Frontline patient safety, currency training and continuing professional development linked to the workflow process for anaesthesia

Over the last three decades, beginning with the NASA aviation safety initiative, massive strides have been made in many complex and high-risk industries in terms of enhancing human performance and the application of a systems-based approach to the workflow process. The result, for many of these industries, has been safer working environments, better outcomes and improved satisfaction for all users of the system. Large reductions in aviation-related incidents and deaths, the attainment of greater than sigma-6 level safety in certain environments such as aircraft carriers, and many more, are examples of how the application of relevant and effective frontline techniques have changed the working environment in these complex and stressful work environments.

This has, unfortunately, not been the case in the field of healthcare delivery. Despite the Medicine Institute article in 1999: To err is human, quoting nearly 100 000.00 deaths per year in the USA (440 000 in 2013) attributed to human-factor errors within the healthcare industry, we, as a fraternity, have not progressed beyond limited pockets of excellence in tackling this issue. There are many reasons for this, some of which include:

1. The persistence of an archaic hierarchical structure that is pervasive throughout training and the working environment.
2. The development of programmes and standard operating procedures that are not linked to the frontline processes that we, as healthcare professionals, face on a daily basis.
3. A failure to appreciate the need to change our culture, our fundamental belief, to one that values effective human communication, appreciates the dangers in our working environment and that continually makes its priority the improvement of the workflow process for both professionals and patients.
4. The training of the healthcare professional remains rooted in the technicalities of performing one’s role within the system but teaches very little regarding safety, communication and human-factor error prevention and management.

The resulting system that has arisen is one which, when compared with other technically challenging and dangerous professions, has the following characteristics:

1. Unsafe environments for patients and healthcare professionals.
2. Growing discontent amongst patients and healthcare professionals regarding the system of delivery of care.
3. Adversarial engagement between stakeholders.
4. Scattered and ineffectual attempts at correcting the situation through endless guideline production without concern for what is really occurring at the frontline.

A case in point would be our current continuing professional development (CPD) strategy. Has the implementation of the CPD system in its current form really enhanced clinician currency or improved patient safety? I think most of us would say no. There is a clear discrepancy between the value system of the frontline parties, i.e. healthcare practitioners, and the regulatory body tasked with the maintenance of standards. The frontline system requires clinicians to engage in relevant and helpful activities that have a real and discernible impact on the efficiency and safety of care, whilst the regulatory body needs to manage a system that makes clinicians accountable for their ongoing development. Our CPD system is merely a reflection of where the medical fraternity is with regard to understanding the aforementioned issues, namely:

1. We believe that our base training and thereafter our on-the-job experience has adequately equipped us with the tools to manage highly complex scenarios, despite foundational level changes occurring in our work environments.
2. We do not appreciate the impact of human-factor error and still view this area as individually driven rather than systematically driven.
3. We do not place value in the non-technical aspects of our work, despite there being very convincing evidence that our consistent failures have little or nothing to do with our technical ability. Even with respect to our technical training, we demonstrate little understanding of the need to continuously practise and refine these skills.
4. We continue to support a system, namely our training platforms and CPD strategy, that is not designed to achieve their fundamental premise and which has clearly not delivered on this premise, namely that our training and continuous professional development must be geared toward developing clinicians who function well technically within a team and system designed specifically for optimum outcome.
5. Whilst many of the academic centres run excellent CPD programmes, these tend to be supported by a small number of clinicians and unfortunately do not emphasise enough the need for us to change our working environments.

Surely a system where all stakeholders share the common value of real and measureable clinician currency for the purpose of enhancing patient safety would be better because it can truly address the problem? We would propose an ongoing clinically relevant assessment and training process, with the aim of keeping clinicians current, and which would be used as a tool to further enhance their understanding of the science of safety, human-factor error prevention and efficiency. This could be structured in many ways, for example two-yearly simulation sessions, mandatory non-punitive near-miss and accident
reporting, two-yearly objective structured clinical examination-like sessions as well as focused training in clinically relevant scenarios such as understanding human errors, learning effective communication strategies and many more. The structure of the final programme is beyond the scope of this communication.

What must happen is that we, as a fraternity, need to prioritise the development of a safety culture first and foremost. We need to develop expertise in the science of safety, professional communication and performance and we need to develop frontline strategies for improvement and then make these the new gold standard of care. In short, we must first acknowledge that there are fundamental and dangerous flaws in the way we execute our daily work, collectively strategise an improved process and then implement this process.

If we do this properly, there is mounting evidence to suggest that we will not only save countless lives but that we will do it at a lower cost and that, as the deliverers of care, we will have greater fulfilment at work. The goal is simple: develop training and professional development strategies that ultimately characterise our work environments as highly safe, efficient and cost-effective, where professional communication is effective, collegial and non-punitive.

CPD is just one example of our failure to truly assess and then change the way we do things, but the problem strikes at the very foundations of our profession.

The ever increasing cost of care, the litigious nature of our society, the loss of life and increasing clinician burnout and dissatisfaction may seem dire, but do provide us with the perfect opportunity to effect meaningful positive change in our system.

We would implore that all stakeholders in ANAESTHESIA create a forum where we begin to discuss the issues mentioned above and that, at national level, we begin to develop an effective strategy for improvement. The South African Society of Anaesthesiology would be the obvious institutional home for such an initiative and we believe it is imperative that the society begins in earnest to tackle this issue.

Yours sincerely

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