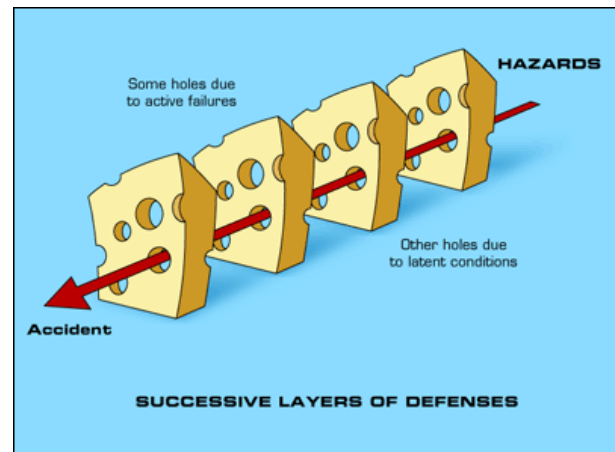
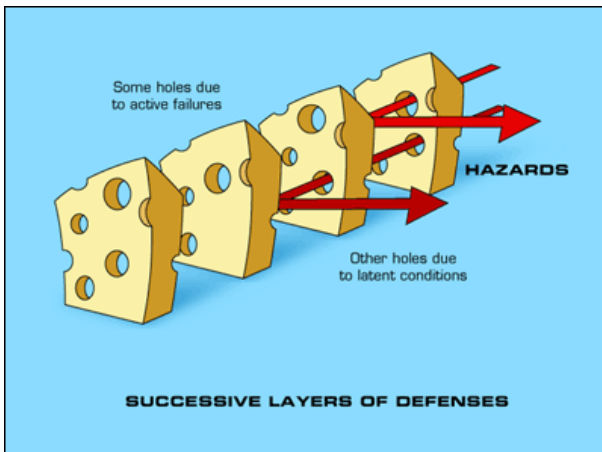


Keynote address 2

Medical errors and patient safety: teaching and assessing at undergraduate level

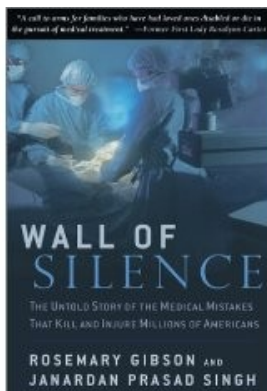
Professor Ara Tekian (Associate Professor of Medical Education, University of Illinois, USA)

- There is a need to integrate patient safety into curriculum. Why? Because knowing how, why and where injuries occur, leads to an increase in quality of patient care
- Why is **disclosure** of errors avoided?
 - Fear of malpractice lawsuits
 - Threat to autonomy
 - Lack of expert faculty
 - Other demands on practitioners (time)
- What are the **barriers** to the implementation of safety systems in institutions?
 - Scarce resources
 - Resistance to change
 - Lack of understanding from senior staff
- Patient safety issues often make **headline news**, therefore there is a large public interest
- Types of errors:
 - *Diagnostic* – errors, delays, failure to act on diagnosis
 - *Treatment* – incorrect dosages, procedure, methods used
 - *Preventative* – failure to provide prophylactic treatment
 - *Other* – failure in communication
- **To err is human: building a safer health system** (*Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson*)
 - Book available for free for South Africans online from <http://books.nap.edu/openbook.php?isbn=0309068371>. Register to download the PDF.
 - 98 000 patients die every year because of medical errors
 - The 8th leading cause of death in the United States
 - How can we trust the healthcare system?
 - How are we training students?
 - Defines the following:
 - Errors – unintended acts, either of omission or commission
 - Adverse events – incidents in which unintended harm occurred
 - Near misses – an incident which could have been an adverse event but did not
 - Errors need to be:
 - Recognised
 - Analysed
 - Reported
 - Reduced
 - Prevented
- Reason's Swiss cheese model of system failure explains how hazards move through various layers of defence and become accidents.



Images taken from Duke University Medical Center
http://patientsafetied.duhs.duke.edu/module_e/swiss_cheese.html

- Changes in the curriculum that need to be made:
 - There is a need to *change, sustain and continually assess* medical students skills, attitudes and knowledge regarding medical fallibility, which led to the introduction of a module called **“Patient safety and medical fallibility”** into the medical curriculum.
 - *Questionnaire* pre- and post-course that assesses students strengths, weaknesses, frequency of errors, awareness of chances of mistakes with serious consequences and communication skills.
 - Found that the opportunity to present the error to the patient led to enhanced confidence regarding discussion of the problem.
 - 94% of students found that the course was a *useful learning experience*.
- Students must develop interpersonal communication skills, self awareness and a willingness to take responsibility when patient safety is compromised. Team working skills are also important.



Wall of Silence

The Untold Stories of the Medical Mistakes That Kill and Injure Millions of Americans

by Rosemary Gibson and Janardan P. Singh

Up to 100,000 Americans die each year as a result of some form of medical mistake. And this is just the reported number of deaths. The total number of deaths and other disabilities is estimated to be triple (or more) of what’s actually reported.

Wall of Silence takes you behind the scenes to expose heartbreaking stories of medical malpractice, careless misdiagnosis, and downright neglect on the part of health care personnel across the country. Victims are young and old, healthy and infirm, who innocently entrusted their lives to those who took an oath to “do no harm.” Yet doctors, nurses, hospital administrators, and other medical professionals cover up mistakes every day.

Wall of Silence is the complete story of the breadth and depth of medical mistakes. Gibson puts real names and faces to the countless that suffer and die every day because of ineptitude, poor quality, and lack of management in a system that is badly broken. Doctors and nurses also provide first-

hand accounts of what actually goes on behind the curtains, describing the mistakes that do happen, but also how terrifyingly close every practitioner is, every moment, to disaster.

In *Wall of Silence*, Gibson breaks this unspoken code of silence gripping our nation's health care system. With her connection to The LeapFrog Group, a coalition of Fortune-500 companies whose mission is to raise the nation's awareness of and to reduce medical errors; and her position as a senior program officer for a major foundation specializing in health care, Gibson has a unique vantage point from which to report on this national tragedy.

Book review taken from:
http://www.regnery.com/lifeline/021230_wallofsilence.html

**Interview with one of the authors of “*Wall of silence*” available at:
http://www.growthhouse.org/books/wall_of_silence.htm**

“Without disclosure of errors, there is no learning from mistakes, which keep being made”.

- Patient safety is a personal and emotional issue.

What to do when an error occurs?

- Only 1 in 4 errors are disclosed.
- Perform a root cause analysis – review of unexpected bad outcomes, systems failure and near misses.
- Full disclosure with an apology. Skills include effective communication, honesty, compassion. Non-abandonment leads to fewer malpractice suits.

There is an institutional culture of “deny and defend”.

There needs to be a formal and informal integration of patient safety into the curriculum, including:

- Brief presentations
- Discussions
- Simulations
- Self-reflection
- Debriefing

What would students be expected to know?

- How to *prevent* errors from occurring?
- *What to do* when they happen?
- Find out *why* it happened.
- What are their *ethical and legal obligations*?

Students will only take anything seriously if there is **assessment**, which must include:

- Exams
- Self-efficacy scales
- Portfolio
- Presentation

Advice

- Establish a taskforce to integrate patient safety into the curriculum.
- Champions to support them.
- Design a formal and informal curriculum.
- Establish a culture of patient safety.
- Monitor the process and evaluate.
- If nothing is done, start something yourself. Take small steps.