in all decisions
• Practice true informed consent
• Solicit feedback from patients
• Share responsibility for care/follow-up with patients
Physician’s Role

• Design and implement communication systems with all members of the interdisciplinary team

• Partner with Patients
2. UNDERSTAND THE ROLES OF PATIENTS AND DOCTORS IN PATIENT SAFETY, INCLUDING PARTNERSHIPS IN CARE
PATIENT AS PARTNER IN PATIENT SAFETY: 6 KEY FACTORS FOR A MAJOR CULTURAL CHANGE

• LEARN TO MAKE CHOICE: THE NEED OF A GRADUAL EMPOWERMENT OF THE PATIENT TO MAKE INFORMED HEALTH CHOICES
  ➤ PATIENT CAPACITY TO NEGOTIATE CHOICE IN ORDER TO PROGRESSIVELY BECOME A SAFETY PARTNER

• PATIENT AS A COMPETENT CAREGIVER: RECOGNIZING THE EXPERIENTIAL KNOWLEDGE OF THE PATIENT AND THEIR ABILITY TO DEVELOP CARE COMPETENCIES
  ➤ PATIENT EXPERIENCED-BASED KNOWLEDGE: A TRIGGER TO DEVELOP PATIENT’S COMPETENCIES TO MANAGE THEIR OWN SAFETY
PATIENT AS PARTNER IN PATIENT SAFETY: 6 KEY FACTORS FOR A MAJOR CULTURAL CHANGE

- **LIFE PROJECT ALIGNMENT:** RECOGNIZING THAT A QUALITY CARE DECISION IS ADJUSTED TO THE PATIENT SPECIFIC CONTEXT
  
  ➠ CLINIC DECISIONS ALIGN ON PATIENT LIFE PROJECT TO REDUCE ADHERENCE ISSUES AND, CONSEQUENTLY, SAFETY RISK

- **PATIENT AS A MEMBER OF THE CARE TEAM:** THE NEED TO WORK WITHIN THE CONTEXT OF INTERPROFESSIONAL TEAMS THAT INCLUDE PATIENTS
  
  ➠ RECOGNIZE PATIENT AS A POTENTIAL CAREGIVER AND MEMBER OF THE CARE TEAM WITH RESPECT TO HIS OWN CARE AND SAFETY
PATIENT AS PARTNER IN PATIENT SAFETY: KEY SUCCESS FACTORS FOR A MAJOR CULTURAL CHANGE

• **SHARED RISK:** THE NEED FOR A COMMON ASSESSMENT AND TO SHARE THE RISK BETWEEN THE CARE TEAM AND THE PATIENT

  ➔ A SHARE UNDERSTANDING OF THE RISKS THROUGH THE CARE PROCESS

• **PATIENT AS A POTENTIAL EXPERT:** RECOGNIZING THAT PATIENTS AND THEIR FAMILIES ARE NECESSARY PARTICIPANTS IN THE EDUCATING OF THEIR PEERS AND FUTURE HEALTH PROFESSIONALS

  ➔ INVOLVE PATIENTS’ IN PATIENTS AND HEALTH PROFESSIONNALS’ SAFETY TRAINING
WHAT A PATIENT PARTNER CAN DO FOR HIS OWN SAFETY

PATIENT LEARNING CAPACITY AND TRUST

RISK MANAGEMENT CAPACITY

Self-determination
Autonomy process
Auto-regulation
Competencies development

PATIENT PARTNERSHIP REINFORCEMENT

PATIENT LEVEL OF INTEGRATION IN THE CARE PROCESS
PATIENT SAFETY: A SYNCHRONIZATION ISSUE

1. Collect information
2. Diagnosis disclosure
3. Care plan establishment
4. Care compliance

1. Desire to understand
2. Desire to know
3. Desire to live
4. Desire to educate

PROFESSIONALS

MAJOR CULTURAL CHANGE IN TERMS OF COLLABORATION AND RESPONSIBILITIES SHARING

SHARING MUTUAL TRUST
RISK SHARING
SHARED DECISION MAKING

PATIENTS

Adapted from « Savoirs de patients, savoirs de soignants : la place du sujet supposé savoir en éducation thérapeutique », C. Tourette-Turgis, 2010
Gain new perspectives on the role of Canadian medical education:

Why and how should we develop patient safety curriculum
Why Should We Develop Patient Safety Curriculum?

• Increased complexity leads to increased risk of incidents
• Multidisciplinary teams lead to increased need for good communications skills
• Skills do not come naturally
How Should We Develop Patient Safety Curriculum?

- Undergraduate
- Postgraduate
- CPD
- Train the trainers
- Patients
Resources

• ASPIRE  http://www.royalcollege.ca/portal/page/portal/rc/events/aspire
• CMPA  http://www.cmpa-acpm.ca/
• CPSI  www.patientsafetyinstitute.ca/
3. GAIN NEW PERSPECTIVES ON THE ROLE OF CANADIAN MEDICAL EDUCATION: WHY AND HOW WE SHOULD DEVELOP PATIENT SAFETY CURRICULUM
THE LAST SAFETY NET: PATIENTS

ESSENTIAL PATIENT’S CAPACITIES TO DEVELOP

- Capacity to communicate and collaborate
- Capacity to understand disease
- Capacity to take care of himself
- Capacity to manage stress and anxiety
- Capacity to rehabilitate
- Capacity to be resilient
- Capacity to create new meaning
- Capacity to enhance experiential-based knowledge
- Capacity to build a different life project
- Capacity to understand himself through the illness

GROWING SUPPORT FOR PATIENTS

STRUGGLING SUPPORT FOR PATIENTS

CHALLENGES FOR MEDICAL EDUCATION...
PATIENT SAFETY CHALLENGES FOR MEDICAL EDUCATION FOR MD AND POST-GRADUATE PROGRAMS

1. DEVELOP STUDENT’S CAPACITIES TO MANAGE GROWING HUMAN COMPLEXITY, FACE CHALLENGING SOCIETY ISSUES AND REINFORCE PARTNERSHIP WITH THEIR PATIENTS

2. IMPLEMENT LONGITUDINAL COMPETENCY-BASED LEARNING: COMMUNICATION, COLLABORATION, PROFESSIONALISM, HEALTH PROMOTION, ...

3. INVOLVE SYSTEMATICALLY TRAINED PATIENTS IN PATIENT SAFETY CURRICULUM (INCLUDING DESIGN)
A NEW ROLE FOR PATIENTS

IMPLICATE SYSTEMATICALLY SELECTED AND TRAINED PATIENTS

1. MEDICAL EDUCATION

2. RESEARCH PROJECTS

3. CARE QUALITY IMPROVEMENT PROJECTS
TOWARD A NEW CULTURE OF COLLABORATION...

PATIENT SAFETY, A DRIVER FOR A PARADIGM CHANGE?

VINCENT.DUMEZ@UMONTREAL.CA
See You in 2014!

Ottawa, Ontario, Canada

16th OTTAWA CONFERENCE AND 12th CANADIAN CONFERENCE ON MEDICAL EDUCATION

Transforming Healthcare through Excellence in Assessment and Evaluation

2014

16th OTTAWA CONFERENCE
12th CANADIAN CONFERENCE ON MEDICAL EDUCATION

April 26-29, 2014