Editorial

Safety in Anesthesiology: Embracing the Culture

The first recorded death due to complications of anesthesia took place in 1848 when 18-year-old Hannah Greer received an anesthetic of chloroform to sedate her for removal of a problem toenail. Her cardiac arrest was attributed to an overdose of the anesthetic. Efforts at resuscitation were unsuccessful. It was purported that brandy and water were poured down the unconscious girl’s throat in an attempt to revive her.

Now, 165 years later, the medical community is still burdened by deaths related to medical interventions. More people die each year from medical error than from breast cancer or motor vehicle crashes or AIDS.\(^1\) In fact, according to the Harvard Medical Practices Study\(^2\) which estimates medical injuries in hospitals, mortality from iatrogenic cause likely approaches 100,000 deaths a year in the U.S.

In addition, the National Patient Safety Foundation revealed in a study almost 15 years ago that roughly one in six Americans had a personal experience with a medical error.\(^3\) The culture of medicine emphasizes the character and the skills and competencies of the physician as the main weapons against medical error. The prevailing perception is that quality and safety will be achieved if the physician has integrity, cares about his patient, and works and studies hard. The incident report, a retrospective investigation for dealing with adverse events that is still a commonly used approach at hospitals, is an ineffective strategy for creating a safety culture. It punishes individuals, yet even if weeding out healthcare’s bad apples through these means was successful, this would still only decrease medical errors by five percent. In fact, most experts suggest that only five percent of medical errors are due to incompetent or poorly rendered care, while 95 percent of errors that cause harm involve conscientious and competent caregivers trying to achieve determined positive outcomes for their patients.\(^4\)

Meanwhile, a growing body of research has shown that system flaws often set good people up to fail and an understanding of latent system errors is necessary to prevent them from happening. These concepts are important to grasp when looking at the current system for monitoring and managing medical errors. The shame-and-blame model, widely used in health care, involves identifying individuals and individual performance as causing a bad outcome. It is activated only after a mistake or sentinel event is recognized and a crisis has occurred hence leading to little success for several decades. The better alternative is engaging in risk management which involves anticipating and expecting human errors and designing a system to prevent them. Risk will definitely not go away as there will always be inherent risks, but at least they can be managed and prevented from becoming full-blown crisis. Risk management is definitely better than crisis management.

How has such a culture been created in the aviation industry? In the late 1970s, a series of commercial airline mishaps led to several exhaustive studies looking for the root causes of these aviation errors. One of the sentinel events involved a United Airlines plane heading into Portland, OR, after a shock absorber broke and the landing gear descended prematurely. Though the crew had contingency plans for landing safely, the pilot was preoccupied with the malfunction and ran out of fuel while waiting for instructions from the ground. The pilot failed to verbalize his problems, and the crew did not voice their concerns about fuel. The plane crashed in a wooded area six miles from the runway, and seven people died because of a lack of communication and teamwork.

So how do we build a safety culture in anesthesiology? How do we promote a climate of safety in the anesthesia workplace?
The Health Foundation defines safety culture as “the way patient safety is thought about, structured and implemented in an organisation” while the safety climate focuses on staff attitudes about patient safety. Recent years have seen the expansion of translational research from industry to healthcare particularly regarding issues and ways to measure safety culture and safety climate in healthcare. Highlighting the interventions to improve organisational safety culture and staff attitudes towards safety is expected to promote the safety culture that will directly or indirectly affect patient outcomes.

Before we are able to institute change however, we ought to get baseline data and in this issue of the Philippine Journal of Anesthesiology, Luna and Bautista studied the patient safety cultures of the different departments of an institution in their paper entitled “A comparative database report on patient safety culture of the surgical departments in a private teaching hospital.” Parameters measured and compared were based on twelve composites of patient safety culture: communication openness, feedback and communication about error, frequency of events reported, handoffs and transitions, management support for patient safety, nonpunitive response to error, organizational learning and continuous improvement, overall perceptions of patient safety, staffing, supervisor/manager expectations & actions promoting safety, teamwork across units, and teamwork within units.

Let all of us therefore be resolute and focus the efforts of the members of our anesthesiology departments to work together and uphold the current culture of patient safety with improvements on the reporting and analysis of adverse events. Only then can we truly say that we have embraced the culture of safety in our institutions.

2. Harvard Medical Practices Study