Patient safety, the latest fad?

Even the profession of medicine has its fads, trends, and catch phrases. The latest seems to be the concept of patient safety—often alluded to as if it were a newly discovered concept! We seem to be bombarded in both the medical and lay press with articles describing the hundreds of patients who die every year and the thousands who are harmed by adverse events in our medical system, particularly our hospitals. Great attention is given to adverse drug reactions, though I always find it difficult to tell from the statistics how many of these reactions are predictable (and thereby preventable) and how many result in truly adverse consequences for the patient involved. There is a lot of difference between nausea caused by erythromycin and anaphylaxis caused by penicillin being given to the wrong patient.

In all of the rhetoric surrounding this topic, I keep searching for concrete, practical solutions that the practising physician can implement in his or her daily routine. For example, the pharmacy at the hospital where I work sent around a newsletter with two very pertinent suggestions. The first was to stop using trailing zeros when writing a drug dosage. For example, writing "5 mg prednisone" is a lot safer than "5.0 mg prednisone." If the period is not clear the dosage could easily be mistaken for 50 mg. Preceding zeros, on the other hand, are safer. For example, "0.6 mg digoxin" is safer than ".6 mg digoxin." Their second suggestion was to avoid using QD, OD, or any other designation for once daily other than "daily." Practical, cheap, and easily implemented.

Another way that the prescribing of medications could be made a lot safer would be to give physicians the ability to interact directly with the PharmaNet computer. Let me describe a scenario: I see a patient in the office with an acute exacerbation of COPD and prescribe a course of clarithromycin unaware (because the patient had forgotten to tell me and I forgot to ask about new medications) that the previous day the patient had been started on a statin by his cardiologist. The patient goes off to the pharmacy where the pharmacist discovers the potential drug interaction and for the next several hours the pharmacist and I play telephone tag, ultimately resulting in a different antibiotic being prescribed. The 2006 version: using the Internet I log onto the PharmaNet computer while the patient is with me in the office, prescribe the clarithromycin, am informed of the interaction with the statin, and change the antibiotic—which is then waiting for the patient by the time he gets to the pharmacy! Faster, simpler, and very much safer—and no one needs to read my writing.

The situation on busy hospital wards, of course, is more serious and complicated. Getting buy-in from health care workers about reporting and discussing medication errors will require a cultural shift away from pointing fingers at individuals to focusing on the system and encouraging all of us to report dangerous situations and to try to be creative with solutions. In a number of teaching hospitals, weekly safety huddles are becoming popular, providing a blame-free environment for trying to improve the system.

As everyone involved becomes more comfortable and trusting, ideas begin to emerge. Concerns regarding patient safety are not new and will never become passé. Checks and balances have existed in the system for many years. Where we have been slow is in using the power of modern technology to make our patients' interactions with the medical system even safer.

—**LML**

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