Role of Medical Education in patient safety

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This year (2007) marks the fifth year after the World Health Assembly (WHA) adopted WHA Resolution 55.18(WHO, 2002) on patient safety during its fifty-fifth session in May 2002. The resolution urged WHO member states to pay the closest possible attention to the problem of patient safety and to establish and strengthen science-based systems necessary for improving patient safety and the quality of healthcare. The incidence of adverse events is a challenge to quality of care, a significant avoidable cause of human suffering, and a high toll in financial loss and opportunity cost to health services. Significant enhancement of health systems' performance can be achieved in WHO member states by preventing adverse events in particular, and improving patient safety and health care quality in general (WHO, 2002).

The World Alliance for Patient Safety was launched in October 2004 to facilitate the development of patient safety policy and practice in all WHO member states and to act as a major force for improvement. The Alliance is chaired by Sir Liam Donaldson, chief medical officer of the United Kingdom with WHO as its secretariat. The Alliance aims to fulfill the requirements of WHA Resolution 55.18 through international leadership and by creating an over-arching strategy, action programmes and a coalition of nations, stakeholders and individuals to transform the safety of healthcare worldwide(WHO, 2006).

In October 2005, the Alliance launched the first Global Patient Safety Challenge with the theme 'Clean Care is Safer Care', to bring together the WHO Guidelines

on hand hygiene in healthcare with ongoing work on blood safety, injection and immunization safety, safer clinical practices, and safe water, sanitation and healthcare waste management. It emphasizes that hand hygiene is the primary measure to reduce healthcare-associated infection, which is a major area of concern in patient safety, and the spread of antimicrobial resistance.

Among other activities to address patient safety, it is noteworthy that by end of June 2007, 44 countries, including Bangladesh, Bhutan, India and Thailand from the WHO South East Asian (SEA) region, have signed the pledge to address healthcare-associated infections. Additionally, the first regional patient safety workshop on "Clean Care is Safer Care" was also organized successfully to share experiences among SEA countries during 20-22 June 2007 in Bangkok, Thailand.

In a recent attempt to draw the scope of the problem in member countries of WHO-SEA Region where lapses in patient safety are yet to be documented, Mugrditchian and Khanum (2006) showed that Thai and Indonesian situations are similar to those in industrialized nations where it has been estimated that 10% of hospitalized patients suffer an adverse event and 5–10% acquire a healthcare associated infection. They cautioned that the Thai and Indonesian findings should not be used as national estimates or extrapolated to other countries in the region. However, the incidence of adverse events is likely to be significantly higher in hospitals and in countries where services and accreditation programmes are less well developed. They showed evidences that when compared to industrialized countries, the risk of acquiring a healthcare associated infection is estimated to be 5–20 times higher in developing countries and

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neonatal infections are 3–20 times (Mugrditchian & Khanum*, 2006).*

Sir Liam Donaldson (Donaldson, 2005) once wrote "The biggest challenge for patient safety is not to place blame or to punish, but to prevent errors—both human and systemic—from occurring. That requires both greater transparencies in healthcare systems and greater willingness on the part of health professionals to confront our failings. To err, after all, is human. But to cover up is unforgivable, and to fail to learn is simply inexcusable. We all make mistakes, but it is our duty to learn from them and find ways to make sure they never again cause harm." His statement clearly calls on all health professionals, including physicians, that they should be willing and have ability to learn how to prevent errors and achieve improved patient safety. Along this line and regarding doctors, medical education needs to be taken into account.

In recent years some medical educators (Flanagan *et al.*,2004; Singh *et al.*, 2005) have explored and noted that patient safety is fundamental to healthcare professional practice, is a common goal for healthcare providers, and transcends all competencies desired in doctors. However, patient safety issues are not a priority in undergraduate curricula and receive only scant attention in most residency curricula. In the USA, safety is a subject that transcends the Accreditation Council for Graduate Medical Education's 6 core competencies. The current trend of emphasis on training and assessment of professionalism in health profession education, continuing professional development and recertification of physicians is aimed to promote patient safety as an important component of quality of care.

To improve patient safety and quality of healthcare delivery through the education and training of doctors, various promising efforts have been tried. One group used Patient Safety as a focus to motivate practitioners and found that Crisis Resource Management courses adapted from aviation to healthcare demonstrate the value of simulation in bridging the gap between 'knowing' and 'doing' and keeping the focus on patient safety(Flanagan *et al.*, 2004). The other group designed a new patient safety residency curriculum in collaboration with the schools of nursing and pharmacy to address the US's required core competencies of doctors and at the same time to establish a culture of safety for sustainable improvement in health care through integration of safety into residents' daily activities (Singh *et al.*, 2005).

Based upon emerging evidence on patient safety, we trust that it is only a matter of time for medical educators in our region to identify better ways to train medical students and educate doctors so that they can serve as role models in the new culture for patient safety in our specific settings.

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