



TEHRAN UNIVERSITY
OF
MEDICAL SCIENCES



MONASH
University

Ethical Aspects of Patient Safety

A Review of the World Health Organization's (WHO) Position on Clinical Ethics and Patient Safety

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GLOBAL PATIENT SAFETY ACTION PLAN 2021–2030

Towards eliminating avoidable harm in health care



World Health
Organization

What is patient safety?

Patient safety is: “A framework of organized activities that creates cultures, processes, procedures, behaviours, technologies and environments in health care that consistently and sustainably lower risks, reduce the occurrence of avoidable harm, make errors less likely and reduce the impact of harm when it does occur.”

Principle of
Nonmaleficence

The harm is
unintentional

The risk/harm is
avoidable

Different with
adverse events
and side effects

It is different
with Negligence

Importance of
Accountability

How big is the problem of unsafe care?

Every year, large numbers of patients are harmed or die because of unsafe health care, creating a high burden of death and disability worldwide, especially in low- and middle-income countries. On average, an estimated one in 10 patients is subject to an adverse event while receiving hospital care in high-income countries. Available evidence suggests that 134 million adverse events due to unsafe care occur in hospitals in low- and middle-income countries, contributing to around 2.6 million deaths every year. According to recent estimates, the social cost of patient harm can be valued at US\$ 1 trillion to 2 trillion a year.



Justice

Equity

Trust

Solidarity

Vision

A world in which no one is harmed in health care, and every patient receives safe and respectful care, every time, everywhere

Governments
Health care facilities and services



Stakeholders
World Health Organization

Mission

Drive forward policies, strategies and actions, based on science, patient experience, system design and partnerships, to eliminate all sources of avoidable risk and harm to patients and health workers

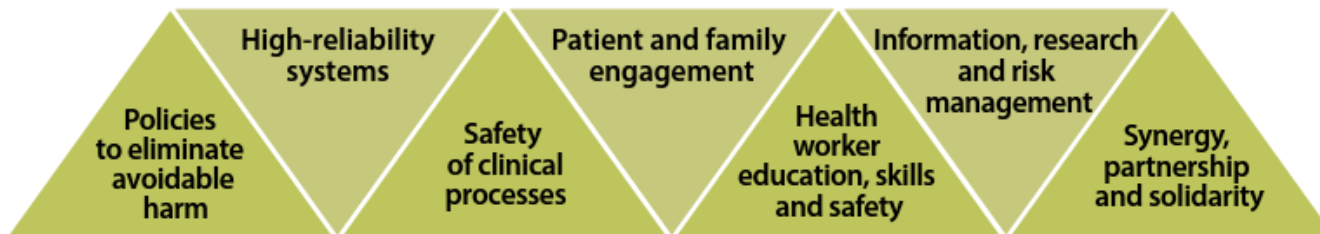
Goal

Achieve the maximum possible reduction in avoidable harm due to unsafe health care globally

Patients and families as partners
Results through collaboration
Data to generate learning
Safety culture



Evidence into improvement
Policies and action
Scientific expertise and
patient experience



Use both scientific expertise and patient experience to improve safety

Engage patients and families as partners in safe care

Base policies and action on the nature of the care setting

Achieve results through collaborative working



A word cloud centered around the phrase "INFORMED CONSENT". The words "INFORMED" and "CONSENT" are the largest and most prominent, written in a dark red, bold, sans-serif font. Surrounding them are numerous other words in various sizes, colors (including shades of brown, tan, and grey), and orientations (horizontal and vertical). The words are related to healthcare, medicine, and patient care. Some of the visible words include: "HOSPITAL", "HEALTH", "HEALTHCARE", "EXAMINATION", "DIAGNOSIS", "PROFESSIONAL", "TEXT FRIENDLY", "DIAGNOSTIC", "SURGERY", "THERAPY", "RECORD", "INFORMATION", "SURGICAL", "OFFICE", "CHART", "PEOPLE", "SIGN", "CLINIC", "DOCTOR", "PAPER", "MEDIC", "SURGEON", "MAN", "MEDICAL", "CARE", "MESSAGE", "PHYSICIAN", "INSURANCE", "ILLNESS", "MEDICINE", "TREATMENT", "PERSON", "CONSULTING", "REQUIREMENT", "DISEASE", "DOCUMENT", and "PEDIATRICIAN".

Strategic Objective 2

High-reliability systems

Build high-reliability health systems and health organizations that protect patients daily from harm

STRATEGY 2.1:

Develop and sustain a culture of respect, openness and transparency that promotes learning, not blame and retribution, within each organization providing patient care

Administrative and legal protection mechanisms for reporting adverse events or raising concerns

Independent Review of cases and procedures

No blame culture and non-punitive policy

Define clear-cut boundaries and distinctions between medical errors and medical negligence in order to establish a just culture

Reduce hierarchical structures, attitudes and behaviour throughout the organization, promoting a speak-up culture

Openness and transparency: patient and public disclosure



راهنمای عمومی اخلاق حرفه‌ای
شاغلین حرفه‌پریشی و
وابسته‌می سازمان نظام پریشی
جمهوری اسلامی ایران

۱۳۹۷



ماده ۹۳: بر اساس حق بیماران بر آگاهی از اطلاعات مربوط به سلامت خود، شاغلان حِرَف پزشکی و وابسته، باید در صورت بروز خطای منجر به ایراد خسارت، مسؤولیت عمل خود را بپذیرند و ضمن عذرخواهی و انجام اقدامات اصلاحی و پیش‌گیرانه، اصل بروز خطا و جزییات مربوط بدان، از جمله علل و عوارض ناشی از خطا را برای بیماران آشکار کنند.

ماده ۹۴: برای حفظ اعتماد متقابل جامعه و حرفه‌ی پزشکی، لازم است شاغلان حِرَف پزشکی و وابسته، در موارد بروز خطای منجر به ایراد هر نوع خسارت جسمی، روانی، اجتماعی و اقتصادی به بیماران، ضمن پرهیز از هرگونه پنهان‌کاری، با توافق بیمار و به‌صورت داوطلبانه، برای جبران خسارت وارد شده بر اثر بروز خطای خود، اقدام کنند.

منشور حقوق جامعه‌ی پزشکی ایران

ماده‌ی ۴۶. اعضای جامعه‌ی پزشکی حق دارند اطلاعات و تحلیل‌های مربوط به شکایات یا خطاهای رایج پزشکی و علل و زمینه‌های آن را که جنبه‌ی آموزشی دارد، از نهادهای رسیدگی‌کننده به خطاهای پزشکی دریافت کنند. از آنجا که ارائه‌ی این اطلاعات به اعضای حرفه، به کاهش شکایات و خطاهای پزشکی کمک می‌کند، سازمان

نظام پزشکی مکلف است با انجام‌دادن اقدامات لازم، از جمله انجام‌دادن پژوهش‌های تحلیلی، موارد مستخرج از پرونده‌های بررسی‌شده در سازمان را به‌صورت بی‌نام و با حفظ حریم خصوصی ذی‌نفعان پرونده منتشر کند و از سایر نهادهای رسیدگی‌کننده، از جمله سازمان پزشکی قانونی بخواهد نمونه‌هایی را که جنبه‌ی آموزشی دارند، در دسترس اعضای حرفه قرار دهند.

گر طیبانه بیایی به سر بایستم

به دو عالم ندیم لذت بیماری را



از توجه شما
سپاسگزارم .