Patient Safety in India: Time to speed up our efforts to reduce avoidable harm

The 1995 Supreme Court declaration bringing hospitals under the purview of the Consumers Protection Act (CPA) of 1986 was possibly the start of the movement for the safety of the patient in India. Even though the phrase ‘patient safety’ did not become a part of common medical vocabulary until the late 1990s, the CPA made the members of the profession realize that they would be held accountable for shortfalls in care. Since then, there have been several high-profile incidents in which the safety of patients was grossly neglected. These include the deaths of 14 patients in the J.J. Group of Hospitals following the administration of contaminated glycerol, an incident that was probed by the 1997 Lentin Commission,1 the report of which held the physicians liable; the Hepatitis B epidemic in the district of Sabarkantha, Gujarat in which 94 persons died;2 the deaths of 18 pregnant women at Umaid Hospital in Jodhpur;3 and most recently, the fire at the AMRI hospital in Kolkata.4 While there have been such large incidents, as well as regular newspaper reports of individual cases, there is little scientific data on the extent of the problem of patient safety in India. The one major study by the International Clinical Epidemiology Network (INCLEN) on injection safety showed that nearly two-thirds of the injections given were potentially unsafe (personal communication, Professor N.K. Arora). Elsewhere in the world, it has been reported that the risk of acquiring a healthcare-associated infection or neonatal infection is estimated to be 2–20 times higher in developing countries than in industrialized ones (http://www.who.int/features/factfiles/patient_safety/en/index.html). A recent study in 26 hospitals in eight developing countries in the Eastern Mediterranean and Africa showed that there was an adverse event in 2.5%–18.5% of hospitalized patients.5 So, patient safety is clearly a major public health issue in India, and some would argue that the problem is likely to be much more serious, given the concerns about counterfeit drugs, faulty medical equipment, unsafe blood banks or unregulated organ donation, for example.

Are we doing enough to tackle the problem and ensure safer care? And what else should we be doing to speed up progress? Since the publication of the Institute of Medicine’s seminal report6 in 1999, which showed that healthcare itself was the eighth leading cause of death, after AIDS, breast cancer and motor vehicle accidents, in the USA, there has been a growing interest in patient safety internationally. The WHO launched the World Alliance on Patient Safety (WAPS) to help stimulate further research to ascertain the extent and root causes of the problem and, more importantly, develop innovative solutions to reduce the burden of harm due to unsafe healthcare. Much progress has since been made, in the past decade, but it is equally clear from some high-profile instances, for example, in the National Health Service (NHS) in the UK that a lot more needs to be done (http://www.midstaffsinquiry.com/).

In India, while the CPA was a stimulus that made doctors aware of the problem and encouraged safe practice, it also led to ‘defensive’ medicine, causing an overall rise in litigation, though with few doctors being penalized. Further, it led to an increase in healthcare costs. The tendency to resort to litigation, and harsher sanctions, received
another impetus in 2003 with the Mashelkar Committee on Spurious and Counterfeit Drugs, which suggested the death penalty for offenders. However, such measures are not enough and given the slow judicial system, they cannot bring about the sea change that is necessary in medical practice. For the moment, they have only set in motion a negative trend of blaming and shaming individuals, which is seldom appropriate, given that most inquiries into adverse incidents show that there are systemic problems. The current approach has also made it difficult, nay impossible, for doctors to report adverse incidents and thus learn from errors. There is a vicious cycle whereby the lack of reporting makes it difficult to understand the root causes and fix the systemic problems, which, in turn, perpetuates the situation and causes it to worsen. All this is further compounded by our society’s general ‘laissez faire’ approach to safety, whereby in almost all spheres of our daily lives, we accept that things go wrong and attribute them to ‘divine intention’.

On the other hand, though it is not right to blame a single person, we should resist the temptation of glossing over the problem by proclaiming that the ‘system is rotten’ or there are ‘no resources’. We can, and should, fix things by formulating standard operating protocols for treatment and procedures, introducing physical barriers and training for the use of technology, for example. Atul Gawande’s work on a surgical safety checklist is a good example of a simple and low-cost intervention. Of course, not all complex medical practices can be oversimplified into checklists, but the evidence shows that most errors are fairly elementary. The final collapse is usually a result of glitches in communication, over-reliance on human memory, inadequate access to information, not knowing whom to ask and non-standardized operating guidelines. None of these gaps requires the investment of too many resources, and money is not the concrete that can fill the cracks in the patient care pathway.

Bringing about the changes mentioned above is easier said than done. History shows that medical practice does not change fast: it was in 1847 that Semmelweiss emphasized the importance of hand-washing to save pregnant mothers, yet hand hygiene remains the first global priority for patient safety in the 21st century. So, we need to avoid gimmicks and quick fixes, and while we can learn a lot from the developed world, we should recognize that the Indian context is different and create appropriate solutions.

Healthcare is a burgeoning industry in India. The early experience with the ‘knee-replacement-with-a-free-trip-to-the-Taj’ medical tourism model shows that patients are not easily seduced by glossy interiors and good catering. They would like to see more attention being paid to the important but invisible interventions of the committees for hospital infection control, as well as to operation theatre safety standards. While private hospital patients may be more educated and discerning and may help create the necessary pressure for change, patients in the public hospital system are unlikely to be either demanding or effective. The recent proposal to introduce universal healthcare coverage under the 12th Five-Year Plan will mean a massive growth, given the huge unmet need for healthcare in India. When the floodgates open, the provision of more care, without the creation of systems for safer care, will result in more harm and the policy may turn out to be a lose–lose proposition.

We, therefore, need to take stock and develop a longer term strategy. India is a signatory to the WAPS and institutions such as the Quality Council of India have been set up. There are also other initiatives, such as the National Initiative on Patient Safety at the All India Institute of Medical Sciences and the Indian Confederation for Healthcare Accreditation, to promote action. We need to build on these developments.

We could start with a five-pronged approach:

1. Lobbying and assisting institutions and the government with the creation of systems for recording, learning and reporting on the quality of services and adverse events in a ‘balanced’ manner (neither too heavy-handed, nor too light), and making it possible to set up such systems given the concerns of such documentation.

2. Accelerating the implementation of proven patient safety interventions, such as the Global Patient Safety Challenges work on hand hygiene and surgical checklist,
by the introduction of mandatory compliance with ‘Never Events’ (http://www.telegraph.co.uk/health/healthnews/4933949/List-of-eight-blunders-the-NHS-must-never-commit-released-by-watchdog.html).

3. Empowering patients to question and work with professionals, for example through the Patient Safety Alliance (www.patientsafetyalliance.in), which also draws on the work being done by the Health Education Library for Patients (www.healthlibrary.com).

4. Capacity-building through education and training at the undergraduate level by using the WHO curriculum on patient safety and for established professionals through distance learning, for example through the People’s Open Access Education Initiative (www.peoples-uni.org).

5. Undertaking further research by building on the work started by the INCLEN.

The healthcare profession’s ability to remain unmoved, despite well-known examples, such as the incidents mentioned earlier, is no longer acceptable. Such incidents prompt newspaper headlines for a few days, and business resumes as usual soon after. We should give patient safety a higher priority. Of course, we will need time, but this should not induce complacency; the need is urgent.

While divisive, the Lokpal Bill and the recent television series, ‘Satyamev Jayate’, show that the tide may be turning and the public is getting ready to discuss and tackle difficult issues. Soon they will want to hear from us, the doctors, about what we are going to do to protect them and their dear ones from healthcare-related harm. Hiding behind the excuses of general corruption, limited resources or the lack of any serious governmental directive will not endear us to the general public; nor should we attempt this for the sake of our professional pride. We should be true to our Hippocratic Oath, which tells us, ‘First, do no harm’.

REFERENCES


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