Meaningfully Teaching Patient Safety to Physician Residents

BY BARBARA K. CHANG, MD, MA, AND LINDA C. WILLIAMS, RN, MSI, US DEPARTMENT OF VETERANS AFFAIRS

A resident may have lots of ideas for how things should be improved, . . . but until now there has been no framework.¹

Introduction and program history

Emphasis on quality and patient safety in residency training programs has become a pressing concern for graduate medical education (GME) programs. When the Accreditation Council for Graduate Medical Education (ACGME) revised its standards in 2011, the commitment to promoting patient safety and involving residents in interprofessional quality improvement (QI) and patient safety (PS) activities was incorporated into the common program requirements.² Further revision in 2013 strengthened the QI/PS requirements by designating them as “core” requirements—that is, those deemed to be necessary for each graduate medical educational program to meet.³

Nevertheless, many training programs have struggled to meet the QI/PS training program requirements due to a number of factors, first and foremost of which are: a) an insufficient number of faculty members who are qualified to teach patient safety and quality; and b) an institutional culture that views QI and PS as activities that are separate from ongoing, day-to-day provision of care to patients. Many teaching hospitals have approached these requirements mechanically, as “one more box to check off”—for instance, by scheduling a lecture or series of seminars or by engaging residents in short-term QI projects—rather than transforming the learning environment through changes in organizational culture.

The US Department of Veterans Affairs (VA) has long promoted change and innovation in medical education and beginning in 2007 began linking increased GME funding to development of innovations that incorporated an emphasis on PS and QI.⁴ The Chief Resident in Quality and Patient Safety (CRQS) program got its start as part of the GME Enhancement⁴ initiative and its Educational Innovations request for proposals (RFP), which allowed programs to propose innovative approaches to GME. The Indianapolis VA Medical Center (VAMC) proposed a new, nontraditional chief resident, who would focus on integrating concerns for PS and QI into residency education. A year later, a second CRQS site was added at the Omaha VAMC.

The VA’s Office of Academic Affiliations realized the value of the program and encouraged expansion of CRQS positions at other sites. By July 1, 2013, 42 CRQS positions were approved at 34 sites. Several sites were so enamored with the benefits of the program that they had applied for and were approved for a second position, often in a different specialty from the first position (see Figure 1). July 2012 saw the inauguration of the first year of the National Curriculum for CRQSs, discussed in more detail below.

CONTINUED ON PAGE 2
The Chief Resident in Quality and Patient Safety position (CRQS): What it is and what it does

The CRQS is a post-residency chief resident—ie, holder of a nonaccredited year position, which must nevertheless relate to an accredited, core training program, such as internal medicine. CRQS positions are open only to those licensed physicians who have completed their core residency training and are eligible for credentialing and privileging as licensed independent practitioners. Although most CRQS positions have been in internal medicine, the CRQS is not restricted to any program or setting. Current program sponsors also include anesthesiology, psychiatry, radiology, and surgery. Many CRQS incumbents are interested in hospital-based medicine, but some programs have focused on ambulatory settings.

The CRQS is both a learning and a teaching role, which includes training in QI/PS, as well as clinical and educational system redesign. Instruction includes both didactic and participatory (eg, simulation-based) learning, which is gained through attending the CRQS “Boot Camp” early in the academic year, participation in patient safety rounds and root cause analyses, working directly with QI/PS managers and their interprofessional teams, and participating in the National CRQS Curriculum and improvement projects.

Although those taking on the CRQS position initially have a steep learning curve, the individual is then expected to play a major role in the education of more junior residents by disseminating QI/PS information and methods. For example, in one program, the CRQS organizes an “Immersion Week” for post-graduation year 3 residents during their continuity clinic and supervises them on specific QI/PS rotations. The local curriculum includes clinical reminders and quality indicators, including “resident report cards,” and is updated annually and delivered largely by the CRQS. Some sites include Lean and Six Sigma training, along with the possibility of appropriate certifications, for the CRQS and other health professions trainees. CRQSs have implemented multi-professional morbidity and mortality (M&M) conferences that incorporate a systems approach to case discussion, migrating away from the “shame and blame” approach associated with traditional M&M conferences.

CRQSs are actively engaged in clinical activities, but spend no more than 20% of their time in direct clinical assignments. Nonetheless, the CRQS has an active presence in the clinical arena and involvement with residents on a frequent, if not daily, basis. In part, the CRQS program works because...
Getting On Board: Training Patients for Safety Rounds

BY ROBIN E. MOULDER, RN, BSN, MBA, CPHQ. MEMORIAL SLOAN-KETTERING CANCER CENTER

What we have to learn to do, we learn by doing.
—Aristotle, Nicomachean Ethics

The role of the volunteer in health care is important in improving the experience of patients in the hospital.1 Volunteers are often motivated by goals of personal fulfillment or the experience of a loved one. Because their service is unpaid, they are less likely to be subject to the dynamics of the employer-employee relationship. As a result, feedback shared with a patient volunteer is likely to be heard in a neutral way without the complications that could arise from sharing negative experiences with involved individuals.

Engaging patients to learn from patients

Memorial Sloan-Kettering Cancer Center (MSKCC) wanted to more fully involve patients in the safety improvement work of the organization and established a patient safety advisory council (PSAC) in 2007 to support that goal. Patients were recruited from the existing database of patient volunteers based on a self-defined ability to participate in team activities and for being comfortable with listening, expressing personal views, and asking for clarification in a meeting setting. A group of 5 patient advisors and additional staff members—from areas such as patient escort, nursing, patient advocacy, pharmacy, and the board—were selected to participate. The PSAC was co-chaired by a patient and a staff member.

The council was divided into two committees that addressed a majority of the items and that were in keeping with the organization’s goals and current interests: improving the medication reconciliation process and establishing the Patient Safety Rounds Program. This group developed goals for the program (see inset: Memorial Sloan-Kettering Cancer Center Patient Safety Rounds Program Goals), designed an interview tool, and outlined a training program for the volunteers who would be performing the rounds. This article describes elements of the program, explains how volunteers were trained, and discusses how other organizations might benefit from the MSKCC experience.

Patients actively receiving care may interact differently with volunteers who have “walked in their shoes” than with the staff actively providing care.

Elements of a training program

The Patient Safety Rounds Program (PSRP) was developed to collect data to evaluate what safety means to patients and to determine whether they, in fact, “feel safe” with the care they receive both in the hospital and as outpatients. Subsequently, the data was shared as feedback with frontline staff by patient and staff committee members. Part of the rounds program involved training patient volunteers (known as patient safety advisors) to conduct interviews with patients actively undergoing treatment. One of the committee’s goals was to establish opportunities for patients to communicate their experiences in a non-vulnerable manner,

CONTINUED ON PAGE 4
thus enhancing the institution’s culture of safety. Having the interview process conducted by patient volunteers enabled a safe, transparent culture of learning and inquiry. It was felt that patients actively receiving care would interact differently with volunteers who had “walked in their shoes” than they would with the staff actively providing care. All patients on the PSRP committee chose to participate in rounds. In order to increase capacity, patient volunteers outside of the committee were recruited and trained as interviewers with the help of the Patient Volunteer Office. All participants were required to be current volunteers in good standing at MSKCC.

Volunteers empowered through training

Training of the patient volunteers took place in two sessions. The first part of the training was informational. A job description for the patient advisors conducting interviews was developed and was discussed with each participant. Requirements such as dress code, specific confidentiality issues, and expected behavior were reviewed. Didactic presentations were given on interview skills, maintaining boundaries, etiquette, cultural consideration, use of eye contact, and when to call for assistance from staff. Infection control, as appropriate to the volunteer role, was also covered. The volunteers asked questions, such as what an appropriate response to a situation might be or how to handle patient requests, developed the role, and thought through the personal impact this volunteer activity might have on them.

The second portion of the training consisted of engaging patient volunteers in role play with a simulated patient using a professional actor. As discussed by Mast and Van Atta (1986), Malcolm Knowles’s work shows that adult learners retain and apply knowledge most effectively through an active learning experience such as in role play. As noted by Blatner (2009), the developmental psychologist Jean Piaget identified two types of learning: “accommodative” and “assimilative.” The use of role play creates an experiential learning that involves gaining a skill (as in accommodation) that is “almost impossible to fully forget.”

The use of simulated patients is effective in communication skills training. This practice benefits students as it facilitates the practice of new skills, provision of direct feedback, and real-time scenario adjustments. In addition, at MSKCC it offered the ability to create an oncology-specific set of tools. The usual disadvantage of this approach is the associated cost. MSKCC was fortunate to have 2 professional actors on staff who volunteered their time and talents to serve as simulated patients.

The scripts for the role play were developed by patient safety staff and the volunteer actors. There were 4 “patient type” scenarios designed:

The **angry patient** scenario allowed the volunteer trainee to develop a communication style and use language that was neither defensive nor confrontational.

The **manipulative patient** scenario focused on skill building for the volunteer to remain connected to the patient yet maintain boundaries. In this situation the simulated patient presented the volunteer with multiple requests, such as getting them water or more pain medication or helping them to the bathroom. The volunteer had to acknowledge the request and direct the patient back to the staff member (e.g., nurse, physician) or department (e.g., patient representative) most appropriately trained to safely respond to the request.

---

**Memorial Sloan-Kettering Cancer Center Patient Safety Rounds Program Goals**

- Establish an environment where patients are able to communicate their experiences in a non-vulnerable way
- Provide feedback on the patient and family experiences of health care delivery systems
- Educate staff on the role of patient advisors in communicating current patients’ safety needs
- Increase visibility of patient volunteer involvement
Are Patients Safer with Access to Their Own Health Records?

BY PEGGY ZUCKERMAN, EXPERT PATIENT

Does access to a patient’s own personal health care data spur that patient to be engaged in the safety of his or her care?

Not many years ago, most patients would have found that question confounding. They would have assumed no need to doubt the safety of their care in any health care setting, leaving such concerns to their various care providers. The occasional sensational story of an infection or a wrong-limb surgery would have been thought atypical, and certainly not of general concern.

That situation changed dramatically with the appearance of the Institute of Medicine (IOM) report To Err Is Human, the very title of which reminded the public that errors were possible in the very human health care setting. More dramatic were statistics that estimated that as many as 98,000 deaths arise from such errors annually.1 (A recent study suggests that the number is even higher—as many as 400,000 annually.)2 Although patient safety concerns had been examined in studies years prior to publication of the IOM report, the reaction to the report signaled the first widespread public recognition of safety issues in health care.

To Err Is Human indicated that errors often arose from faulty communications, with some emanating from misinformation in the medical record. The results of the problems were diverse, including treating the wrong patient, confusing one medication with another, or operating on the wrong side of the body.¹ It was hoped that as electronic health records (EHRs) came into wider use these errors would decrease. Nevertheless, it is reported that as “cumulative capabilities for electronic flowcharts, error checking and picture archiving and communication systems” grow, so does “concern over the potential safety implications of these systems.”³(p113)

Access to electronic records increasing

Despite the potential for errors in records and the challenges of dealing with new systems, the use of electronic records globally has increased dramatically. In a 2009 study, just 1.5% of US hospitals had a comprehensive electronic records system implemented across all major clinical units, and only 7.6% had a basic system that included functionalities for physicians’ notes and nursing assessments in at least 1 clinical unit.⁴

In a 2012 survey, using a different definition of “comprehensive electronic records system,” about 47% of doctors in 8 countries claimed routine use of electronically shared clinical data about their patients, up from 33% in 2011. Such records are here to stay, but with more changes to come, direct comparisons between benefits of past and future EHRs will likely be difficult.⁵

Other studies have explored how ready access to records has affected the patient-physician relationship. In 2012, 77% of Australian doctors stated that enabling patients to access their records had helped to reduce medical errors. They reported increases in electronic prescriptions as a result of the data becoming part of a single record. Others reported using clinical decision support systems when seeing patients. In much smaller numbers, they reported communicating with patients electronically in consultations and diagnostics.⁵

Although 66% of physicians claim they enter data into the patient’s record, there is little data to indicate that this is done during the appointment with the patient present.⁶ In fact, those same Australian doctors were less enthusiastic about allowing patients to modify information in their records, with the exception of changes to demographic data and family history. This suggests physicians

CONTINUED ON PAGE 6
may support sharing of general personal information with patients for the sake of correctness, while limiting the patient’s access to treatment and medication data.5

**Patient engagement increasing**

The American Medical Association (AMA) Code of Ethics, Opinion 10.02, supports an active role for the patient. “Patients have the responsibility to communicate openly, to participate in decisions about the diagnostic and treatment recommendations, and to comply with the agreed-upon treatment program.”6(np)

Having greater access to their records enhances patients’ ability to meet those responsibilities and to be served by their physicians. The AMA notes that “participation in medical education is to the mutual benefit of the patient and the health care system” and concurs that such education requires individuals to have access to the information in their records.6(np)

There is evidence that when patients are given access to their EHRs, especially when multiple individuals contribute to those records, patients are more engaged in their own safety. Jha and colleagues in 2009 note the presence of “clinical hazards as patients move from one unit to another”4(p1636) when some hospitals’ records are paper-based in one unit and electronic in another. The lack of uniformity between units within hospitals, as well as the lack of interoperability between and across systems, even those with electronic records, makes weighing the advantages additionally challenging.

The patient who finds and corrects an error in his name and address no doubt simplifies communication with his various providers. Such corrections alone can create a more complete record in that they can help to ensure that a given patient’s test results and comments from earlier physician encounters will be properly gathered. Patients generally assume that their physicians have complete records available, so the ability to provide missing elements of medical history, such as documentation of surgeries undergone or medications taken, can be essential for a comprehensive clinical view.

**Better access may mean safer care**

Does such access truly create a safer experience for the patient? Beyond the issue of the patient being treated on the basis of outdated information or with misidentified records, there appears to be a lack of definitive evidence as to the benefit. Given the nascent interest in availing patients access to their records, whether paper or electronic, it is to be expected that a mechanism to measure and define a relationship between that access, the quality of those records, and improved outcomes has yet to be defined, developed, and universally embraced.

In a review of the literature of the effects of permitting patient access to medical records, a shift in attitudes by physicians and patients is suggested.7 The studies ranged from the 1970s to the early 2000s and demonstrate an increased interest by patients to view their records, though far fewer actually do so. The earliest studies regarding such patient access were based on paper records and were stimulated by requirements established through the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA acknowledges the right of patients to access and amend those records. Naturally, such early records were not integrated into one single record, which has only become practical in the electronic era.

The Patient-Centered Access to Secure Systems Online (PCASSO) project at the University of California, San Diego, principally addressed security issues and access to medical records as HIPAA requirements emerged and as California’s legislature mandated that patients have access to their complete medical records. In addition to showing that patients and physicians could rely upon such records to be both generally and securely accessible, the project demonstrated that there were additional benefits. Over 70% of patients who viewed their records via the PCASSO project found
this chief resident is much closer to the residents’ level than are faculty, who may be too busy with other activities to spend as much time with trainees.

One noteworthy innovation was the initiation of patient safety consults (PS consults) at one site. PS consults are run by the CRQS and provide a means by which any clinical staff, including residents, can request a consultation regarding a perceived PS issue or problem. Such issues could include adverse events resulting in harm to the patient as well as near misses, such as medication errors without harm to the patient. PS consults were found to have two major advantages over the traditional ways that residents and staff report adverse events. First, residents felt less threatened by submitting a PS consult than when submitting an incident report, which felt to them like blaming someone or admitting their own mistakes, and in some facilities, residents were concerned about retribution from other clinical staff if they reported someone. Second, typical methods of filing adverse event reports provided no feedback loop, whereas, with the PS consult, feedback to the person submitting the consult is built-in and an important part of the educational process.

Outcomes of the program, as noted in testimonials from VA staff in institutions that have implemented the CRQS, include facilitation of beneficial changes in patient safety culture8 and the development of PS projects that have significant benefits for the institution.

**CRQS National Curriculum**

The National Curriculum was developed by the Office of Academic Affiliations in collaboration with the VA National Center for Patient Safety (NCPS) and with support from Dartmouth College. There are three major components. First, a face-to-face CRQS “Boot Camp” occurs early in the academic year. Prior to establishing the National Curriculum,
CRQSs. A grand rounds focusing on raising awareness regarding adverse event reporting by the Milwaukee CRQS was entitled *Safety Starts with “S,” but Begins with “You.”*

**Who benefits?**

**The patient**

Patients are the beneficiaries of safer care while seen in inpatient or ambulatory settings, as CRQSs have addressed a number of issues related to, for example, procedure protocols, medication reconciliation, and improved transitions of care. They may experience more efficient and safer admission, discharge procedures, and transitions of care (see Examples of CRQS Projects).

**The chief resident**

Participants gain perspective, knowledge, and skills that will last throughout that person’s career. Several CRQSs have gone into faculty or hospital leadership positions that focus on quality and patient safety. Regardless of the field of endeavor, however, the graduate’s ability to see health care from a systems perspective, constantly look for ways to improve care, and envision how to make it safer will remain part of that physician’s professional armamentarium and ethos.

**The residency training program**

Programs not only immediately close a teaching gap in order to satisfy accreditation requirements, but also produce physicians who are competent in addressing systems-based patient safety issues. The ability to produce graduates skilled in delivering safe care and addressing safety issues ultimately may enhance the reputation of the program and facilitate recruitment.

**The institution**

Institutions may see benefits that include not only improved performance metrics (eg, online report cards by which hospitals are compared), but also improvements in the financial bottom line, as complications and preventable readmissions are avoided. When a CRQS is present, the hospital benefits through active CRQS participation in problem-solving efforts whether in interprofessional teams (eg, root cause analysis or health care failure mode and effects analysis) or in finding innovative solutions to singular issues that otherwise might not be addressed. Moreover, a CRQS is a strong ally for spreading information and implementing change likely to improve health outcomes.

In summary, the CRQS program is designed to fill teaching gaps and produce immediate, short-term benefits to a facility in terms of QI performance metrics and avoidance of adverse events. Important for its success are its integration into teaching programs and a close relationship between the CRQS and residents. Longer-term benefits include dramatic changes in the patient safety culture of an institution and a growing cadre of clinicians who are well versed in providing safe practice and who can serve as the QI/PS faculty and leaders of the future. The CRQS program is a clinical education innovation that is still in evolution. Additional information about the model and its benefits will be made available as the program matures and the graduates publish the results of their interventions.

**References**


Meaningfully Teaching Patient Safety

CONTINUED FROM PAGE 8

The patient who goes off topic scenario provided the trainee an opportunity to develop communication skills in redirecting the patient back to the survey questions and to keep the focus of the visit on track. During this scenario the volunteer was challenged to handle questions about the volunteer’s opinion of the institution or the patient’s course of treatment or prognosis and to discuss the patient’s experience only with respect to safety issues.

The overly content patient scenario aimed to train the volunteer to increase patients’ comfort with discussing what they were not happy with in their care experience. This unique scenario was developed to support the intent of the rounds to elicit feedback that could be difficult to capture due to patients’ and family members’ reluctance to speak up when things did not go well. This scenario taught volunteers to rephrase questions and to frame the dynamic between patient and care team as a peer relationship rather than a hierarchical one.

Since training centered on role play required some risk taking on the part of the learner (eg, trying out new behaviors in front of a group), development of a safe learning environment was important. Patient volunteers were managed with this in mind and the committee handled this concern in 2 ways. A staff member unassociated with the project served as a group facilitator during the initial phase of the PSAC development. Additionally, each patient volunteer was encouraged to share their story and both positive and negative experiences as a patient in the group. Storytelling served as a powerful mechanism to create empathy and make sense of the experience for all involved.

Experience with the program

The volunteers reported the training to be helpful and supportive. While there were questions about certain technical considerations (eg, infection control procedures), the volunteers were comfortable from the beginning with their interactions with patients and staff. Giving patient volunteers adequate time to learn and allowing them to share their individual experiences in a safe environment were key factors in building cohesiveness among the participants. The volunteer group formed a true “working team” early on, and this enhanced their enthusiasm for and commitment to the program.

The volunteers brought a neutral perspective to both the data collection and survey tool revision process. Their experiences helped to suggest modifications to the survey tool that encouraged candid responses from the patients being interviewed. One such question was: “Patients tell us that there are times when their care could have been coordinated better either between the nurse
and physician or between physicians. Can you tell me of a time when you feel that your care could have been coordinated better?”

The volunteers’ comments on the Patient Safety Rounds Program focused mainly on, as one volunteer put it, “trying to get at the good stuff” that will influence change and improve the patient experience. One barrier that presented itself was the limited ability to implement PSRP with the non–English speaking patient. The group felt that having an interpreter involved in the interview might impact the volunteer-patient relationship and block feedback. A future focus of the volunteer program is to recruit more multilingual participants who can communicate directly with patients in their native languages.

**Motivation for spread**

Evolution of the program will include more direct feedback of the results of the data to staff and expanding the program throughout the system’s regional network. As new volunteers join the group, role play with simulated patients will continue to be a significant technique used in training. The use of rounding volunteers to conduct the interviews is a strategy that should be embraced beyond MSKCC by other organizations that seek to establish feedback mechanisms to inform safe patient-centered care improvement efforts. Anecdotally, benefits of the rounding program include:

- Use of the survey tool with patient volunteers creates useful data or information, rather than passing along anecdotal responses. The information is shared with the staff, who in turn become more aware of the patient perspective and can apply this new knowledge in their work.

- Patient volunteers convey empathy to the patient and a desire to “hear” their perspective and experience in a way that may be harder to accomplish through the professional-patient relationship, given their purpose is to complete each rounding conversation without the distraction clinicians might have due to other demands.

- In a hospital, the “customer” is the patient and the family. Gleaning information about their experience and creating a sense of caring about the safety of the environment and the care provided is crucial in preventing harmful events from occurring. It can lay a foundation for dealing with future experiences.

- Patient-focused care is just that. This model of patient safety rounding engages the patient/consumer at multiple points in their experience. First, information is captured at the time of treatment/care. Then, using as volunteers patients who are no longer in active treatment provides a positive connection to the organization. It also supports institutional growth and development through knowledge capture and sharing.

The volunteer base in a hospital or health system is crucial to how the institution is viewed in the community. Volunteers who are trained and invested in the system’s improvement become a positive voice to those around them, reflecting a message of hope and life. They represent an active and evolving community of people who favorably embody the institution’s services and care providers.

**References**


it either “somewhat valuable” or “very valuable.” The authors observed that the system allowed patients to find and report errors and “assisted clinicians in providing care.”

A clinical trial conducted at the University of Colorado Hospital examined patients’ and physicians’ experiences with an electronic medical records system in which patients were given access to their records. A group of patients with congestive heart failure who were treated in a specialty clinic of the hospital were randomly selected to receive secure online access to their records, including clinical notes and laboratory reports. At the outset of the study, physicians anticipated that patients would find such access to their records confusing or worrying, and fewer than half thought patients would find such information empowering. Post-trial, physicians reported that patients were likely to be less worried or confused and 100% of physicians endorsed the statement that patients were indeed empowered. In the course of the study, patients reported avoiding duplicative tests, confirming proper dosage of required medications, and relaying physicians’ instructions accurately to other providers. Physicians reported being more careful and thorough in writing notes, and they accepted patient-provided corrections to the records.

A more recent study comes from Beth Israel Deaconess Medical Center in Massachusetts, Geisinger Health System in Pennsylvania, and Harborview Medical Center in Washington. In an initiative known as the OpenNotes project, these organizations enabled patients to have access to doctors’ notes as well as their own records. Those patients reported clinically relevant benefits and minimal concerns.

The data demonstrate the benefit to the patients of access to their records and benefit to the physicians, who can confirm and document improvements that have been made to those records. Can these benefits be enhanced by the immediate sharing of that record as the physician and patient meet? The typical electronic health record can now be viewed on a computer screen in the exam room and as it is modified by the physician. Though there is some perception that use of a computer during a visit may adversely affect the personal interaction between physician and patient, it may in fact depend upon the manner in which the computer is used.

Physicians shifting to EHR systems were initially concerned about the negative effects they might have on their relationships with patients, while noting the benefits of more immediate access to records and online health data. Once those physicians became more experienced with their systems, those initial concerns were mitigated.

Studies and expert opinion support the premise that the engaged patient plays a more responsible role in his or her health care and that data and effective tools for sharing that data are vital.

They self-reported that the exam room EHR access supported effective patient-physician communication and collaboration.

A 2011 study found that physicians can engage patients in a collaborative sharing of data. This sharing was found to encourage greater activation by patients in managing their health, as they had access to not only to data but also to the physician simultaneously. Patients were inclined to be more engaged as they received approval for that interest through direct real-time interaction. This interest was also perceived as likely to continue over time.

A 2013 viewpoint article in the *Journal of the American Medical Association* recommends the expanded use of electronic tools by patients to access their records, test results, educational materials, and disease management reminders. The expansion of a patient record access strategy could include
Providing educational information in a mix of languages and reading levels, price comparisons of medications, advice on side effects of medications, and portals for asking questions and reporting adverse events.12

### Engagement, responsibilities, and safety

As noted above, studies and expert opinion support the premise that the engaged patient plays a more responsible role in his or her health care and that data and effective tools for sharing that data are vital. A key assumption of these publications is that patients will naturally seek out safe care. Will that same patient actively pursue engagement and safety activities currently being discussed in the larger safety movement—such as preparing questions prior to each clinician encounter and advocating for hand washing in their presence?13

The National Patient Safety Foundation found in 1997 that many Americans were sensitized to medical mistakes and perceived the health care environment as only “moderately” safe — safer than nuclear power or food handling, but less safe than airline travel or the workplace.14 Will greater engagement of patients in their health via access to their electronic records translate into the ability to recognize vulnerabilities in that care? That will depend entirely on the nature of the challenges to their well-being and the depth of their engagement.

Just as there is clear evidence that patients can be engaged in their health care, evidence has also shown that patients can learn to recognize and respond to opportunities to enhance the safety of their care. Effective access to data and records documenting that care can facilitate such engagement. It is the obligation of all parties to facilitate that opportunity. NPSF

### References


