MASTER CLASS I

PATIENT SAFETY IN HEALTHCARE

Day: Friday

Date: May 1st, 2015

Time: 4:15 p.m. to 5:15 p.m.

Venue: Auditorium, Symbiosis International University, Lavale campus, Pune

Speakers: Dr. Nikhil Datar

The speaker began the presentation by explaining medical errors and negligence. According to a survey, medical errors cause more deaths than tuberculosis. It is observed that 5.2 million deaths are reported every year on this account.

There are three major factors that result in medical errors: potency of medicines, human error, and the rising cost of healthcare. The victims of medical error are the patients and their relatives; healthcare organizations are characteristically marked by a "blame and a shame" culture, which means people are quick to shun responsibility and blame others when things go wrong.

Later in his presentation, he questioned whether litigations can really help patients and their relatives. The WHO has launched "world alliance patient safety" program, which includes strategies to avoid medical negligence.

He elaborated on the "Swiss cheese model of medical errors," which was developed in the UK. Swiss cheese looks solid but when cut into small slices, reveals holes, which are metaphor for the weakness within the system. When the holes are lined up, one can see through them, which figuratively means that when weaknesses are acknowledged, they can be overcome.

The harm that results from medical negligence falls in one of the three categories: human actions, system or organization, and circumstances. A video by the Patient Safety Alliance explained the dynamics in a dramatized documentary.

The speaker discussed issues of "situational awareness;" Dr. Atul Gawande's "safe surgery checklist," which has reduced mortality rates by 30%; and "ineptitude," the inability to take appropriate action.

The key goal in all of this is the attainment of uniformity. The presentation covered the activities of NICE (National Institute for Health care Excellence) and Patient safety Alliance (tools for the safety of patients--tools for communication, past record presentation, medication card, and checklist at the time of patient admittance).