

# A Patient Perspective

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for patient safety and justice

# WHAT IS AvMA?

- An independent UK patients' charity established 1982
- *against* medical accidents, for patient safety and justice
- Provides medico-legal advice and support to individuals affected by a medical accident (about 5,000 per year)
- Work with the National Health Service, NPSA, health professionals and lawyers

What patients want...

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*Patient Safety*

*and Justice*

# ‘PATIENT SAFETY’

- First do no harm
- Benefits outweigh risks
- Qualified, competent practitioners
- Evidence base
- Safe environment
- Checks
- Lessons learned

# **‘JUSTICE’**

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- **“Fairness”**
- **Information**
- **Explanation**
- **Apology (if appropriate and real)**
- **Action to prevent re-occurrence**
- **Compensation**

# ‘PATIENT SAFETY CULTURE’

- “No blame” implies “no accountability”
- Although errors are usually systemic, they can be down to individuals
- Someone needs to be accountable, even for system errors!
- “OPEN & FAIR” better describes a culture conducive to patient safety
- Requirement of openness, there is still accountability, but consequences are fair and proportionate

# Essential Elements of a Safety Culture

- Open and honest with patients, and fair and proportionate with health professionals
- Fair systems of investigation and compensation
- Involvement and empowerment of patients

# ‘Open’ means Open and Honest

- An absolute moral, ethical (and ideally legal) requirement to report patient safety incidents to patients / their families
- Open reporting to patients is usually met with understanding – “***to err is human***”
- However failure to do so suggests a health professional is unfit to practice – “***to err is human, but to cover up is unforgivable***”
- Yet facts are hidden from patients on a regular basis – the scandal is that it is tolerated

# REPORTING SYSTEMS

- Too much emphasis on confidentiality & anonymity implies that failure to inform patients is tolerable
- Anonymous reports are better than no reports, but are only for the 'bad guys' or frightened whistle blowers
- An ethical health professional will already have informed the patient
- A confidential or anonymous report is no substitute for being open with patients

# Fairness / Justice includes Compensation

- “No fault compensation” ? – no thank you!
- If there is no fault, we don’t want ‘compensation’- just the treatment /care we are entitled to expect anyway
- If there is fault, acknowledgement of the fault is as important if not more important than the compensation

# Access to Justice that is more conducive to Patient Safety

- Corporate rather than individual liability (eg NHS – UK)
- Lessen the burden of proof (eg Denmark) or reverse the burden of proof
- Independence
- An ‘avoidability test’ : could the incident which caused harm not have been avoided by following accepted good practice / guidelines?
- Specialist advice for patients

# Put the 'patient' in 'patient safety'

- Involvement early in root cause analysis
- Specialist advice to empower patients in processes
- Involvement in planning, solution work and monitoring (see '*Patients for Patient Safety*' in UK – AvMA and NPSA and WHO)

# Some useful tools

- ‘A Charter of Understanding between Health Professionals and People affected by Medical Accidents’: see [www.avma.org.uk](http://www.avma.org.uk)
- ‘Being Open’ : see [www.npsa.nhs.uk](http://www.npsa.nhs.uk)

# Slogans?

- *“To err is human, but to cover up is unforgivable”*
- *“ethical health professionals do not need the protection of confidential reporting or immunity”*
- *“reverse the burden of proof for comensation”*

**Thank you for listening!**

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