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International Federation of Infection Control

IFIC e-News

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Terrie Lee
Chair, 2019
IFIC Board

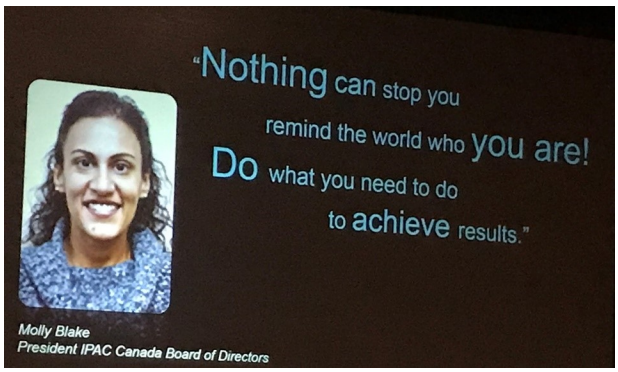
Chair Update

Message from the Chair and Greetings from the IFIC Board

Greetings from the IFIC Board! We were happy to see so many of you at the annual IFIC Congress, held in conjunction with IPAC-Canada in Quebec City, Canada. We enjoyed our time there, with the conference being held May 26-29. High points of the conference included plenary presentations from Alicia Cole, patient safety advocate, Michael Bell from CDC, Michael Borg (Graham Ayliffe award recipient), Mamta Gautam of Ottawa, Jason Stull from the Ohio State University, and a closing conversation with the audience by Michael Borg and Ruth Carrico.

Michael BORG, Terrie LEE

These sessions gave us many insightful looks at critical aspects of the work we do every day. In addition, there were several concurrent sessions, some of which were provided by IFIC member societies: Healthcare Infection Society (HIS), Infection Prevention Society (IPS), Association for Professionals in Infection Control and Epidemiology (APIC), and Australasian College for Infection Prevention and Control (ACIPC). Many thanks to these societies for their ongoing support of IFIC and for delivering timely evidence-based aspects of IP&C work.



Many sessions were provided by our colleagues from IPAC Canada and we appreciate their sharing their expertise on many topics. The conference also included sessions for oral presentations of abstracts, as well as poster presentations.

A very special thanks also goes to the scientific program committee. From IFIC there was Biljana Carevic, Birgit Ross, Nagwa Khamis, and Terrie Lee. IPAC-Canada members of the committee included Natasha Salt, Natalie Bruce, Ramona Rodrigues, Suzanne Rowland, and Nicole Kenny. Conference planning was provided by Gerry Hansen, Executive Director of IPAC, and her wonderful team of organizers. We thank all these individuals and groups for providing a tremendous experience for conference participants!

Inside this issue:

Chair update continued

We are grateful to the many industry sponsors of the conference. Our exhibit hall was very well attended and provided great information related to various aspects of infection prevention and control.

IFIC Scholarships to the conference were provided to the following individuals:

- Full Scholarship Recipient: Afolabi Oyapero, Lagos State University, Nigeria for an oral presentation of the abstract: Hand hygiene perception and practices among nursing students in Lagos State.
- Partial Scholarship Recipients:
    - Yvengenii Grechukha, NGO "Infection Control in Ukraine," Ukraine for the poster presentation of the abstract: Causes and consequences of the main mistakes in infection prevention and control in tuberculosis-specific hospitals.
    - Heidi Poole, Mayo Clinic Health System, USA for the oral presentation of the abstract: Increased effort required to decline influenza vaccinations.
- IFIC Scholarship funds were provided by:
    - Altrusa International of Longview-Kelso, USA
    - Association for Professionals in Infection Control and Epidemiology (APIC), USA
    - Infection Prevention and Control (IPAC) Canada, Canada
    - Ms. Glenda Schuh, USA
    - Swedish Association for Infection Control (SAIC/SFVH), Sweden

M. Cruickshank, E. Ridgway, N. Wigglesworth

We look forward to greeting you at the 2020 IFIC Congress being held in beautiful **Belgrade, Serbia, 11-14 March 2020**!

Recently, a call for nominations went out to paid member societies in Regions A & B for a seat on the IFIC Board. Elections will be held soon, so please watch for that activity and participate in the election!

Please contact me for any questions or concerns. The IFIC Board is meeting in September and we look forward to hearing from you.

Terrie Lee, IFIC Chair—tleewv@msn.com

IFIC annual conference 2019

2019 Conjoint Conference

IPAC Canada and IFIC
Québec City, Canada
May 26 - 29, 2019

T. Lavigne, N. Khawis, B. Carevic, C. Fortaleza, M. Cruickshank

IFIC annual conference 2019 (continued)

Elisabeth RIDGWAY, UK
IFIC Board member

As a new IFIC Board member (representing Region A), the Conjoint Conference with IPAC Canada was the first IFIC Conference I have attended for many years. Quite apart from a superb venue and a very interesting scientific program, the thing that really impressed me about the meeting was the great sense of community amongst the delegates. Although many delegates clearly knew each other, and were enjoying meeting up with old friends, they were equally welcoming to newcomers and interested to share their knowledge and experience. I particularly enjoyed the workshops because of the insightful contributions made by individual delegates. The sense that patients were at the center of all their efforts and are the motivation for improving practice was palpable, and this was reinforced by Alicia Cole's memorable presentation which clearly struck a chord with all those in the audience.

Nagwa Khamis, Egypt
IFIC Board member — IPAC/ IFIC scientific committee member

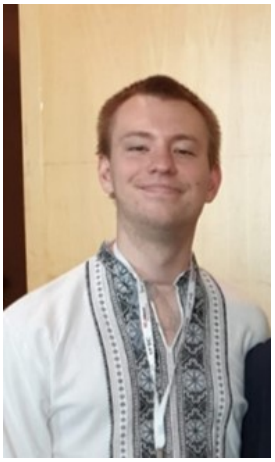
The IFIC congress this year was different, with a "Quebecois" taste, for me it was another important station in my carrier as IPC professional.
Being involved in many aspects of the event, I would rather say it was an immense "added value". Meeting, discussing, debating and mutually impressing would be a good indicator of merge between IPC professionals leading to fusion and melt of all kind of barriers.
I had the opportunity to represent my hospital/ country and change experiences with colleagues from around the globe; on the other hand, I had the chance to witness how "patients" would be the best ambassador for IPC in the new world overwhelmed with technology especially social media.

2 scholarship recipients

Afolabi OYAPERO
(BDS, MPH, FMCDS)
Nigeria

He's a consultant in dental public health and lecturer in the Department of Preventive Dentistry, Lagos State University College of Medicine.
He has a special interest in quality of life outcomes of medical conditions such as diabetes mellitus and their effects on oral health.

Yevgenil GRECHUKHA
(MD)
Ukraine



He's a young pediatrician with a big interest in infectious diseases.
He's working in the pediatric department of the Bogomolets National Medical University, Kyiv, Ukraine.
He's started to work in the field of infection control and prevention and was involved in the organization of a workshop about vaccination.

SumVac

IFIC annual conference 2019 :
Special guest: Mrs Alicia Cole, how I became a patient's advocate

***Thierry LAVIGNE (TL)*:** Hello Alicia Cole. I'm Thierry LAVIGNE. I'm a French physician, member of IFIC's board and I'm in charge of our newsletter. I did listen your communication at the IFIC-IPAC joint congress 2019. It was a very nice and touching presentation. Thank you. I thought it could be very interesting to have a discussion with you about your story and your patient's advocate activity, and to produce a report in the newsletter.

***Alicia COLE (AC)*:** My name is Alicia Cole and I'm a patient's advocate.

TL: Can you tell us your story?

AC: August 15th, 2006 was my first surgery. I developed necrotizing fasciitis. I had an open abdomen for three and a half years after that. And then I was doing physical therapy for about three and a half years. Starting and stopping because the new skin was so shear, thin and fine... it was like thinner than crepe paper or rice paper. It was kind of translucent.

TL: You told us that your surgeon did open your fresh abdominal scar in your room (not in the operating room) and without any precaution, neither any analgesia. Of course, sadly I know also some cases in my country. I'm an intensivist and I saw sometimes people making strange things like opening one or two stitches and pinching the scar with their fingers to check if pus is coming outside... I was shocked that he did it without anesthesia and that he did ask for help your mother.

AC: Now that I know better because I work in infection prevention. It makes me think when I look back at the pictures, I think he didn't even stop and get like the Betadine or the wipe to cleanse me off. And just, you would imagine that as a surgeon for many years, it would have been second nature to him before he cut anything, he clean it... or before he would do something in a deep organ space, in a deep cavity, that he would take the patient back to the operating room.

TL: He didn't even propose that to you?

AC: No. Well what I learned later was that this was not his first experience with necrotizing fasciitis. And that's why when he said "if this is what I think it is"… And when I asked him, he wouldn't tell me what he thought it was. And then I also learned that my hospital had an infection problem at the time. And they were trying to keep it very quiet.

TL: That's why the nurse gave you the information? She was shocked and she was afraid of what was going on.

AC: She knew that there was a problem going on and that the hospital did not want them discussing it. So that's why they were not permitted to talk to me openly about my infection and they had to do it secretly. And I later met several people who had infections in my hospital, within a few months before and after me. And it's very very devastating…

AC: You put your trust in a hospital and in the doctors to be honest with you and to really be transparent and share ... When we say informed consent: That means: you tell me everything I need to know to make a good decision. But if you withhold certain information from me, like the fact that you have an infection problem, then my consent isn't really informed ... because, perhaps if I knew you had problems you were working on, I could reschedule my surgery and say "let's do it after you have the issue resolved". Or "let's don't do it in OR 6". You should only use OR 7 and 8, because they know that something - that they haven't figured out - is wrong with OR 6.

AC: And so just as a patient, it's hard because you put your faith and your trust that everyone is doing the work as they are at the top of their game.

TL: And did you go to the court?

AC: Yes, we went to court which was an eye opener.

Mrs Alicia Cole, patient's advocate

(continued)

TL: You did go to court... Sorry for the question, did you go to the court for revenge or to have the answers to your questions?

AC: To have answers to my questions. And because the doctor in the hospital changed.

AC: When I first survived. I was so happy and full of gratitude. Having to fight my hospital was the last thing on my mind. I don't know if you remember that late night show... David Letterman used to have a talk show. He had a heart attack and when he came back to his show, he had a day where he brought all his doctors on TV and publicly thanked them. I was an actress. I thought. I'm alive. I'm safe. I have my leg. I don't care what went wrong. I'm going to have a big party and thank everyone: "team saved Alicia".

AC: But what started to happen was: I couldn't get aftercare and treatment. The insurance started saying "No". And I could not figure why my insurance kept denying my treatment. And so finally I learned that my doctor wrote my discharge papers saying that I was in excellent condition. Excellent health and able to go back to work in two weeks.

TL: He did lie?

AC: Basically, he lied... even when the health department inspectors came in. They made him rewrite the discharge papers because he did not include many of the things that are required on a discharge. And when the investigators from CMS and the Joint Commission came in. He was required to rewrite my discharge papers. But because he said I was able to go back to work in two weeks and that I was perfectly fine, the insurance stopped covering my wound care. They stopped covering anything.

AC: In the medical records when they sent them to me, were missing large chunks of time. And there were absolutely no photos in my medical records. All the pictures you see in my presentation were taken by my mother. The hospital said they never took photos of me. I said well that's crazy. That's ridiculous: of course, you took photos of me

TL: They did lose your medical records?... accidentally? It can happen but it's like they did try to keep no evidence.

TL: Usually when something happens (adverse effect or wrong evolution) ... The first thing we do is to take a photo ... so we can see the evolution. Good or bad.

AC: That's right... They took photos ... they absolutely took photos. It took me four years of writing letters to the Department of Health and Human Services and to the Joint Commission. A US Senator from California got involved. The governor of Ohio got involved. We did a letter writing campaign with friends and family. We sent over a hundred letters to different Government oversight agencies. Finally, someone told me to file a claim as a HIPAA (Health Insurance Portability and Accountability Act) violation with the Office of Civil Rights, because my medical records were altered. So that's a HIPAA violation. And the Department of Health and Human Services stepped in. And I had Polaroids that they had given me, that had the hospital grid on them. I had screenshots of the medical records where my doctor talked about the photos. And I had a picture, my mother took, of the nurse holding the camera over my open abdomen taking a picture. And I said "For four years you have allowed them to say I was delirious and on drugs. And imagining that they took pictures". And after four years they turned over the photos and said they were misfiled. With this kind of treatment, I had to go ...

TL: Why didn't they just explain to you that there was a problem ... Why didn't they just tell you "OK we did perhaps something wrong... something did happen" and why didn't they try to investigate what really did happen? As a physician, he must explain you that something went wrong …

AC: I think because ... As they knew they had an infection problem at that time. I found out later that

Mrs Alicia Cole, patient's advocate

(continued)

the month that I had my surgery, they began a study to reduce post surgical infections. I found out they had already been cited by the Health Department for infection control problems. And so, I believe, with me, they thought if we acknowledge the problem here, then we'll have to acknowledge it with the other patients as well. And then it could have become a major problem for them to acknowledge with the other patients as well as me. So, they had to vigorously deny my infection in order to deny the others.

TL: OK so, it became much bigger than just you. But they couldn't realize that this destroyed your life ... your acting career was going well, and you had very promising prospects. With what happened to you, you had no real guarantee of being able to resume your acting career.

AC: That's right. I was very disillusioned and very hurt by the things that I was seeing, and I learned ... and it's so funny thought because, had I been treated properly or had they done things correctly, I probably would not be an advocate today. Because I would have been able to get the medical care that I needed, I would have been able to go on with my life. But because they denied my health care insurance and because they wouldn't give me medical records and I started having to fight for things ... basic things ... They made me an advocate. I had no idea about that there was even such a thing as a patient advocate. But then they made me a patient advocate.

AC: I did often stay in bed because some days I had so much drainage with my abdomen when it was open, and all I could do was just lay in bed. And so, I started ... I said I'm going crazy. I'm going to do something. I can't just lay here. I bought a talk-to-type program on Amazon and started blogging about my experience; what I was going through; what kind of things patients need to know. At the time there was no Facebook; there was MySpace. I started a group on MySpace for survivors of infection. And then it grew to survivors of just medical harm in general. And before I knew it, I had almost 3000 people in my group. And they were sharing their stories. We were sharing advice.

AC: I got a call from a woman. Her husband was in my room. And they saw what I was doing. They lost their son: 15-year-old son, Nile, to infection ... MRSA infection at a hospital. And so together we went into create the two laws in the state of California for public reporting of hospital infection rates. And the law is named after their son Nile, Nile MOSS.

AC: So, we went in together for the law and then I got a call from the people at Consumer Reports and they wanted to do a story on infections. And they wanted to know about my organization. And I was like... "me? and my talk-to-type program?" And so, my mom and dad and I created a patient safety organization and we started speaking with other families.

AC: It's called ASAP for Alliance for Safety Awareness for Patients. We created a Web site and started handing out brochures. We started going to health conferences like that the news station would have or if a woman's group was putting on a health conference and we would partner with Consumers Union. Consumers Union was the advocacy part of Consumer Reports magazine and they had the safe patient project.

AC: They would give me hand sanitizers that I would hand out at conferences and I had little brochures about how to protect yourself when you go in the hospital. That was the beginning of my advocacy: talking to other patients and sharing. And then we passed the law. I was appointed to the Health Department committee in the state of California. And just grew from there, sharing and teaching, talking at nursing programs, talking at residency programs for doctors, ... Anyone that I could think of who would listen about infection prevention. Because I think it's important not just for health care providers, but patients and their family members need to know as well. And so, I try to talk to everyone.

Closing ceremony of the IFIC-IPAC congress

Mrs Alicia Cole, patient's advocate

(continued)

TL: You know in France. A non-profit organization called "le LIEN" started also with a story like your story. The patients created this organization because they didn't feel safe anymore inside the health care system.

AC: That's the thing that's going to help improve health care. It's not going to come from hospitals. It's like this quote from Albert Einstein: "You can't change something with the same mindset". You need that fresh perspective and that's what patients bring, because we see it from the other side... We see it from the gap in the system.

AC: And patients see it in an urgent way whereas health care is slow. "We take our time". "Well let's do a study". "Well we'll see how much does it cost". "What is the return on investment". "How many people have experienced this"... They have like a laundry list of obstacles and barriers and excuses often. Whereas because patients have been harmed in a real way and they're experiencing the burden financially, physically, emotionally. They see urgency to fixing the problem.

AC: You have that culture in the hospital. And what people don't realize is: culture is like the iceberg; you see what's on top. And on the top, they have their programs, their campaigns, all the things that look beautiful like a snow-capped mountain. But below the surface, you have the egos. You have the real beliefs .... Like, so many times doctors really don't think you can get to zero infections. They think that's unattainable; it's ridiculous; it's unrealistic and so, if you really don't think that you can prevent infections, how hard will you really try? ... And if you are a hospital that is resting on your laurels, you may not think you need to improve or learn something new. Are you a hospital that has some implicit biases about your patients? Or it's only that demographic that gets the infections... the smokers, the obese, the elderly, ... so there's so many underlying issues... why these hospitals are slow to accept change, progress and improvements.

AC: It's not because it's the right thing to do. Change should happen because it's the right thing to do.

TL: What about the surgeon himself?

AC: When I met him, I saw him as very confident. He said: this is what we're going to do. I do open incision operations, I don't do laparoscopic procedures. So, this is what we're doing. And I saw him as a confident man. When things started to go bad. I saw that, that was not necessarily confidence but arrogance. Then, when things went bad, the way he treated the nurses. It was a different way than when things were going well. Even so. I saw him as a human who felt badly. He was not an evil man... He cried. I know that man cried. I know he felt bad.

AC: And I felt bad. I still went to him even after I got out of the hospital. I came and we cried together. But as soon as I couldn't get bandages and I couldn't get services, and when I would ask him: he didn't know. He would say: he didn't know why they wouldn't cover that. I called my insurance company and had a long talk with my insurance company: I learned what he wrote. And then I started learning of these other things that the hospital had put in place to protect themselves.

That were: Prohibiting me from getting the necessary treatment I needed going forward. That's when I said: maybe this man isn't doing everything, he can to help me heal. He's protecting himself first. I was so naive. At first, I just didn't imagine that. Because I was still as I told my friends, this is "team saved Alicia". And I believe that he started out being very sincere initially. In his pain and his sorrow for what happened to me. I think he started out very sincere. But when, I think, I started to discover things that had gone wrong and to really start to understand the scope of the negligence and the malpractice. I think that's when his defensiveness and his lawyers kicked in. And that's when I had to stop going to him for aftercare. That's when I started because the behavior changed. The compassion was gone. It was more … eluding questions to elicit certain answers from me, so that he could say on record: what she said, this and this, and that

Mrs Alicia Cole, patient's advocate

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kind of things.

TL: At the time you were treated there, was an infection control team there?

AC: They had one part-time infectious disease specialist I learned. And as part of their plan of correction from CMS, they had to make that infectious disease specialist full time.

TL: Despite what did happen to you, you didn't lose your mind?

AC: I was close. And that's also what I want to share. You cannot imagine the mental and emotional strain it puts on a patient and their family and their loved ones.

AC: Because it's such an emotional rollercoaster. You start making progress, you feel good. Then you have a setback and instantly everybody's terrified. What does that mean? What's going to happen? Are you going to be back in the hospital? Have you used up all your insurance? How much is this going to cost? I've used up all my family time. And you're trying to coordinate help between your friends, your co-workers, your family, people who can take you to the doctor and you're fighting depression. You're fighting PTSD (posttraumatic stress disorder). You're fighting the disillusionment of what you thought the health care system was. You're afraid to speak out because you know you must continue going to doctors. And so, you don't want to be seen as a problem patient. So mentally, it's a very hard thing to get through. A lot of crying. A lot of not sleeping.

TL: It's a private question. Your family did stay with you?

AC: My mother and father came for two weeks from Ohio to California thinking they'd be there for the surgery and leave and go home. And they ended up staying with me for eight months. And then when they left, my sister came for three weeks. And when she left, my aunt came for two weeks. And when she left, my parents came back for three months. And so on ... through all.

TL: Thanks God you had your family.

AC: Yes. I'm truly blessed. And that's another reason that I speak. It's because so many patients don't have the support network that I had. I want the health care community to understand that sometimes these patients are alone and they're counting on you to protect them and to advocate for them. And they're trusting you because... we really don't know. Like I told my parents: don't come. I'll be fine. I don't need you to come from Ohio. I would be dead if my mother had not seen that black dot on my scar.

AC: Because I thought "Oh, I'm into one of the best hospitals in California. I'm good. I'll be out in no time". So many times patients don't have someone to come with them, but they're trusting that they've picked a great doctor; they've picked a great hospital; that the doctor and the hospital are doing everything they can and operating at the best of their ability in a facility that is cleaned and safe to the best of the facilities ability. Those are the things we trust as a patient. And you must be able to trust in order to allow someone to put your body to sleep, cut on you and touch you.

AC: That's why it's so important for health care to rebuild those bridges of trust with the patient. It's important because that's the foundation of our health care system. The trust between a hospital and its customers. And a doctor and his clients.

AC: You know we say patients ... and patients when that whole word can contain so many things that are dismissive. But when I say: I'm your customer; I am the paying customer. That gives a little more weight.

TL: Yes. It's a commercial contract.

TL: Can you tell me your "take home messages" to transmit to everyone, our societies, our infection control teams who are reading our newsletter.

AC: I think the first thing, I would tell the infection prevention societies is that they have to own their knowledge and power. Own it and be confident about your specialty. Don't let a doctor or an administrator influence what you know is best for your patients. That means if time is of the essence, you put a fire under them. If they need resources that you don't have, you go and talk to a trustee and you get that money allocated.

AC: And you educate! Educate the environmental staff on their importance. Because they're not cleaning a hotel room. They're cleaning a hospital. Big difference. You educate the nursing staff at the bedside that they have life and death in their hands with every decision. And then, you educate the doctors. And for this one, you must get a physician champion on your side to begin to re-educate doctors. That you are their equal counterpart. That you are a specialist. And you are willing to stand your ground and demand respect before resources are spent and before patients are harmed..

AC: And the bottom line is: patients are counting on you. We need you. That's because as the infec-

Mrs Alicia Cole, patient's advocate

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tion control person, infection prevention person, you have to explain us ... you are the one who did study this ... when the doctor comes in and say: well let's just wait on that a little bit... We must be able to say NO.

TL: In your opinion, should IPC societies include patients in their members? Would this be interesting for you?

AC: I would love to see those societies begin to... Like I think, this conference (IPAC-IFIC conference) is doing a wonderful job with the patients' scholarships. And I've met several patients here. I think more conferences and workshops should include patients and patient's advocates. Because then we go back and teach one another, and it spreads the information. And then also, when I saw Dr. M. Bell (from CDC in Atlanta) talked about in some countries there are no nurses, the families are the ones that is cleaning. In those cases, I would love to see the infection prevention team teaching them how-to do-good cleaning technique of the patient; how to bathe them properly; How to... I mean if we're in a situation where that's all you have, then let's show them how to do it the right way. Because you have to start where you are. And if you're in a situation where you don't have many nurses and it's the family who takes care of them, then let's start having some workshops to educate those families right away so that they're using good techniques. They're not sitting on beds with them. They're not contaminating the environment and spreading ... and everybody's getting colonized.

TL: But more specifically, should we include in the board of our societies a patient or a patient's advocate? I mean the board with a full voice for voting...

TL: In France, we don't have to include a patient in our society board, but inside the hospital, we must include a patient in the Committee in charge of infection control and prevention. The patient must be a representative of a patient's defense association. And I'm not so happy with that ... because, for example, the person, which is joining us in my hospital, is a professional from the consumers union. Half of the time she's not coming. She's always busy. She has a lot of jobs to do. She's not like you. She's not involved like you. She's not a full-time patient's advocate.

TL: I will be honest when I saw this new law, I was scared in the first place. I thought it will be just more difficult to have a lot of discussion when she's here on the committee. But now, two years later, I can tell it was not a problem because she's not active... What do you think about this system, with this patient's association?

AC: I would like to see a patient like a real patient. Not a patient representative from an organization. I've been on many committees and I'm even on a presidential advisory council appointed by President Obama. I'm the only one who represents the consumers of America on this presidential council. What I find on a lot of committees is: everyone has someone to answer to. That influences the decisions that they make on that committee. So, you don't often get practical real-world bedside type decisions made. You get a lot of academic solutions, a lot of studies that come out of these committees. You don't often get practical hands on right now solutions. Patients bring immediate examples and often they're dismissed as anecdotal.

AC: However, for example, if you're on a committee with five doctors who represent their hospitals, you already know what they're going to vote on everything for the most part. And then if you've got three people from industry, you know how they're going to vote. If you've got two people from academia, they're going to always opt for a study. Whereas a patient representative ... and you must be selective... You don't want a patient who is bitter and angry and can't express themselves. You don't want a patient who has, for example, a child or a spouse who is being treated at the hospital who is hosting the committee because they're not going to say certain things, because they don't want to jeopardize the care that their loved one is getting. But you do want a patient who has been through some

Mrs Alicia Cole, patient's advocate

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things who maybe has written a well written objective, a clear letter back to a hospital or an association outlining some things that they've seen that could be improved. And there are hundreds of patients, over the life of the hospital, I know who have written cohesive intelligent letters saying this is what I experienced in your facility and I'd really love to see you work on this. Find those people. Because they've been able to articulate and work through their feelings to try to help improve the situation. So, if we find that kind of patients to have one sit on a board … and honestly it should never be just one. Because with one patient, you get only one little voice, and everyone dismisses their comments with platitudes, and they all pat you on the back and they play catch you. Which is condescending. But if you have at least two, maybe a parent caregiver and then an actual patient. Then you're getting more than just one patient perspective and you're getting someone who can help build the confidence of the other person. Because I can tell you, it is very hard to be the only patient in the room in a roomful of doctors who don't even acknowledge nurses and their peers. You must be a very strong, very special kind of patient to not let that intimidate you and shut you down. And this is the reason why a lot of times when patients get on committees like they may at first try to speak up, try to say things, but if they see: they're always getting shot down.

I'll give you a perfect example. My friend Ray. Her husband died horribly at a major teaching hospital. After she became a patient's advocate, later she was invited to be on the quality and safety committee for that hospital because they said they wanted a patient voice. Only what they were doing is, every time they had a meeting, they had already made all their decisions and it was just basically reporting out to the committee. So, they never really took any suggestions. They let you say whatever you wanted to say, but the decisions were already made. And when she would bring up something, all the doctors in the room would give her all these reasons why not. Why that can't happen; why we don't do that. "Oh well yeah. But you really don't understand". And she was going to quit the committee. And she called me up in tears and I said "No, no, you're not quitting that committee, that's not what we do. We are advocates. We are strong. We are fighting for people who can't fight for themselves. You are fighting for your husband who is no longer here. You're going to call the chair of the committee. And you can have a talk with him. And you're going to say: I don't understand the process. My original thought was that we're here to bring new fresh ideas, but I feel as though you were just reporting to us what you've already done. And I don't want to waste your time or mine. And I think going forward; I would like to have a more proactive role". And she was just very honest with him and I think it caught him off guard, because he realized she's right. We have been dancing around that and they've kind of changed the way the committee was operating. But you've got to have someone who is not afraid to go up against a bunch of doctors and scientists in the room.

TL: In my hospital, sometimes in the Patient's Safety Committee, the two patients were doctors... Retired, but from my hospital. And nobody did feel uncomfortable about this.

AC: I'll tell you why. They say sooner or later, everybody's a patient. And I answer: excuse me! No! No! No! No! There's a difference when we're talking these kinds of categories. I've been told before when I ask about patients.

TL: Even when you're a doctor as a patient: it's not easy to talk. Some of my colleagues had health problems and had to go to the hospital. They couldn't say something when they witnessed something wrong. They told me: I'm not OK with what I saw, but I'm afraid they would change their attitude in front of me and that I wouldn't be treated normally anymore.

AC: Isn't that very telling of the system? Then even though you are a provider, once you become a patient, you lose all your rights... You lose your rights; you lose your respect. You can be a highly respected architect, a highly respected professor, a highly respected heart surgeon... But once you put on that gown, suddenly you're seen as less than.

TL: Thanks a lot for your time and for all the work you're doing.

See also :

- https://patientsafetymovement.org/advocacy/patients-and-families/patient-stories/alicia-cole/
- https://www.imdb.com/name/nm1036404/bio?ref_=nm_ov_bio_sm
- http://4patientsafety.org/staff/alicia-cole/

Videos :

- https://youtu.be/TVtTEerE0vo
- https://youtu.be/67vDXQMxUz4

Regional contribution : Region C

Biljana Carevic, IFIC board

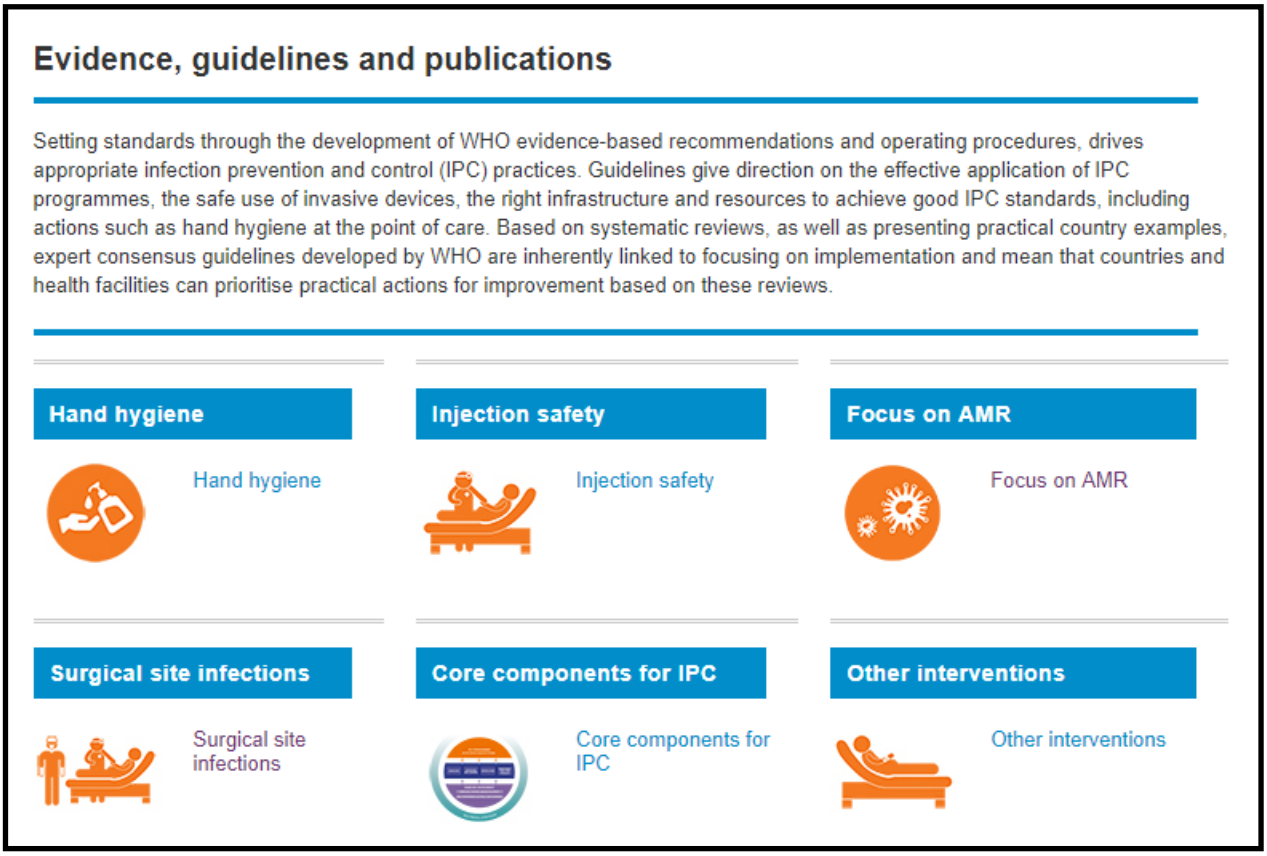
The **Serbian Association of Prevention and Infection Control** (SAPIC) was founded in May 2007 with the following goals:

1. to improve the health of the population by preventing and reducing the risk of hospital infections;
2. to affirm an interdisciplinary approach in prevention and control of hospital infections;
3. to enable domestic and foreign exchange of experiences in the prevention and control of hospital infections;
4. to organize scientific and professional meetings, congresses and seminars;
5. to organize lectures and visits of experts from abroad;
6. to conduct research in the field of hospital infections;
7. to educate new experts interested in hospital infections and
8. to launch a professional journal together with other publications in the field of hospital infections and related disciplines.

From 2014 to 2017 we have organized and repeated three times Basic Schools of IPC and we are happy to say that more than 120 participants from Serbia, Macedonia and Montenegro successfully finished our four days of training.
Until now, the most significant event in the organization of the Association is the 6th EurAsia Congress of Infection Diseases, Epidemiology, Immunology and Clinical Microbiology in 2014.
4-5 of October, we have organized a two days Course, we used WHO Guideline of multimodal strategy for Hand Hygiene. We are pleased to say that Dr Nizam Damani was our invited speaker and he held a practical training. Participants (40) had an opportunity to hear from Ann Versporten (G PPS Coordinator) what kind of changes have been made in a new Global PPS study protocol.
SAPIC works closely with similar domestic and international associations in order to exchange knowledge, experience, staff and publications and it is a registered Member Society of IFIC since 2007.

WHO Global Infection Prevention and Control Network

https://www.who.int/infection-prevention/publications/en/



The IFIC's new website!

Please visit our website and give us any feedback!

http://theific.org/

International Journal of Infection Control

The International Journal of Infection Control (IJIC) our fully open access journal continues to be published quarterly. Editor Kathy Suh, of Canada, has been focusing efforts on improving the turn-around time between submission of manuscripts and the final publication decision.
IJIC welcomes submissions that cover topics of interest related to infection control, especially from low and middle resource settings, and encourages members of IFIC societies to submit their research and practice findings to IJIC (https://www.ijic.info/index).

SUBMIT MANUSCRIPTS TO THE INTERNATIONAL JOURNAL OF INFECTION CONTROL

We invite you to submit your manuscripts to be considered for publication in the International Journal of Infection Control (IJIC). The aim of the journal is to provide a forum for staff working in infection control (IC) to disseminate research and practice information, and encourage IC initiatives on an international level. IJIC welcomes submissions that cover topics of interest related to infection control, especially from low and middle resource settings, and encourages members of IFIC societies to submit their research and practice findings.

IJIC is a fully open access journal, available online at www.ijic.info. It is published online only, usually quarterly. There is no cost for publication of accepted manuscripts, or for access to the journal. Submission is performed online and you can keep track of the whole process in the authors' section of the IJIC website.

For more information, please refer to the journal website. Once on the website, the Instructions for Authors outlines the different categories of manuscripts as well as general guidelines for manuscript preparation and formatting. We look forward to your submissions!

See the current issue of the journal:
Vol 15 No 4 (2019)
Published: 2019-12-11

Original Articles

The development and effect of the education program on hand hygiene and use of personal protective equipment: A randomized controlled study.
Eun-gyeong Kim, Ihn Sook Jeong

Factors influencing hand hygiene compliance of healthcare students.
Salah H Elsafi, Shahad Y Al-Howti

A comparative study of practicing cross-infection control of dental prostheses and implant components among prosthodontists and dental technicians in Qassim province, Saudi Arabia.
Nabila Ahmed Sedky

Sharps injuries among health care workers in Al Ahsa region, Saudi Arabia.
Hanan Ahmed Al Shaikh, Maher Mohammad Al Mahdi, Balaji Rama Naik

Short Reports

Evaluation of the acceptance of three types of alcohol-based hand sanitizing solutions by nursing professionals at a university hospital.
Ignacio Hernández-García, Teresa Giménez-Júlvez, Laura Zazo, Silvia Veleda

http://www.ijic.info/

SAVE THE DATES!

Our Twentieth International Conference will be a stimulating event, and is planned for March 2020, in beautiful Belgrade, Serbia.

The conference will provide up to date infection prevention and control topics, a mix of plenary and concurrent sessions, and presentations from international experts, with some sessions offered by our member societies. IFIC will continue to include opportunities for attending workshops, with topics presented in a comprehensive, participative format, allowing for open discussion and exploration of issues, and the practical application of in-depth material. With this mix of detailed, contemporary content, along with traditional sessions of cutting edge infection prevention and control content, we have planned a conference that will be of interest to anyone in our professional field.

Belgrade, capital city of Serbia is a perfect location for the IFIC annual conference. Built on the confluence of the Danube and Sava rivers it has a rich history and a varied architectural and cultural heritage. It is also an upcoming tourist attraction, with notable and beautiful landmarks, great gastronomy and a rich nightlife.

On behalf of IFIC and the local organizing committee, we look forward to welcoming you to the Twentieth Congress of the International Federation of Infection Control in Belgrade!

http:// www.ific2020.com/

Conference venue
Hilton Belgrade
Kralja Milana 35, Belgrade, Serbia, 11000
Website: https://www3.hilton.com/en/hotels/serbia/hilton-belgrade-BEGBSHI/index.html

Abstract submission
Abstracts will be accepted through the conference website from 15 November 2019. ***The deadline for submission is 05 January 2020.*** *The final decision will be communicated by 17 January 2020. Submissions can be either research based or practice oriented.*

Registration
Conference registration will commence from 25 November 2019. Early bird reduced fees will remain applicable until the ***01 February 2020****.*

Congress language
The official language of the congress is English. Simultaneous interpretation of the plenary sessions and one of the parallel sessions to Serbian will be provided.

SAVE THE DATES!

2020 – The Healthcare Infection Society 40th Anniversary year!

In 1979 a group of UK medical microbiologists formed a society aimed at fostering the scientific interests of those who were interested in nosocomial (or hospital-acquired) infections. The first formal meeting of the Society took place in 1980 and a journal was launched. Now known as the Healthcare Infection Society (HIS), the Society has over 1000 members and publishes the Journal of Hospital Infection (JHI), a leading publication in the field of healthcare-associated infection, and a gold open-access online journal called Infection Prevention in Practice (IPIP). The Society aims to provide healthcare professionals with the information, evidence and skills they need to prevent and control healthcare-associated infections and to promote and publish high-quality research.

In 2020, the Healthcare Infection Society (HIS) and the Journal of Hospital Infection (JHI) will celebrate their 40th anniversaries with a series of events and initiatives. The highlight of the year will be a special educational event to celebrate the achievements of the Society and the Journal. The meeting (open to HIS members) will take place on 10-11 June in London and will review 40 years of progress in the science, education and practice of preventing healthcare-associated infection, and will explore how we can use this knowledge to address future challenges. The programme is currently being developed and updates will appear on the website. Information on how to join HIS can be found on the Society's website here.

Don't panic! | 23 June 2020 | Hilton Manchester Deansgate, UK

The annual Don't panic! conference takes a practical approach to current infection control issues and will be of interest to microbiologists, infection control practitioners, public health staff and biomedical scientists working in this area. More information will be available shortly on the meeting web page https://his.org.uk/training-events/dont-panic-2020/

FIS / HIS International 2020 | 8 – 10 November 2020 | EICC Edinburgh, UK

In November 2020, the Healthcare Infection Society will host the Federation of Infection Societies (FIS) conference in Edinburgh. FIS is a unique conference that unites a collaboration of 17 UK societies with interests in different aspects of Infection Control, Infectious Diseases and Clinical Microbiology. The 2020 conference will bring together distinguished speakers from across the world and deliver a programme with broad appeal to infection specialists, and particularly to Infection Prevention practitioners. Make sure you are part of this exciting event, which usually attracts over 700 delegates https://his.org.uk/training-events/fis-his-2020/.

If your society is a member of IFIC,
Send us your important announcements.
We will publish it in this section!

The IFIC Borad member (from left to right): *Dr Linus Krimi Ndegwa from Kenya, Pr Dr Nagwa Khawis from Egypt, Dr Carlos Magno C. B. Fortaleza from Brazil, Dr Marilyn Cruickshank from Australia, Dr Thierry Lavigne from France, Dr Donna Moralejo from Canada, Dr Neil Wigglesworth from UK, Dr Elisabeth Ridgway from UK, Dr Biljana Carevic from Serbia, Mrs Terrie Lee from USA.*

ProMED - the Program for Monitoring Emerging Diseases - is an Internet-based reporting system dedicated to rapid global dissemination of information on outbreaks of infectious diseases and acute exposures to toxins that affect human health, including those in animals and in plants grown for food or animal feed. Electronic communications enable ProMED to provide up-to-date and reliable news about threats to human, animal, and food plant health around the world, seven days a week.

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We hope to continue to satisfy all our readers!
Don't hesitate to make any comments or to express your wishes for this eNews.

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