

GUEST EDITORIAL

The hidden sharks of clinical practice

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‘The doctors of tomorrow will be applying knowledge and deploying skills which are at present unforeseen.’ This was written by General Medical Council, UK in “Tomorrow’s Doctor” 1993, (General Medical Council, 1993), but this still holds true. We as health care providers strive to provide best of care to our patients and perhaps doing a good job. You may object to this “perhaps “as obviously at a glance the health care appears optimal. But we do not know that underneath this poise and calm sea are deadly sharks that gulp and bite our results. Statistically speaking, there is one in eleven million risk of being bitten by a shark. In comparison, the risk of patient death occurring due to a preventable medical accident, while receiving health care, is estimated to be one in three hundred. It is obvious that you are safer in diving in the ocean than receiving a treatment at a health care facility. Yet it is preventable. This preventable medical accident is the hidden shark of our clinical practice that bites our results without us even knowing about it.

Hippocrates defined patient safety as *primum no nocere*, or “First, do no harm.” Yet we discovered it quite recently. A television program by the name of “Deep Sleep” aired in April 1983 first shocked the public that six thousand patients die due to anesthesia related deaths. In 1983, the Harvard Medical School and the British Royal Society of Medicine, jointly sponsored a symposium on anesthesia, deaths and injuries. They also agreed to share statistics and to conduct studies for all anesthesia accidents. In 1984, the American Society of Anesthesiologists (ASA) had established the Anesthesia Patient Safety Foundation (APSF). The foundation marked the first use of the term “patient safety” in the name of a professional reviewing organization. The Australian Patient Safety Foundation was founded in 1989 for anesthesia error monitoring. Both organizations were soon expanded, as the magnitude of the medical error crisis became known. The studies expanded to all specialties, areas and actual impact was measured. It is now estimated that that healthcare errors impact one in every ten patients around the world, the World Health Organization calls patient safety an endemic concern.

Alarming, isn’t it?

Yes, it is quite an alarming situation and it is the time that we all

must blow the whistle to this global as well as regional problem. We are at very initial stage where most of us are not even aware of its serious concerns. The waters are infested with sharks, and we must know and learn how to tackle them.

The errors typically include surgical, diagnostic, medication, devices and equipment, and systems failures, infections, falls, and healthcare technology. Wrong or missed diagnosis and side effects of drugs are more common. No area of health care delivery is exempt, but they occur more so in emergency room and outpatient clinics. (Bari, Khan, & Rathore, 2016)

Errors are classified as two types:

1. Errors of omission occur because of actions not taken. Examples are not putting a strap to a patient.
2. Errors of the commission occur because of the wrong action taken. Examples include administering a medication to which a patient has a known allergy.

You must be wondering why I chose this in a medical education journal. First and foremost, it is one of serious international health concern in the current era. Globally, almost a million patients die each year along with the cost associated with medication errors of about \$42 billion USD annually. Secondly, the key to the solution lies with medical educationists. By now, you must be wondering how medical educationist could solve the predicament. Well! The solution lies in developing skills like communication, organization, teamwork, leadership, and decision-making. Not just the skills but also patient safety attitudes have to be adapted along with developing a “safety culture” at work place (Ayub & Khan, 2018).

Our doctors of future and health care centers will only be safe if the safety is taught and assessed, at every level of learning and teaching. The culture of patient safety is created by identifying errors, developing systems based on newer technologies to recognize and correct errors. A broad range of safety culture properties can be organized into multiple subcultures like leadership, teamwork, evidence based patient care, communication, learning from errors, identifying systems errors, and providing patient centered care.

Currently the issue is remotely addressed in learning and teaching at both graduate and postgraduate levels. It is imperative that medical educationist should play their role by not only learning but also teaching all the necessary skills required to develop a safe environment for patients. The waters are full of sharks, and we must take protective measures.

Stay safe

References

Ayub, A., & Khan, R. A. 2018. Learning to cure with care: Awareness of faculty and medical students about students' roles related to patient safety. *J. Pak. Med. Assoc.*, 68(9).

Bari, A., Khan, R. A., & Rathore, A. W. 2016. Medical errors; causes, consequences, emotional response and resulting behavioral change. *Pakistan J. Med. Sci.*, 32(3) doi:10.12669/pjms.323.9701.

General Medical Council, U.K. (1993). *Tomorrow's doctors: Recommendations on undergraduate medical education*. London.