جامعة الملك سعود
King Saud University

Professionalism Team
435

Loyalty Kindness Ethics Integrity
Professionalism434

Professionalism

All lectures in one file

- Correction file.
- Quizzes file.

Thanks to all 434 team members:

- Reema Alrasheed
- Malak Alkhathlan
- Elham alghamdi
- Maha alrabiah
- Meshael hussain
- Nada alamri
- Sarah alsalman
- Sarah almubrik

Revised by team 435 members:

- Nouf Altwaijri
- Luluh Alzeghayer
- Malak Alsharif

College of Medicine
Department of Medical Education
Curriculum Development Unit

Professionalism Topics (2016-2017)

Year 2

CNS Block			
NO.	**Lecture title**		
1	Overview and key elements of professionalism		
2	Accountability, integrity and altruism		
3	Patient safety definition and **Human factors** involved in patient safety		
4	Understanding systems and the impact of complexity on patient safety		

GIT Block			
5	Continuous Professional development		
6	The concept of effective communication skills in medicine		
7 8	Understanding and learning from errors Being an effective team player		

ENDOCRINE Block			
9	Community services and volunteer work		
10	Professionalism through mentoring		
11	Professionalism in different cultural contexts (Sensitivity to others belief and world views)		

REPRODUCTION Block			
12	Professional and unprofessional behaviors		
13	Breaking bad news		

TOTAL NO.OF TOPICS= 13

Objectives:

Lecture 1: course objectives:

- To understand and define the professionalism concept.
- To act along the professionalism guidelines
- To practice the needed skills to reach highest standards of professionalism in the daily life.
- To enhance and demonstrate their interpersonal skills, communication skills and the ability to communicate with respect.
- To demonstrate sensitivity and responsiveness towards others and show the ability to work with others in a professional way.
- To be aware and to avoid unprofessional conduct.

Lecture 2: Accountability, Altruism & Integrity:

- Upon completion of this lecture, students should be able to:
- Discuss the meaning and the key components of Accountability.
- Discuss the place of accountability in professionalism.
- Explain why Accountability is needed in the medical profession.
- Discuss the meaning and key components of Altruism and Integrity.
- Interpret some practical examples about Accountability, Altruism and Integrity.
- Apply knowledge learnt to case scenarios.

Lecture 3: Human factors & Patients Safety:

- Define and describe the Human Factors and its relation to patient safety
- Recognize the importance of applying human factors in healthcare
- Summarize the impact of Human Factors on people's health and patient safety
- Differentiate between the different types of Medical Errors
- Describe several specific Actions to reduce medical errors as related to Humans Factors

Lecture 4: Patients Safety:

- Recognize the magnitude and the importance of patient safety
- Discuss the facts and concepts relevant to patient safety.
- Define and describe the key elements of healthcare quality and explain how each element contributes to safer care for patients.
- Summarize the differences between error and harm
- Describe the Swiss cheese model of error including the difference between active failures and latent conditions
- Explain how medical errors are a significant cause of death and disability
- Recognizing characteristics of a just culture
- Differentiate between the different types of clinical incidence
- Describe what improvements can be made in the healthcare system, and in human functioning, to avoid most medical errors.
- Describe several specific behaviors you can practice to foster a culture of safety in your workplace

Lecture 5: CPD:

- Understand what is Competence and differentiate its Levels?
- To plan for their own Continuous Prof: Devp: (CPD)?
- Appraise, What is Reflective Learning and how to utilize it in day to day learning
- Identify Challenges hindering CPD and learn how to overcome.

Objectives (cont.):

Lecture 6: The concept of effective communication skills in medicine.

- Define communication, its theory and types.
- Discuss importance of communication in medicine.
- Demonstrate effective communication in day to day practice.
- Overcome barriers to effective communication.

Lecture 7: Understanding and learning from errors

- Understand the nature of error.
- Define the following terms error, slip, lapse, mistake, violation, near miss, hazard, risk and Risk management.
- Understand how you can learn from errors.
- Identify situational and personal factors that are associated with the increased risk of error.
- Participate in analyses of adverse event and practice strategies to reduce errors.
- Know how to apply risk-management principles in the workplace.
- Know how to report risks or hazards in the workplace.

Lecture 8: Effective team player.

- Understand the importance of teamwork in health care;
- Know how to be an effective team player;
- Identify teams type and nature;
- Differentiate between the stages of team development;
- Assess the successful teams;
- Utilize different tools to promote communication and the performance of the team

Lecture 9: Community services and volunteer work

- The concept of community service.
- The social, public and community responsibilities of a professional.
- The concept of volunteering.

Lecture 10:Professionalism through mentoring

- The concept of Mentoring.
- The roles of Mentor and Mentee.
- What is to be expected from Mentoring?
- Professionalism through Mentoring.

Lecture 11:Professionalism in different cultural contexts (Sensitivity to others belief and world views)

- The role of culture in health care
- Different Consultation Models
- Importance of Respect to others' beliefs
- PEARLS Concept

Lecture 12:Professional and unprofessional behaviors

- Define unprofessional behavior
- Identify various elements of human nature that contribute to unprofessionalism
- Provide examples of such behaviors from daily life
- Avoid unprofessional behaviors.

Lecture 13:Breaking bad news

- Define what is breaking bad news & how to deliver it
- Recognize the challenges for sharing bad news
- Apply an effective 6 step protocol for breaking bad news
- Recognize its significance in the emergency department

1 Definitions, key elements, attributes and general concepts

What does Professionalism mean? Different sources

Profession is an occupation whose core elements is work, based on the mastery of a complex body of knowledge and skills. *Oxford English Dictionary*	**Profession** is the conduct, aims, or qualities that characterize a person in a work setting or profession
Professionalism is exhibited by one of the *professional character, spirit , methods* or the standing practice , or methods of a professional as distinguished from an amateur". *American College Dictionary*	**Professionalism** "constituting those *attitude* and *behaviors* that serve to maintain patient interest above physician self-interest." *American Board of Internal Medicine*

Ottawa Conference: professionalism is intrinsically related to the social responsibility of the medical profession.
Professionalism has three main discourses/characteristics:
1) Individual 2) Interpersonal 3) Societal

The Holy Quran & Hadith:

The holy Qura'an and Al-Hadith have stated that Muslims has duty to care for the sick and this often referred to "Medicine of Prophet'.
According to the sayings of the Prophet Mohamed' peace be upon him' that 'Allah has sent a cure for aliment and that it was the duty of Muslim to care of the body and spirit."
This includes improving the quality of care and ensures access of healthcare to every body.

MEDICINE: is a vocation in which a doctor's knowledge, clinical skills ,and judgment are put in the service of protecting and restoring human well-being.
This purpose is realized through a partnership between a patient and doctor, one based on mutual respect ,individual responsibility and appropriate accountability.

What is medical professionalism?

Medical professionalism is the 'heart and soul of medicine'. More than adherence to a set of medical ethics; it is the daily expression of what originally attracted them to the field –a desire to help people and to help society as a whole by providing quality health care. *Advancing medical professionalism to improve health care*

Professionalism in medicine:

Professionalism embodies the relationship between medicine and society as it forms the basis of patient –physician trust. It attempts to make tangible certain attitudes, behaviors, and characteristics that are desirable among the medical profession. *University of Ottawa,*

Why professionalism is important?

- There is a great increase in interest in developing medical professionalism of the students.
- The *ethical* demands upon medical profession have increased due to changes in the traditional modes of health care delivery, increased complexity in the methods of reimbursement, and developing national trends toward managed care.
- **Medical professionalism sets out three principles**: ***ethical principles, knowledge and skills & selflessness***
- Most people desire to be treated by physicians who, in addition to being competent, care deeply about their patients.
- Professionalism and humanism sometimes confused as being synonymous.
- It denotes a way of behaving in accordance to certain normative values.
- Professionalism is not only about being competent and skillful but also *behaving in an ethical way*
- ***In Short:***
    - Being productive.
    - Effective management of relationships.
    - Handling conflicts.
    - Being an ambassador.
    - Being mission-minded.
    - Being able to know and avoid the unprofessional behavior.

Concepts Of Professionalism:

- **Professionals** have *codes, guidelines, creeds, oaths, commitments* statements, belief statement such as statement on *ethics*.
- **Professionals** in many professions are *licensed, certified* and specific initial and *advanced education*, many require both initial and ongoing testing for admission and maintaining membership.
- **Examples of professionals** : medical doctors, engineers, pilots, etc,..

Professionalism	Humanism
A way of acting. It comprises a set of observable behaviors.	Manifested as : altruism, duty, integrity, respect for others and compassion.

Professionalism key elements:

Professional Values (Six Columns of the building)	Key bases of professionalism (Four steps of the building)
• Excellence. • Humanism. • Respect. • Accountability. • Altruism. • Integrity and justice	• Ethical and Legal Boundaries. • Communication and Interpersonal Skills. • Continuous Learning and Self Development. • Clinical Competence (Knowledge and Skills)

Professional Attributes:

Confidentiality	Keeping conversations between doctor and patients unrevealed.
Trustworthiness	Deserving trust or confidence.
Honesty	Being truthful in representing facts.
Loyalty	Unfailing fulfillment to one's duties and obligations.
Reliability	Keeping your word, honoring your commitments.

Professionalism key elements:

Key elements	Example
Excellence (a talent or quality that is unusually good and surpasses ordinary standards)	1) Time management /Punctuality 2) Positive attitude (enjoy work). 3) Commitment to lifelong learning, to exceed ordinary expectations. 4) Confidentiality. 5) Consider the language and culture of work. 6) Give the best of your talents and skills. 7) Recognition of professional limits 8) Protection of life 9) Prioritization 10) development in commitment, communication, interpersonal relationship, ethics and more .
Humanism A way of being. It comprises a set of deep-seated personal convections about one's obligations to others especially others in need	1) Empathy & Compassion. 2) Encouragement. 3) Support. 4) Love and care. 5) Positive attitude. 6) Values and integrity.

Key elements	Example
Respect	1) Respect patients, patients' families, colleagues, and other healthcare professionals. 2) Treat patients with dignity and respect. 3) Demonstrated good attitude and effective communication. 4) Respect all patients in the same way regardless to their social status. 5) Respect for the feeling of others. 6) Respect for differences. 7) Respect for rules. 8) Self-respect.
Accountability	1) Accept responsibility. 2) Always consider confidentiality. 3) Work on resolving conflicts. 4) Avoid the business of blaming others, circumstances or how much you are busy. 5) Addressing the health needs of the public. 6) Adhering to medicine's precepts. 7) Honoring the patient/physician relationship.
Altruism To go beyond the call duty to help meeting the needs of others. In other words, to put the duty and patient care ahead of your own needs. The sense of "giving" of oneself in patient care.	1) Put the patient first. 2) Avoid any conflict between your needs and the patients' rights. 3) Give full commitment to your patient. 4) Avoid any financial or relationship biases that could have any negative impact on the patient-doctor relationship
Integrity and Justice Avoidance of relationships that allow personal gain to supersede the best interest of patients.	1) Be a principle-based person. 2) Be honest, and stand by your words. 3) Be fair & Do not abuse your position/authority. 4) Do what you say (Keeping one's word). 5) Behave in a good manner whether you are watched or not. 6) Adhere to good work-place ethic 7) Highest standards of behavior. 8) Don't work in the darkness or get involved in any behavior that aims at harming others or taking their rights without their knowledge.

Professionalism	Ethics
• Competence • Honesty • Compassion • Respect others • Responsibility for the profession & society	• Morals • Deliberation and explicit arguments to justify particular actions • Principles governing ideal human character • Focus on reasons why an action is right or wrong.

Take Home Message

- Although there are common key elements in the definition of professionalism that must be fulfilled, the definition might varies depending on culture, law, and community needs.
- Sources for defining professionalism might include: literature, published research papers, legal and ethical documents, as well as disciplinary action documents in the hospital, and workplace. These documents are confidential.
- The definition components (key elements) should clearly define the unwritten contract between a doctor and patients.
- The definition of professionalism is the benchmark that we could use to check our performance and could help us to direct our goals for continuous improvement
- It is also the measure that could be used to assess our performance by our patients, colleagues, and the profession.

2 Accountability

Definition: Procedures and processes by which one party justifies and takes responsibility for its activities.

It comprises:

- Responsibilities to patients.
- Responsibilities to colleagues.
- Responsibilities to the society and public.
- Patient-physician relationship.
- Responsibilities to the profession.

Key components of accountability (important): (Meanings of accountability)	
Responsibility	1. That means to become responsible (accountable) to patients, their families, society & community. 2. To become accountable for quality of care, resolving conflict, and upholding principles.
Self-regulation in activities	This means that physicians' actions and behavior should reflect legal, good ethical conduct, and no financial conflict in their performance.
Standard setting for current & future members of the profession	Accountability is about our willingness to maintain these professional standards in our day-to-day practices.
Ability to resolve conflict	Conflict might be financial, pharmaceutical. There is a need to disclose any conflict that could damage doctor's accountability.
Free acceptance of duty to serve public	A doctor is accountable for improving the standards of the health care of their community, their country and worldwide.
Explain and give reasons for actions that could have caused harm to the patient, colleagues, and community	A doctor is accountable for actions that could cause harm to the patient, colleagues, and community.

Why do we need accountability?

- It's the key for providing optimal health care services.
- Enables continuing improvements in the health care system at its different levels.
- Helps in protecting the rights of patients.
- It's essential in resolving conflicts.
- It's essential for building trust, and ensuring that the workplace environment is safe and healthy.
- Reflects behaviour and attitude of responsible people.

Responsible style:

- Promise only what can be delivered: Commitment ,delivered on time, accountability.
- Support the basic tents of the profession: Develops a philosophy and sound rationale for professional practice.
- Thinks before reacting: Foresees possible outcomes of professional actions.
- Evaluates his/her professional practice: Confronts discrepancies between intentions and actions.

Why accountability is important to learn by medical students?

Social accountability for medical students is needed as behavior and as a practice and not needed as knowledge.

Social Accountability of Medical Students:

- To enhance **the health of people by educating physicians (e.g., prevention and early detection of diseases) & medical students; by conducting research in clinical and basic medical sciences and working with a research team conducting such studies.**
- **By promoting the skills and attitudes of lifelong learning.**
- Preparation of future doctors to respond to population needs.
- By committing yourself to volunteer work that help in improving health care and awareness about diseases in the community.

Initiative (Read only)

Definition:

The action of creating or starting.

To make a conscious effort to do things without being told to and to find alternatives if an option is not possible.

Characteristics of an Initiative:

- People with initiative character are starters and self-motivators.
- Have the ability to begin or to follow energetically with a plan or task.
- Took the initiative in trying to solve the problem.
- Have the power to or right to introduce a new legislative measure.

Altruism:

What does altruism mean?

- To go beyond the call duty to help meeting the needs of others. In other words, to put the duty and patient care ahead of your own needs. The sense of “giving” of oneself in patient care.
- The roots of the word “altruism” is from the Latin word alter, meaning “other”, meaning to look after others and help them.

What are the key elements in altruism?

- Donate time to humanitarian causes such as Medicine Sans Frontieres (Doctors with no borders).
- Help or treat patients who are poor or cannot afford the costs of the service.
- Going beyond the call of duty to help patients.
- Show selfless behaviour and the willingness to serve others, particularly those in need.
- Unselfish concern for the welfare of others.
- Subordinate your own interest to the interest of others.

Trustworthiness (Read only): The corner stone of the practice of medicine

Definition:Deserving of trust or confidence.Synonyms: true, accurate, honest, faithful

- The demonstration of compassion, service and altruism that earns the medicine profession the trust of the public.
- Trustworthy people keep their promise, are honest, reliable, principled and never inappropriately betray a confidence.
- It embodies FOUR ethical principles:

A- Integrity B- Honesty C- Promise – Keeping D- Loyalty

A-Integrity: *Walk the Talk when it comes to Integrity*

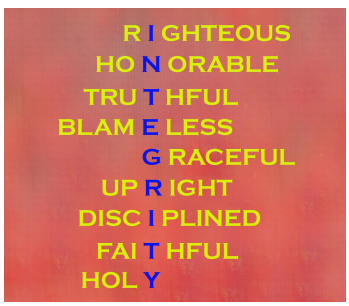
- The most important factor in trust.
- Integrity carries the sense of wholeness: a person of integrity like a whole number, is a whole person, undivided, complete.
- Integrity is doing the right thing when no one is watching. represented by a number of values such as honesty, trustworthy, fairness, and no favoritism.

Meaning in more details:

- Highest standards of behaviour.
- Refusal to violate one's personal professional codes.
- Being fair, honest and truthful.
- Keeping one's word.
- Avoidance of relationships that allow personal gain to supersede the best interest of patients.
- Not working in the darkness or involved in any behaviour that aims at harming others or taking their rights without their knowledge.

Person with integrity: (More info)

- Listen to his consciences and live by his principles no matter what others say and no matter the personal cost.
- Has the courage to do what is hard or costly or failure is probable.
- Is honorable and upright in all actions.
- Build and guard his reputations.
- Don't do anything he feels is wrong.
- Don't lose heart if he fails.



B-Honesty (The whole page, Read only)

✔	x
Being honest in our conduct means playing by the rules and being trustworthy of another's property and belongs.	Dishonest conduct by ways of cheating can come in many forms, such as trickery, fraud , misleading ,deliberately violating the rules, and swindling.
Two types of honesty:	
Communication Honesty: • Being truthful in representing facts and intentions to the best of one's knowledge. • Sincerity and candor.	**Conduct Honesty: Cheating** 1- Using unauthorized materials to achieve better grade. 2- Falsification or invention of any information. 3- Attempting to help another person in an act of cheating. **o Plagiarism** (Submitting an assignment as if it were one's own work). 1- Submitting a work that is purchased or obtained from internet source. 2- Incorporating a word or ideas of an author into one's paper without acknowledging the original source.

C-Promise Keeping

- A vital moral aspect of reliability.
- Promise is a vow, pledge, a declaration assuring that one will or will not do something.

o Two areas of promise keeping:

A. Good work habit: complete our job /task
B. Reliability: being dependable e.g. Return what you borrow, pay your debts, show up on time, and be prepared.

D-Loyalty: This could be loyalty to an oath, one's family, and our country.

It implies the unfailing fulfillment to one's duties and obligations and strict adherence to vow or promise.

Trustworthiness in medicine:

- Physicians are expected to make patients' needs the first priority.
- Physicians should consider their contributions to their individual patients, to their own practice, the community and the health care system.

Physician should (Read only):

- Demonstrate professional competence
- Be aware of their deficiencies.
- Obtain help when needed.
- Be honest and communicate information in complete confidence.
- In communications with the community, physicians must ensure that representations they make are to the best of their knowledge and truthful.

Take Home Message

- Accountability = Responsibility.
- To be accountable you need to have self-regulation in your day-to-day actions.
- Accountability requires that we maintain standard setting.
- Accountability requires that we resolve conflicts (financial, ethical, moral, pharmaceutical etc).
- Altruism means putting the patient's healthcare needs ahead of yours.
- Integrity is not about talking or claiming great values that you know or have. Integrity is about demonstrating that the values you hold you are applying in your day-to-day practice.
- Integrity is not just about a set of great values that you know or talk about.
- Integrity is about demonstrating that the values you hold you are applying in your day-to-day practice.

3 What are Human Factors:

Human factors refer to environmental, organizational and job factors, and human and individual characteristics which influence behavior at work in a way which can affect health and safety.
Human factors can be defined as anything that affects an individual's performance.

Human factors is to think about three aspects:

The job	The individual	The organization/ environmental
This including: • Nature of the task • Workload • Working environment *This includes matching the job to the physical and the mental strengths and limitations of people.	Including: • Competency • Skills (changeable) • Personality,attitude (fixed) • Risk perception • Sleep deprivation * Individual characteristics influence behavior in complex ways.	Including: • Work patterns • The culture of the workplace, resources Communications • Leadership and so on

The Benefit of Applying Human Factors in Healthcare

.To prevent Medical Errors .

.Understand why healthcare staff make errors

.Identify 'systems factors' threaten patient safety

.To prevent occupational accidents and ill health

Medical errors..

Failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim, such as :

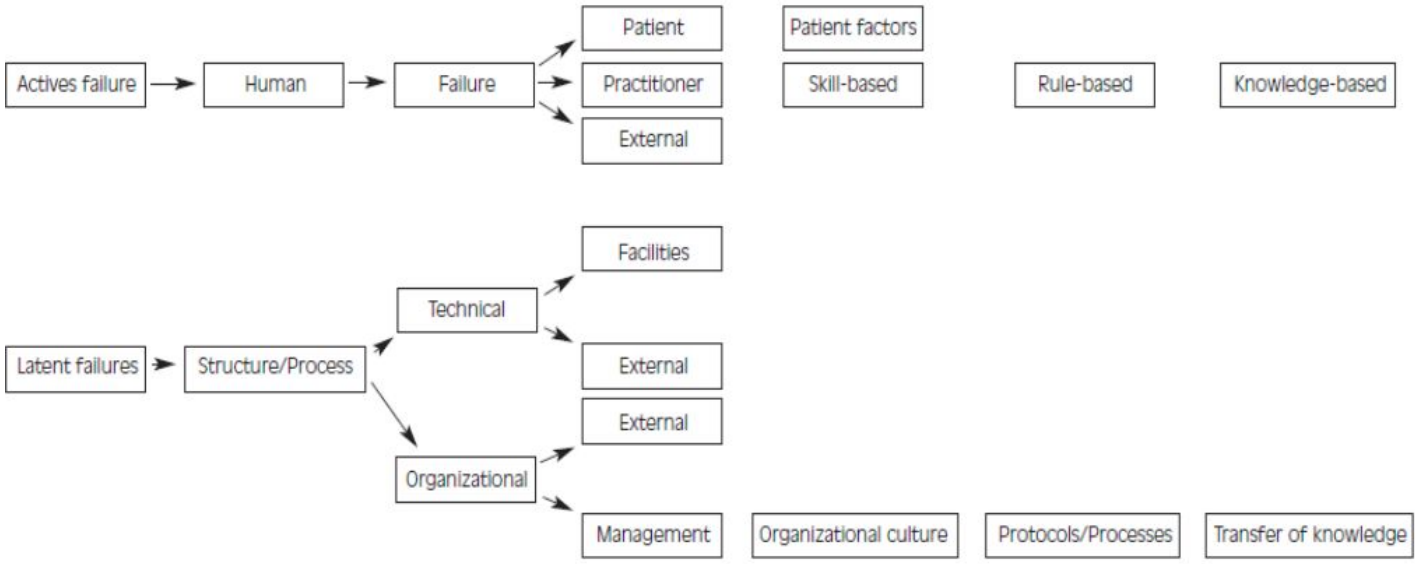
- Retained surgical instruments.
- Restraint -related injuries.

King Saud University Medical City (KSUMC)–Medical Errors:

- Expired medication.
- dispensed Unplanned hysterectomy.
- Wrong Sponge counting.
- Self extubation.
- Wrong patient ID , went to wrong procedure.
- Wrong medication delivered.
- Wrong dose administered.

Table I. Classification of causes (JCAHO - Joint Commission on Accreditation of Healthcare Organizations).

Sources of Error: (Read only)



Modified from Chang et al., 2005 [5].

Types of Medical Errors: (Important)

Treatment

Error in the performance of an operation, procedure, or test(inserting a breathing tube into a patient's esophagus).

Error in the dose or method of using a drug.

Preventive

- Failure to provide
- prophylactic treatment
- Inadequate monitoring or
- follow-up of treatment (no order for anticoagulant post major orthopedic procedure may lead to PE).

Diagnostic

- Error or delay in diagnosis (in the case of the diabetic patient may lead to blindness or glaucoma).
- Use of outmoded tests or therapy.

Other

- Failure of communication.
- Equipment failure.

The Most Common Medical Errors:

- Wrong site surgery (13.4%)
- Patient suicide (11.9%) (not common on our hospitals)
- Operative and post operative complication (10.8%)
- Delay in treatment (8.6 %)
- Medication error (8.1 %)
- Patient fall (6.4 %)

Causes of Medical Errors: (Important)

1- Healthcare Complexity	2-Environmental factors	3-Infrastructure failure
- Complicated technologies. - Drugs interaction. - Intensive care. - Prolonged hospital stay. - Multidisciplinary approach.	- Over crowded services. - Unsafe care provision areas. - Areas poorly designed for safe monitoring.	- Lack of documentation process. - Lack of continuous improvement process.

4- System & Process Design	5- Human Factors and Ergonomics
- Inadequate communication - Unclear lines of authority.	- HALT → Hungry, Angry/ Emotions , Late/ lazy , Tired/fatigue/sleep less. - Lack of skilled workers. - Lack of training

Actions to Reduce Medical Errors as Related to Humans Factors..

Part 1: (Organization level) Organizational Management and Human Factors (important)..

1) Developing a positive safety culture.
   - Just culture.
   - Reporting culture (e-OVR Reporting system).
   - Learning culture(Morbidity and mortality review process).
2) Human factors training in healthcare.
3) Develop Clinical Practice Guidelines , protocols , algorithms.. etc

Part 2: Making your care and work safer (individual level) (important) *Don't memorize the examples

Stress	- Focus first on the tasks that are high risk or where it is particularly important. - In emergency situations : use algorithms and protocols. - Quickly allocate a clear leader. - Consider if there is a way of running a simulation with your team.
Complex calculations	- Find out if there is a pre-calculated list available in your area. - Before you start the task, think about ways of managing or avoiding distractions. For example, ask a colleague to take your bleep for a minute. - Look at the dose strengths of ampoules in your drug cupboard. - Double check with your colleague.
Storage	Look at the products you use and have stored. E.g Look-alike packaging.
Physical demands	- Physical tiredness :get enough sleeping before your duty. - Demands exceeding capability : Most people at some time overestimate their abilities or underestimate their limitations.
Teamwork	Briefing and debriefing can help teams develop a shared mental model of a planned procedure or a patient's clinical status. - SBAR (Situation, Background, Assessment, Recommendation).
Reliance on vigilance and memory	- When you have a large number of tasks to remember making lists can be a helpful. - Checklists or visible permanent reminders (The World Health Organization's (WHO) Surgical Safety Checklist).
Distractions	Think about the tasks you do that require your focus (examples could be giving a blood transfusion, drug prescribing).
The physical environment	Poor lighting: Look at the lighting in the areas where you need to perform detailed or complex tasks.

OVR(Occurrence Variance Reporting) or IR(Incident Reporting):

Occurrence :An Occurrence is defined as any event or circumstance that deviates from established standards of care & safety.

OVR :an internal form/system used to document the details of the occurrence/event and the investigation of an occurrence and the corrective actions taken.

Definition:

- **The World Health Organization's (WHO) defines patient safety as , "the reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum. (WHO, World Alliance for Patient Safety 2009)**
- The IOM Institute of medicine defines patient safety as "The freedom from accidental injury due to medical care or from medical error"
- The goal of the field of patient safety is to minimize adverse events and eliminate preventable harm in health care.
- The Canadian Patient Safety defines patient safety as "the reduction and mitigation of unsafe acts within the healthcare system, as well as through the use of best practices shown to lead to optimal patient outcomes

Introduction

- Significant numbers of patients are harmed due to their health care, either resulting in permanent injury, increased length of stay (LOS) in health-care facilities, or even death.
- About 10% of all patients admitted to hospital will be unintentionally harmed in some way, or about 85,000 adverse events per year.
- 44 – 98,000 deaths annually caused by medical error.
- There are more deaths annually as a result of health care than from road accidents, breast cancer and AIDS combined.
- Recent financial estimates suggest that adverse events cost the Uk £2 billion in 2000 in extra hospital days alone. Other costs, such as suffering of patients, their families and the health care workers involved, are incalculable.

Why is it a problem?

Table B.1.1. Data on adverse events in acute-care hospitals in Australia, Denmark, the United Kingdom and the United States of America

	Study	Year in which data was collected	Number of hospital admissions	Number of adverse events	Adverse event rate (%)
1	USA (Harvard Medical Practice Study)	1984	30 195	1 133	3.8
2	USA (Utah–Colorado study)	1992	14 565	475	3.2
3	USA (Utah–Colorado study)[a]	1992	14 565	787	5.4
4	Australia (Quality in Australian Health Care Study)	1992	14 179	2 353	16.6
5	Australia (Quality in Australian Health Care Study)[b]	1992	14 179	1 499	10.6
6	UK	1999–2000	1 014	119	11.7
7	Denmark	1998	1 097	176	9.0

Source: W

KKUH	2014 2015	47211 38302	2950 3369	6.2 11.2

Patient safety dimensions of healthcare quality:
The 6 key dimensions of healthcare quality

Safe	Avoiding injuries to patients from the care that is intended to help them.
Timely	Reducing waits and avoid harmful delays (sometimes unfavorable delays) for both those who receive and those who give care.
Effective	• Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse). • Doing the right thing for the right person at the right time.
Efficient	Avoiding waste, in particular waste of equipment, supplies, ideas and energy.
Equitable **Equal**	• Dealing fairly and equally with all patients . • Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socio-economic status
Patient centered **Family-centered**	• Should be respectful to patient need & values. • Providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.

Harm VS Error

Harm	Error
Impairment of structure or function of the body and/or any deleterious effect arising from interaction with health care. Harm includes disease, injury, suffering, disability and death.	An error is a failure to carry out a planned action as intended. Errors may manifest by doing the wrong thing (commission) or by failing to do the right thing (omission).
Example: A patient with breast cancer undergoes chemotherapy. The treatment causes severe nausea and vomiting (a known complication) and she is admitted with clinical dehydration.	Example, a patient with shortness of breath is diagnosed with pneumonia and treated with an antibiotic. A few days later she is admitted as her condition worsens. Subsequent investigations reveal a pulmonary embolism as the true problem. This is treated with anticoagulation.

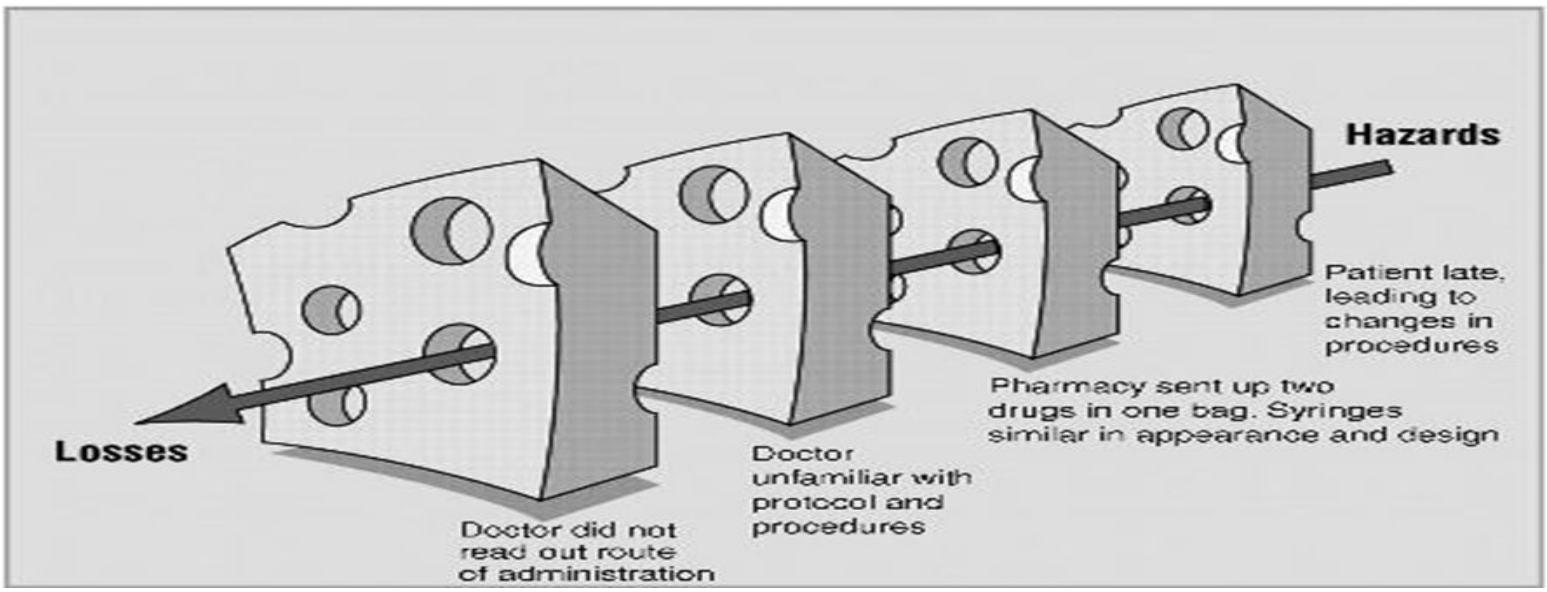
Sources of System Error:

All errors can be divided into two main groups:	
Active errors or human error are committed by frontline staff and tend to have direct patient consequences. Example, giving the wrong medication, treating the wrong patient or the wrong anatomical site, or not following the correct policies and procedures.	**Latent or system errors** are those errors that occur due to a set of external forces and indirect failures involving management, protocols/ processes, organizational culture, transfer of knowledge, and external factors. Example : understaffed wards or inadequate equipment.

Error in medicine:

- Errors in health care can be caused by "active failures" or "latent conditions."
- Most errors are not a result of personal error or negligence, but arise from system flaws or organizational failures

"Swiss cheese" model of accident causation:



- The systems have many holes: some from active failures and others from latent conditions.
- These holes are continuously opening, shutting, and shifting their location. In any one slice, they do not normally cause harm, because the other intact slices prevent hazards from reaching the potential victim.
- Only when the holes in many layers momentarily line up does the trajectory of accident opportunity reach the victim causing the damage.

Culture of patient safety (Definition from the Health and Safety Commission)
The safety culture of an organization is the product of individual and group values, attitudes, perceptions,, and patterns of behavior that determine the commitment to, and the style and proficiency of an organization's health and safety management.

Definition of patient safety culture:

An integrated pattern of individual and organizational behavior, based on a system of shared beliefs and values, that continuously seeks to minimize patient harm that may result from the process of care delivery.

Safety culture divided into seven subcultures and defined as:

Leadership	Evidence based	Communication
Learning	Teamwork	Just a culture and Patient centred

Patient safety culture:

- Previously, in many cases the traditional response to adverse incidents in health care has been to **blame, shame and punish** individuals.
- The opposite of a 'blame' culture is a **'blame-free'** culture, which is equally inappropriate. In some instances, the responsible individual should be held accountable.(in case of negligence or recklessness)
- Recently , the a **'just' culture** has been adapted which means : balancing the 'blame' and 'no blame' approaches

Example:

If a patient is found to have received the wrong medication and suffered a subsequent allergic reaction:

- **Blame culture:** we look for the individual student, pharmacist, nurse or doctor who ordered, dispensed or administered the wrong drug and blame that person for the patient's condition care at the time of the incident and hold them accountable
- **Just Culture:** we look for the system defect such as communication , protocols and processes for medication management , in addition to investigate the negligence or recklessness of the worker.

The concept of Clinical incident:

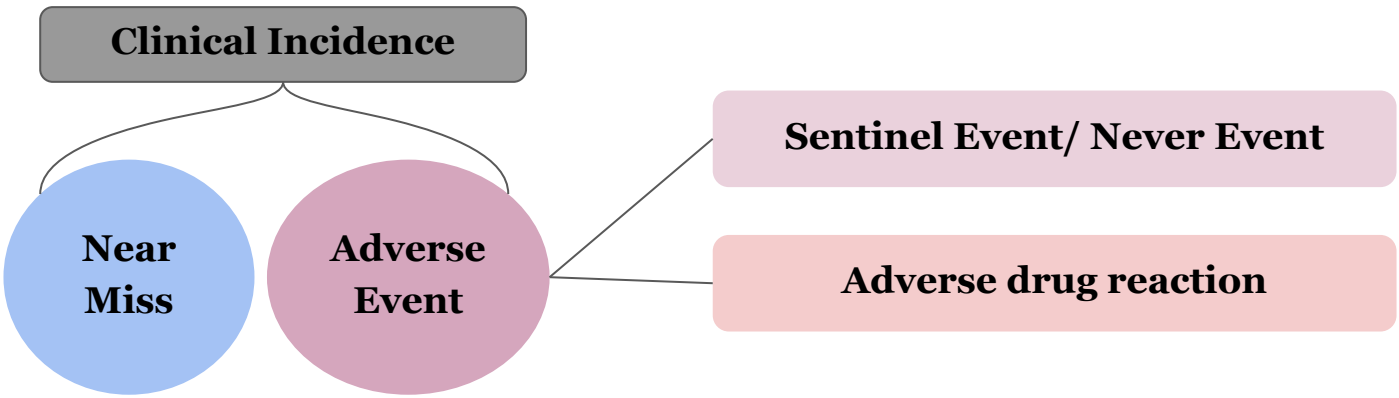
Definition:

A clinical incident is an event or circumstance resulting from health care which could have, or did lead to unintended harm to a person, loss or damage, and/or a complaint. (deviation from standard of care and safety)

Examples:

- Medication errors (e.G. Wrong medication, omission, overdose). - Patient falls.
- Intended self harm or suicidal behaviour. - Therapeutic equipment failure.
- Contaminated food. - Problems with blood products. - Documentation errors.
- Delayed diagnosis. - Surgical operation complications. - Hospital acquired infection.

Types of Clinical incident: (important)



Near miss:

Is any situations that did not cause harm to patients (that did not reach the patient) , but could have done.

Adverse Event:

An adverse event is an unintended injury or complication which results in disability, death or prolonged hospital stay, and is caused by health- care management.

Example: *Medication errors*

A-Sentinel events: (قدر الله وماشاء فعل)

A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function.

Example:

Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities

B-Never Events:

Events should never happen while in a hospital, and can be prevented in most cases.

Example:

- Infant discharged to the wrong person.
- Wrong surgical procedure performed on a Patient.
- Patient death or serious disability associated with a medication error.

C- Adverse drug reaction:

A response to a drug which is noxious and unintended, and which occurs at doses normally used in man for the prophylaxis, diagnosis, or therapy of disease, or for the modifications of physiological function'.(WHO,1972)

Seven (7) levels of safety

- **Patient factors:** such as personality, language and psychological problems may also be important as they can influence communication with staff.
- **Task factors:** The design of the task, the availability and utility of protocols ….
- **Individual factors:** include the knowledge, skills and experience of each member of staff
- **Team factors:** The way an individual practices, and their impact on the patient, is influenced by other members of the team and the way they communicate and support each other.
- **Working conditions:** These include the physical environment, availability of equipment and supplies and the light, heat, interruptions and distractions that staff endure.
- **Organizational factors:** The team is influenced in turn by management actions and by decisions made at a higher level in the organization. These include policies, continuing education, training and supervision and the availability of equipment and supplies.
- **External environment factors:** The organization itself is affected by financial constraints, external regulatory bodies and the broader economic and political climate.

The physician's role in patient safety:

- Standardization, such as the use of order sets, protocols, and reminders.
- **Designing safe systems and implementation of technology:**
  - use smart intravenous pumps that detect medication errors,
  - barcoding to ensure the five rights of medication administration (right patient, right route, right dose, right time, right medication).
- Teamwork
- **Communication:**
  - poor communication can delay diagnosis, create confusion regarding the plan of care, and increase the cost of care through repeated tests.
  - Lack of effective communication creates frustration with patients and families and increases their anxiety
- Involve yourself in measuring, monitoring, and improving quality.
- Avoid blaming when an error occurs.
- Practice evidence-based care.
- Detect adverse events: report and Disclose errors to patients and their families.
- Adhere and follow the National Patient Safety Goals/ ROP (Required Organization Practice) *details next page*

Adhere and follow the national Patient Safety Goals/ROP (Required Organization Practice):

- Adverse reporting
- Client verification
- Medication reconciliation
- Dangerous abbreviations
- Transfer of client information at transition points
- Control of concentrated electrolytes
- Infusion pumps training
- High-alert medications
- Hand hygiene
- Antibiotic prophylaxis during surgery
- Falls prevention strategy
- Pressure ulcer prevention
- Venous thromboembolism prophylaxis
- Safe injection practices
- Safe surgical practices
- Preventive maintenance program

Case study-1

Recommended actions:

- Pharmacists / Technician should READ / CHECK carefully the label of each medication they prepare.
- DOUBLE CHECKING is essential tool to avoid such mistakes
- Look Alike medications should be stored separately with proper labeling to avoid such mistakes, or change the brand the hospital purchases of either drugs if possible.

Tips of improvement patient safety: (Not important)

- Constitution of patient safety committee
- Develop clear policies and protocol for patient safety
- Discuss regularly patient safety initiative within hospital staff
- Orientation hospital staff on patient safety
- Encourage transparency in the regular death review
- Non punitive reporting by staff
- Review , monitor and evaluate safety procedures regularly

Case For Practice

A 38-year-old woman comes to the hospital with 20 minutes of itchy red rash and facial swelling; she has a history of serious allergic reactions. A nurse draws up 10 mls of 1:10,000 adrenaline (epinephrine) into a 10 ml syringe and leaves it at the bedside ready to use (1 mg in total) just in case the doctor requests it. Meanwhile the doctor inserts an intravenous cannula. The doctor sees the 10 ml syringe of clear fluid that the nurse has drawn up and assumes it is normal saline. There is no communication between the doctor and the nurse at this time. The doctor gives all 10 mls of adrenaline (epinephrine)through the intravenous cannula thinking he is using saline to flush the line.The patient suddenly feels terrible, anxious, becomes tachycardia and then becomes unconscious with no pulse. She is discovered to be in ventricular tachycardia, is resuscitated and fortunately makes a good recovery. Recommended dose of adrenaline (epinephrine) in anaphylaxis is 0.3 - 0.5 mg IM, this patient received 1mg IV

Can you identify the contributing factors for this error?

- Lack of communication
- Inadequate labeling of syringe
- Giving a substance without checking and double checking what it is
- Lack of care with a potent medication

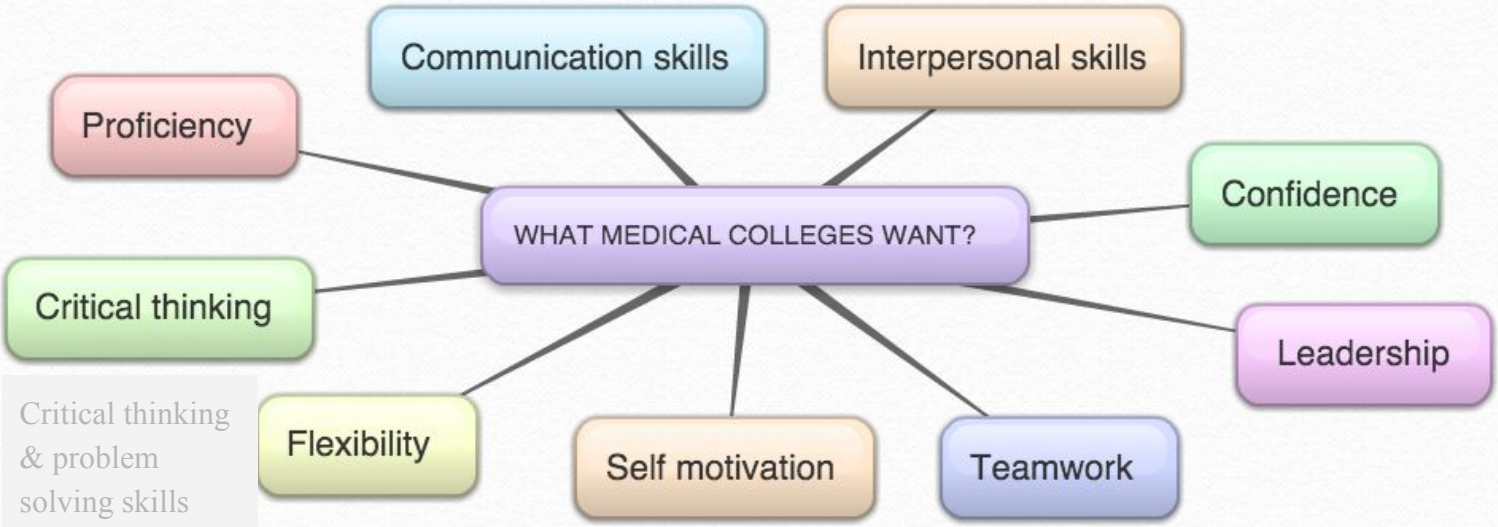
How could this error have been prevented?

- Never give a medication unless you are sure you know what it is; be suspicious of unlabeled syringes
- Never use an unlabeled syringe unless you have drawn the medication up yourself
- Label all syringes
- Communication - nurse and doctor to keep each other informed of what they are doing e.g. nurse: “I’m drawing up some adrenaline”
- Develop checking habits before administering every medication … go through the 5 Rse.g doctor: “What is in this syringe?”

Conclusion:

- The field of patient safety has emerged in response to a high prevalence of avoidable adverse events
- Patient safety is the avoidance, prevention and amelioration of harm from healthcare.
- **Two approaches to the problem of human fallibility exist:**
    - **The person approach:** focuses on the errors of individuals, blaming them for forgetfulness, inattention, or moral weakness
    - **The system approach:** concentrates on the conditions under which individuals work and tries to build defences to avert errors or mitigate their effects
- Some errors cause harm but many do not.
- Blaming and then punishing individuals is not an effective approach for improving safety within the system
- Adverse events often occur because of system breakdowns, not simply because of individual ineptitude prompted the change computerized prescribing reduces medication error but is not a panacea
- Patient, task, individual, team, environment, organizational and institutional context factors may all influence incidents and accidents
- Standardizing and simplifying clinical processes is a powerful way of improving patient safety

What medical colleges want:



Deanship of all Medical Colleges

In Saudi Arabia, a national call to define the competencies of medical graduates has been given a higher priority with the expansion of medical education in the Kingdom (Bin Abdulrahman 2008, 2011).

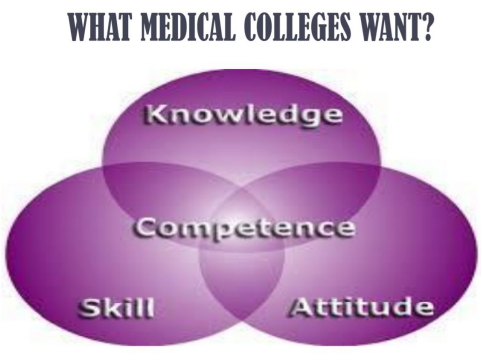
Core competencies:

The national competence framework that has been developed by medical schools in the Kingdom of Saudi Arabia (SAUDI MEDS)

Saudi Meds: A competence specification for Saudi medical graduates

KSU Medical College Outcomes:

1. Communication and consultation skills
2. Clinical care & Research
3. Health promotion and disease prevention
4. The family and community context of healthcare
5. Personal professional development
6. Use of technology and information gathering
7. Attitudes, ethics and professionalism



http://teresachinn.co.uk/is-nursing-competence-evident-online/

Saudi Meds

Competency – based curriculum

Competence

What is competence?

The ability to perform a specific task in a manner that yields desirable outcomes.

Different Aspects of Competence:

1. Knowledge
2. Skills "What you have learned to do"
3. Abilities "What you can actually do"

Competence develops over time and is nurtured by reflection on experience.

Skills	Abilities
- It's the capacity to perform specific actions. - A person's skill is a function of both knowledge and the particular strategies used to apply knowledge.	- The **power or capacity** to do something or act physically, mentally, legally, morally, etc.
(Acquired) **- Can be taught and/or learned.** - Is something that can be learned or acquired through training and can be cognitive, perceptual and motor.	(Innate) **- Is performance, or what you are able to do.** - Is the generic make up of an individual either perceptual or motor in nature that can be inherited from one's parents.

How is competence acquired?

It is **gained** in the healthcare professions **through:**

- Pre-service education.
- In-service training.
- Work experience.

(CPD)

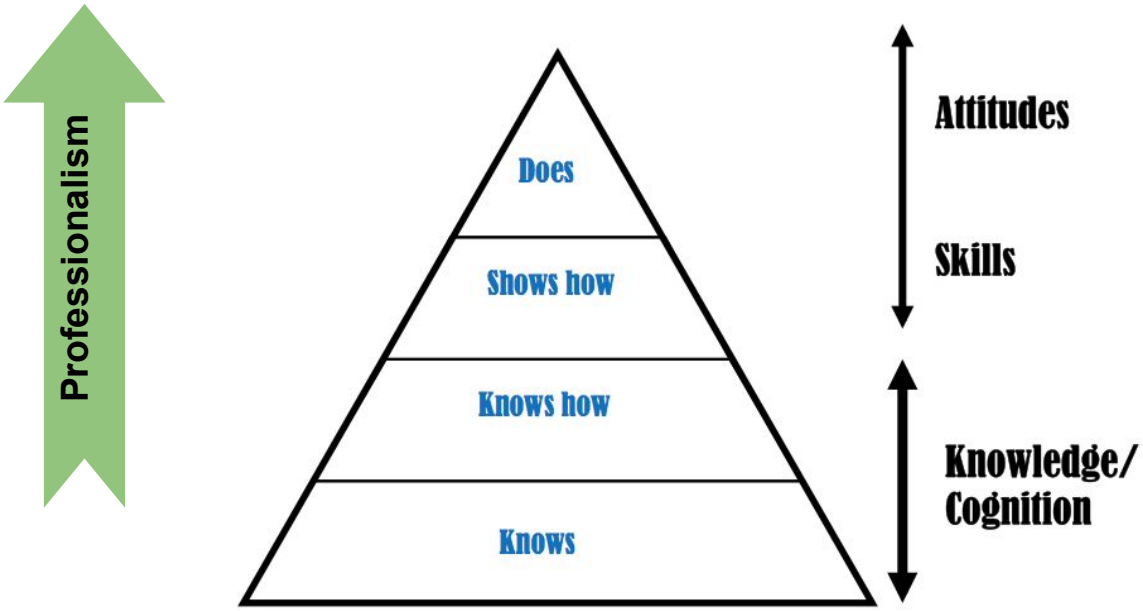
Levels of competence :

Novice → Advanced Beginner → Competent → Proficient → Expert

Levels of competence in Medical Field:

Medical student → Intern → Resident → Registrar → Consultant

Miller's Pyramid of Clinical Competence :



Bloom's Taxonomy :

- Knowledge - What is the most common cause of...?
- Understand - If you see this, what must you consider...?
- Application - In this patient, what is causing...?
- Analysis,synthesis,evaluation - critical thinking?

Continuous Professional Development (CPD)

What is (CPD)?

- The conscious updating of professional knowledge and the improvement of professional competence **throughout a person's working life.**
- It is a commitment to being professional, keeping up to date and continuously seeking to improve.
- It is the key to optimizing a person's career opportunities, both today and for the future.

Why (CPD)?

Improtant

Cardinal reasons:

- Half-life of what we learn is very short.
- If we do not update, we will practice obsolete medicine.
- There is a high chance that patients will not get optimal care.
- Requirement by the governing bodies of the profession. (This is only an ostensible reason).

How is CPD different ?

- CPD is for professionals but not in a formal educational setting .
- There are no class rooms, prescribed curricula, prescribed learning events, etc.
- Therefore, the learner needs to learn from whatever he/she does in the workplace.
- Also, there are no formal examinations , Motivation to learning comes from the necessity to improve practice.

How can we achieve CPD?

- Lecture programs
- CME courses (Continuing Medical Education)
- Others .
- Conferences
- Workshops

Many methods have been tried in the past .Currently, reflective practice/learning is the most favoured .

What is Reflective learning ?

Important

- Systematic revisiting of a learning experience with a view to learning from it.
- Reflection relates to a complex and deliberate process of thinking about and interpreting experience, in order to learn from it

Why Reflective learning ?

Key to become a lifelong learner – if not most learning opportunities are lost.

Reflection Stages:

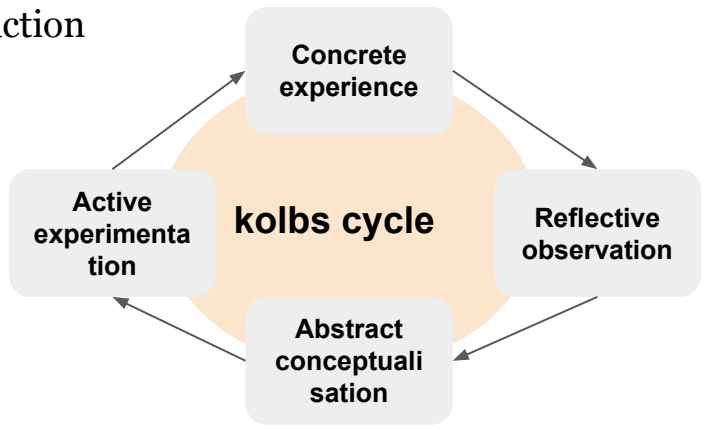
An awareness of uncomfortable feeling → Examination of situation → Exploration of alternative actions → Reflective thoughts results in action

Reflective log : (a simplified version)

1. What is the learning event?
2. What did I learn?
3. What more do I have to learn?
4. How can I learn it?
5. Evidence for further learning / change of practice?

Reflective practice

6. Reflection-in action
7. Reflection-on action



Scenario

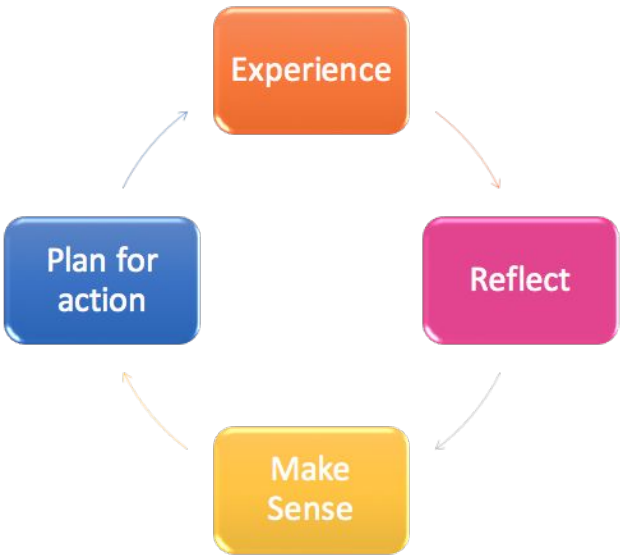
Improtant to be Undestood

- A 55 year old man came to clinic with complaint of low back pain (LBP)
- You have examined his back which was ok.His height was 160 cm, and weight is 100 kg.
- You would like to manage this patient's LBP contributed due to his excess body weight.

How to apply the reflective log ?

1- Learning experience – This obese person who needed to reduce weight.
2- What did I learn? Learned how the patient's activities have been affected by obesity.
3- What do I have to learn more? Did not know the advice that should be given to the patient with a given BMI. Are there guidelines for interpreting BMI?
4- How do I learn it? (SDL) Refer a book/article. Talk to the dietician.
5- Evidence / change of practice – BMI was accurately interpreted. Patient was advised about the dietary/lifestyle changes and referred to an obesity clinic. References of books referred.

Experiential Learning



Constraints on Development

(Development is a continuous process but sometimes it happens to be a broken continuity)

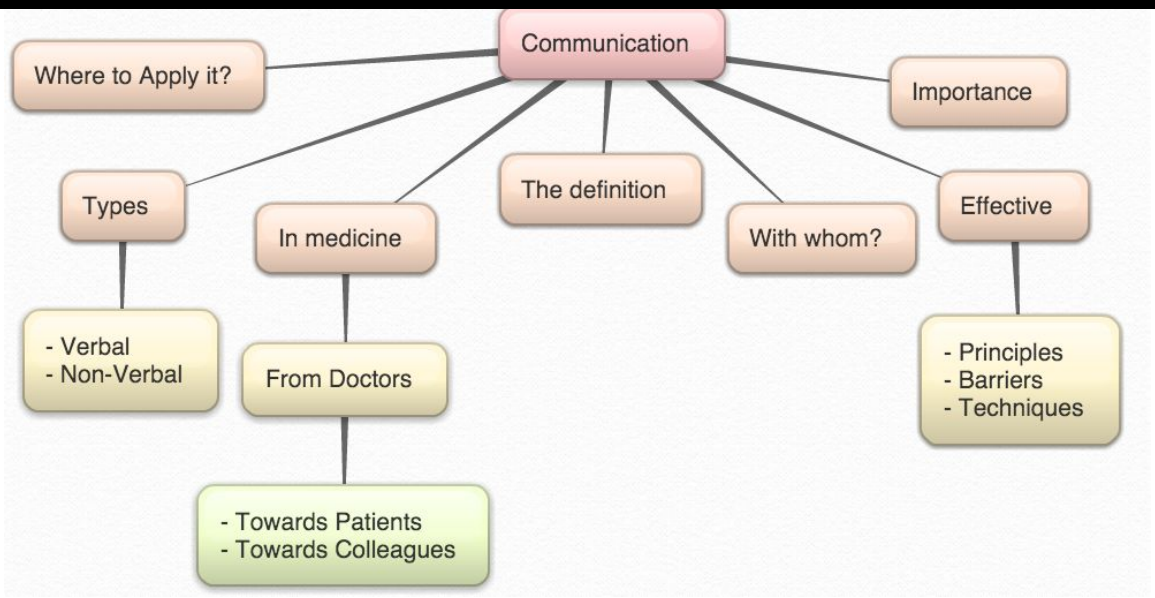
- Time
- Budgets
- Life Cycle Issues
- Motivation
- Lack of Trust and Real Leadership

Notes:

1- Levels of competence are acquired through:
- Continuous Professional Development.
- Reflection & Reflective Practice.

2- Competence develops over time and is nurtured by reflection on experience.

The Concept of Communication Skills In Medicine



What is Communication?

- Is the act by which information is shared between humans
- It is the process by which we relate and interact with other people.
- It includes listening & understanding with passion & respect as well as expressing views & ideas and passing information to others in a clear manner.

Communication theory:

Communication is a learned skill, based on 3 pillars:

Accuracy ✚ **Efficiency** ✚ **Supportiveness** 〓 **Effectiveness of communication**

Communication & medicine:

- Historically the emphasis was on the biomedical model in medical training which places more value on technical proficiency than on communication skills.
- Recently learning communication skills & evidence based practice become the cornerstones of modern medicine.

Types of communication

Verbal = 35% (mainly focuses on questioning)	**Non-verbal = 65%**
1. **Open** (broad) – gives control to respondent, allows disclosure. 2. **Open** (focused) – gives control to respondent within a given area, encourages disclosure of feelings. 3. **Closed** – control is with interviewer, checks information. 4. **Leading** – control with interviewer, suggests desired response.	• Listening (active and passive) • Silence • Touch • Hand gestures • Eye contact • Posture • Facial expression
Speaking to the person: - Look straight in the eye - make eye contact - Show respect	
Clear message: - Relevant - Use understandable language - Support by illustrations if needed	
Good listener: - Allow others to understand the message and reply - Listen carefully - Make a dialogue and not one way instruction	

Importance of communication:

- Effective communication is the basis of **mutual understanding** & trust.
- Poor communication causes a lot of **misunderstanding** & hinders work and productivity.

Why do we communicate?

- To develop relationships
- To increase our knowledge
- To make our feelings and thoughts known
- To find out about people & To find out information

Communication in medicine:

- Increases patient satisfaction and health outcomes (Barlett, Grayson et al., 1984)
- Reduces the risk of complaint and litigation (Beckmam 1994)
- Higher levels of job satisfaction (Kramer et al., Suchman et al., 1993)

Doctors need to learn/practice essentials of good communication more than other professionals, Why ?

- Because patients are humans with sensitive needs.
- Doctors cannot practice medicine without effective communication skills.
- Poor communication causes a lot of medico-legal and ethical problems.

Effective communication: for (patients / you as a Doctor)

- Ensures good working relationship
- Increases patients satisfaction
- Increases patients understanding of illness & management
- Improves patients compliance with treatment
- Reduces medico-legal problems
- Reduces uncertainty
- Communication Influences Your Thinking about Yourself and Others. It Influences How You Learn & Represents You. In addition, Communication Skills Are Desired by all organizations / institutions

What is required from Doctors?

Towards patients	Towards colleagues
❖ Listen to patients and respond to their concerns and preferences. ❖ Give patients information in way they can understand ❖ Taking patient's views into consideration when assessing their condition ❖ Respond to patients questions, keep them informed & share information . ❖ You must make sure, wherever practical, that arrangements are made to meet patient's language and communication needs. ❖ You must be considerate to relatives, carers and partners in providing information and support.	❖ Communicate effectively with colleagues within and outside the team ❖ Make sure your colleagues understand your role and responsibilities in the team and who is responsible for each aspect of patient care ❖ You must treat your colleagues fairly and with respect.

Communication, with whom?

- Patients & care-givers
- Nurses & auxiliary staff الموظفين المساعدين
- Colleagues
- Administrators
- Reporting research findings
- Talking to the media
- Public & legislature الهيئة التشريعية، مثل البرلمان و الكونغرس

Where to apply our Communication skills?

The **medical interview** is the usual communication encounter between the doctor and the patient.

It can be classified according to the purpose of the interview into 4 types:

1. History taking
2. Consultations
3. Obtaining informed consent
4. Breaking bad news

Principles of effective communication:

- Planning
- Interaction rather than a direct transmission
- Flexibility in relation to different individuals and contexts.
- Ability to handle emotional outbreaks

Communication with peers:

- Mutual trust & respect - Exchange information - Ask your seniors

Communication & Medical care:

- Good communication should be established between the patient, the family and the treating multidisciplinary team.
- Patient & family should be encouraged to participate and verbalize in the ward round discussion about:
  - Offered medical care & treatment.
  - Rehabilitation.
  - Follow- up/ re-admission plan.
  - Doubts & worries.
- Proper information to patient and family regarding services available and how they can utilize them.

Communication skills: Some techniques:

- PRACTICE fluent dialogue with patient
- USE silence effectively, allowing patient enough time to express thoughts or feelings
- ENCOURAGE patients with your supportive words
- UTILIZE non-verbal communication.

Listening vs Hearing	
Hearing	Listening
A passive activity; no effort	-Attention - Active involvement. - Full understanding - Takes time and effort

Barriers to effective communication:

- Personal attitudes
- Ignorance
- Human failings (tiredness, stress)
- Language
- Poor time management
- Strenuous working environment

Conclusion

- Effective communication is the key to success in professional career.
- Good communication is essential for proper doctor-patient relationship and help avoids problems of misunderstanding.

Medical error: important

An error is a failure to carry out a planned action as intended. or the use of a wrong plan to achieve an aim.

Violations: are errors caused by deliberate deviation by an individual from an accepted protocol or standard of care.

Principal Types of Human errors :

A- Mistakes: Failure of planning

Rule-based: E,g: wrong diagnosis end with inappropriate treatment plan

Knowledge-based : E.g: when physicians are dealing with unfamiliar clinical situations.

B- Skill-based errors:

Slips error: If the action is observable e.g pushing the wrong button on a piece of equipment

Lapse error: If the action is NOT observable e.g a memory failure, such as forgetting to administer a medication.

Types of medical errors: important

diagnostic	Treatment	Preventive	other
•Error or delay in diagnosis(in the case of the diabetic patient may lead to blindness or glaucoma) •Use of outmoded tests or therapy	•Error in the performance of an operation, procedure, or test(inserting a breathing tube into a patient's esophagus). •Error in the dose or method of using a drug	• Failure to provide prophylactic treatment. •Inadequate monitoring or follow-up of treatment (no order for anticoagulant post major orthopedic procedure may lead to PE).	•Failure of communication •Equipment failure

- **A clinical incident:** Is a deviation from standard of care and safety
  Examples: Medication errors.
- **Near miss:** Is any situations that did not cause harm to patients (that did not reach the patient) , but could have done.

Ways to learn from errors:

1- incident reporting: Incident reporting and monitoring involve collecting and analyzing information about any event that could have harmed or did harm a patient in a clinical setting or health-care organization.

2- Root Cause Analysis(RCA):

- Is a highly structured systemic approach to incident analysis.
- RCA focuses on the system, not the individual.

Factors Associated with an Increased Risk of Error :

1- Situations Associated with an Increased Risk of Error	
Shortage of time:	time pressures encourage people to cut corners and take shortcuts when they should not. •e.g. Not cleansing hands properly is an example of this.
Inexperience	it is very important not to perform a procedure or administer a treatment for very first time without appropriate preparation
Inadequate checking	•The simple act of checking saves thousands of patients from receiving the wrong medications.
Poor procedures:	Inadequate preparation, inadequate staffing and/or inadequate attention to the particular patient
Inadequate information	•Misinformation, incorrect and inadequate information are often factors contributing to adverse events. Due to: •Recoding the patient details inaccurately •Illegible handwriting in the patient record

2- Individual factors that predispose to errors	
Limited memory capacity	Learning to ask for help is an essential skill
fatigue	when they worked frequent shifts of 24 hours or more as compared to when they worked shorter shifts.
Stress, hunger and illness	• HALT : •H Hungry. •A Angry. •L Late. •T Tired. • IM SAFE : •I Illness. •M Medication. •S Stress. •A Alcohol •F Fatigue. •E Emotion.
Language or cultural factors:	Communication errors caused by language and cultural factors is obvious
Hazardous attitudes	Students who perform procedures or interventions for patients without supervision might be said to display a hazardous attitude.

Understanding & Managing Clinical Risk:

- **Hazard:** is any activity, situation or, substance that potential to cause harm, including ill health, injury, loss of product and/or damage to plant and property.
- **Risk:** is the probability that harm (illness or injury) will actually occur.

What is clinical risks?

Is the chance of an adverse outcome resulting from: clinical investigation, treatment or patient care.

Clinical risk management: Organizational effort to identify, assess, control and evaluate the risk to reduce harm to patient, visitors and staff and protect the organization from financial loss

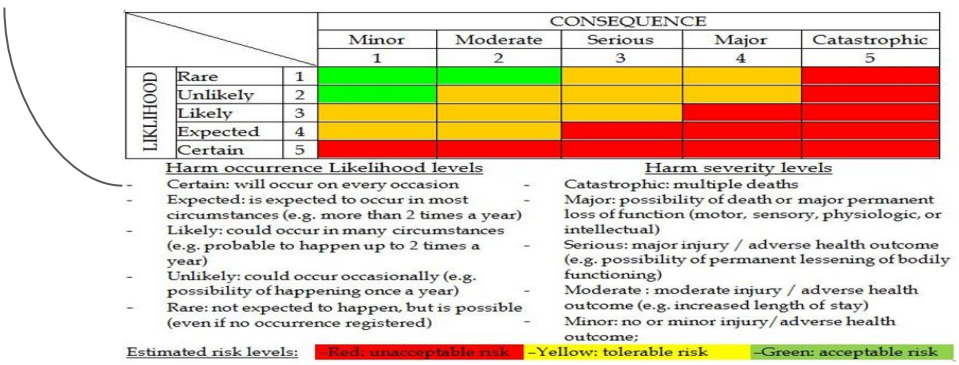
Purpose of Risk Management :

- Improve organizational and client safety
- Identify and minimize the risks and liability losses
- Protect the organization resources
- Support regulatory, accreditation compliance
- Creating and maintaining safe systems of care, designed to reduce adverse events and improve human performance.

➔ **4 step process to manage clinical risks :**

1. Identify the risk
2. assess the frequency and severity of the risk
3. reduce or eliminate the risk
4. Reviewing the effectiveness of the assessment and action plan Assess the costs saved by reducing the risk or the costs of not managing the risk

Clinical risk assessment tool : (Not important)



			CONSEQUENCE				
			Minor	Moderate	Serious	Major	Catastrophic
			1	2	3	4	5
LIKLIHOOD	Rare	1					
	Unlikely	2					
	Likely	3					
	Expected	4					
	Certain	5					

Harm occurrence Likelihood levels

- Certain: will occur on every occasion
- Expected: is expected to occur in most circumstances (e.g. more than 2 times a year)
- Likely: could occur in many circumstances (e.g. probable to happen up to 2 times a year)
- Unlikely: could occur occasionally (e.g. possibility of happening once a year)
- Rare: not expected to happen, but is possible (even if no occurrence registered)

Harm severity levels

- Catastrophic: multiple deaths
- Major: possibility of death or major permanent loss of function (motor, sensory, physiologic, or intellectual)
- Serious: major injury / adverse health outcome (e.g. possibility of permanent lessening of bodily functioning)
- Moderate : moderate injury / adverse health outcome (e.g. increased length of stay)
- Minor: no or minor injury/ adverse health outcome;

Estimated risk levels: -Red: unacceptable risk -Yellow: tolerable risk -Green: acceptable risk

Identify the risk	Assess the frequency and severity of the risk	Reduce or eliminate the risk
Use the following data as a sources for risk identification: •Adverse event reports. •Mortality and morbidities reports. •Patient complaints reports. •Assess the frequency and severity of the risk.	SAC (Severity Assessment Code) Score: it is a matrix scoring system/ numerical scores are given to the severity and likelihood of risks and these scores are multiplied to get a rating for the risk	• extreme risk-immediate action required • high risk-need to notify senior management • medium risk-managment responsibility must be specified • low risk-manage by routine procedures

Activities Commonly Used to Manage Clinical Risk: (Important, try to understand the definitions)

1- Incident reporting :

- **An incident:** as an event or circumstance that could have or did lead to unintended and/or unnecessary harm to a person and/or a complaint, loss or damage.
- **Incident monitoring:** refers to mechanisms for identifying, processing, analyzing and reporting incidents with a view to preventing their reoccurrence

  The key to an effective reporting system is for staff to routinely report incidents and near misses.

2- Sentinel Event:

Is an unexpected occurrence involving death or serious physical or psychological injury ex:opperating on the wrong side or wrong patient.

e.g. surgery on the wrong patient or body site, incompatible blood transfusion.

- Many health-care facilities have mandated the reporting of these types of events because of the significant risks associated with their repetition.

3- Patient complain:

A complaint : is defined as an expression of dissatisfaction by a patient, family member or carer with the provided health care.

- Complaints often highlight problems that need addressing, such as poor communication or suboptimal decision making.
- Communication problems are common causes of complaints, as are problems with treatment and diagnosis.
  - Benefits of complaints:
    - Assist the maintenance of high standards;
    - Reduce the frequency of litigation;
    - Help maintain trust in the profession;
    - Encourage self-assessment.
    - Protect the public.

Fitness-to-practice requirements: (important)

- Accountability.
- Competency of healthcare professionals.
- Are they practicing beyond their level of experience and skill? Are they unwell, suffering from stress or illness.

Credentialing	Registration (licensure)	Accreditation
The process of assessing and conferring approval on a person's suitability to provide specific consumer/patient care and treatment services, within defined limits, based on an individual's licence, education, training, experience, and competence.	•Registration of health-care practitioners with a government authority, to protect the health and safety of the public through mechanisms designed to ensure that health practitioners are fit to practise. •E.g Saudi Commission for Health Specialties •Proper registration is an important part of the credentialing and accreditation processes	•Is a formal process to ensure delivery of safe, high-quality health care based on standards and processes devised and developed by health-care professionals for health-care services. •National Accreditation Program: CBAHI •International Accreditation Program: Joint commission (US), Accreditation Canada(Canada).

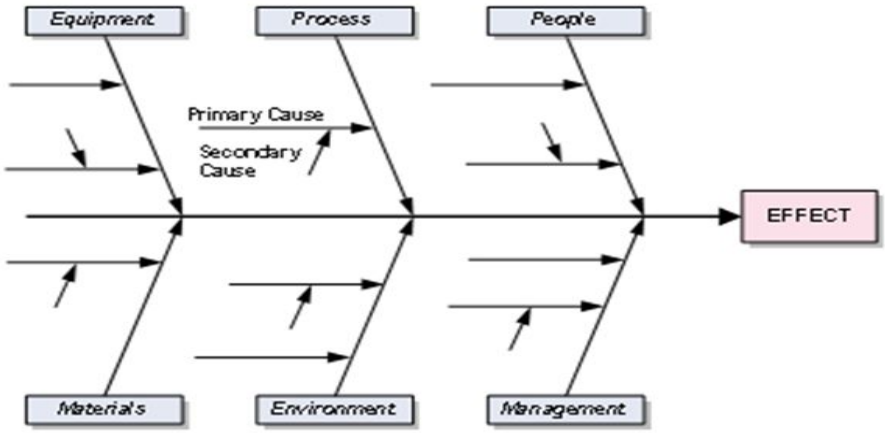
Personal Strategies for Managing Risk and Reduce Errors: READ

- Care for one's self (eat well, sleep well and look after yourself).
- Know your environment.
- Know your task(s).
- Prepare and plan (*what if…*).
- Build checks into your routine.
- Practice the good documentation:
  - A referral or request for consultation : it is important to only include relevant and necessary information.
  - Keep accurate and complete health-care records.
  - Provide sufficient information.
  - Note any information relevant to the patient's diagnosis or treatment and outcomes.
  - Document the date and time.
- Report any risks or hazards/incidents in your workplace.
- Participate in meetings to discuss risk management and patient safety.
- Respond appropriately to patients and families after an adverse event.
- Respond appropriately to complaints.
- Ask if you do not know. Request that a more experienced person.

Case Study:

A 58-year-old female was being treated for non-Hodgkin's lymphoma. Vincristine was prepared in a 20 ml syringe and delivered in a package containing two other drugs, including methotrexate. Route of administration was not indicated on the solutions. The intrathecal treatment was administered at noon. The hematologist was particularly busy and requested help from another doctor who had not recently participated in intrathecal procedures. The medication was delivered in the patient's room.
The nurse who assists was not familiar with the intrathecal procedures. The 20 ml syringe with vincristine was passed to the doctor who started to inject it. After administering approximately 2 ml, he noticed the size of the syringe and ceased administration realizing the error.

- The patient died approximately 100 days later.
- Identifying the care management problems.
- Identifying the contributory factors.
- Suggested actions.



Summary

- Medical error is a complex issue, but error itself is an inevitable part of being human.
- These tips are known to limit the potential errors caused by humans:
  - Avoid reliance on memory
  - Simplify process
  - Standardize common processes and procedures
  - Routinely use checklists
  - Decrease reliance on vigilance
- Learning from error can occur at both an individual level and an organizational level through incident reporting and analysis.
- Root cause analysis (RCA) is a highly structured systemic approach to incident analysis that is generally reserved for the most serious patient harm episodes
- Health-care professionals are responsible for the treatment, care and clinical outcomes of their patients.
- Personal accountability is important, as any person in the chain might expose a patient to risk.
- One way for professionals to help prevent adverse events is to identify areas prone to errors.
- The proactive intervention of a systems approach for minimizing the opportunities for errors can prevent adverse events.
- Individuals can also work to maintain a safe clinical working environment by looking after their own health and responding appropriately to concerns from patients and colleagues.

Mindmap:

What is a team?

A team is a group of two or more individuals (have limited lifespan of membership) who:

- Interact dynamically.
- Have a common goal, objective, mission.
- Have been assigned for specific tasks.
- Possess (have) specialized and complementary skill.

The team might be:

- Multidisciplinary team (OR team), VS Intact team (same discipline e,g IV team)
- Single owner VS **different owner**
- Fixed team, (A constant set of members) VS Fluid team (the memberships may change frequently)
- **Temporary teams VS Permanent teams (**human resources team, operation team)
- Physical Team VS Virtual team

Why teamwork is an essential element of patient safety?

The importance of effective teams in healthcare is increasing due to factors such as:

1. The increased incidence of complexity and specialization of care.
    - E. g. a pregnant woman with diabetes who develops a pulmonary embolus. **The health-care team might include:** Nurses, a midwife, an obstetrician, an endocrinologist and a respiratory physician, as well as the patient.
2. Increasing co-morbiditie. (so you need more than one speciality to treat the patient)
3. Increasing incidence of chronic diseases.
4. Global workforce shortages.
5. Initiatives for safe working hours. (عند وجود فريق سيخفف ضغط ساعات العمل على الفرد)

Teams found in health care:

Core teams الفريق الأساسي	Core teams consist of team leaders and members who are **directly involved** in caring for the patient. • Include direct care providers such as: nurses, pharmacists, doctors, dentists, assistants and, of course, the patient.
Coordinating teams فريق التنسيق	• Is the group responsible for day-to-day operational management, **coordination functions** and resource management for core teams. • Nurses often fill such coordinating.
Contingency teams فريق الطوارئ	Contingency teams are formed for **emergent** or **specific events** (e.g. cardiac arrest teams, disaster response teams, rapid response teams).
Ancillary services الخدمات المساعدة	Ancillary service teams consist of individuals who provide direct, task-specific, time-limited care to patients or support services that facilitate patient care. (e.g. cleaners staff).
Support services	Support services teams consist of individuals who provide indirect, task-specific services in a health-care facility. • Such as Transportation team, security team.
Administration	Administration includes the executive leadership of a unit or facility and has 24-hour accountability for the overall function and management of the organization.

Stages of team development

Forming stage

مرحلة التعارف

1. Initial stage when the team is formed and the members are coming together for the first time.
2. A best candidate should be selected to form a dynamic team , but a flexibility should be adopted in selection process.
3. The skills of the members should match the team task and goals.
4. Voluntary team membership seems to work best when given as a choice.

Storming stage

مرحلة المشاكل

1. Each member tend to rely on his/her own experience.
2. Resistance to work together openly.
3. Hesitate to express new ideas and opinions.
4. Interpersonal disagreement and conflicts.
5. Personal goals rather than team goal.

Norming stage

مرحلة الانسجام

1. Start to know each other.
2. Start to accept each other's ideas and opinions.
3. Understand the strengths and weaknesses of the team.
4. Members become friendly to each other.
5. Work together to overcome personal disagreement.
6. Share responsibilities and help each other.

Performing stage

مرحلة التطوير

1. Member are satisfied with the team progress.
2. Members are capable to deal with any task based on their strength and weaknesses.
3. Work together to achieve the team goals.

How to move from storming to norming stage?

- Team members should be introduced to each other in more details.
- Responsibilities must be assigned accordingly.
- Clear communication.
- Social activities. (e.g lunch break or coffee)
- Role should be in rotation.
- Everyone should be treated equally.

How the use of the team improves patient care ?!

Organizational benefits	Patients benefits
1. Reduced hospitalization time and costs 2. Reduced unanticipated admissions 3. Better accessibility for patients	1. Enhanced satisfaction with care 2. Acceptance of treatment 3. Improved health outcomes and quality of care 4. Reduced medical errors
Team members benefits	**Team benefits**
1. Enhanced job satisfaction 2. Greater role clarity 3. Enhanced well-being	1. Improved coordination of care 2. Efficient use of health-care 3. Enhanced communication

Characteristics of successful teams

1. Effective leadership

- Teams require effective leadership that set and maintain structures, manage conflict, listen to members and trust and support members.
- Effective leadership is a key characteristic of an effective team

2. Effective communication

The following **strategies** can assist team members in sharing information accurately:

- SBAR
  - **Situation** What is going on with the patient?
  - **Background** What is the clinical background or context?
  - **Assessment** What do I think the problem is?
  - **Recommendation** What would I do to correct it?
- **Call-out:** Call-out is a strategy to communicate important or critical information to inform all team members simultaneously during emergent situations. Such as CPR announcement
- **Check-back/read-back**
  - Doctor: Give 25 mg Benadryl IV push.
  - Nurse: 25 mg Benadryl IV push?
  - Doctor: That's correct.

3. Common purpose

Team members generate a common and clearly defined purpose that includes collective interests and demonstrates shared ownership.

4. Measurable goals

Teams set goals that are measurable and focused on the team's task.

5. Good cohesion

Cohesive teams have a unique and identifiable team spirit and commitment and have greater longevity as team members want to continue working together.

6. Mutual respect

Effective teams have members who respect each other's talents and beliefs, in addition to their professional contributions.

Challenges to effective teamwork

Changing roles	Changing settings	Health-care hierarchies رُتب موظفي الرعاية الطبية	Individualistic nature of health care
In many health-care environments there is considerable change and overlap in the roles played by different health-care professionals.	The nature of health care is changing in many ways, including increased delivery of care for chronic conditions in community care settings and the transfer of many surgical procedures to outpatient centres	Health care is strongly hierarchical in nature, which can be counterproductive to well functioning and effective teams where all members' views should be considered	Many health-care professions, such as nursing, dentistry and medicine, are based on the autonomous one-to-one relationship between the provider and patient.

Conclusion:

- The effective teamwork in health-care delivery can have an immediate and positive impact on patient safety.
- The effective teamwork is essential for minimizing adverse events caused by miscommunication, associated with improved and reduced medical errors.
- The teamwork can have benefits for the individual practitioners in the team and the team as a whole, as well as the organization.
- The Characteristics of the effective team are: Common purpose, Measurable goals, Effective leadership (the key element), Effective communication.
- SBAR , Call-out, Check-back are strategies can assist team members in accurately sharing information.

9 Concept of community services

Community is a group of interacting people, living in the same proximity (in space, time, or relationship).

- Community usually refers to a social unit larger than a household that shares common values and has social cohesion.
- The word "community" is derived from the old French communité which is derived from the Latin communitas (cum, "with/together" + munus, "gift"), a broad term for fellowship or organized society.
  (Oxford University Press)

Community service: is defined as donated service or activity that is performed by someone or a group of people for the benefit of the public or its institutions.

- Some people associate community service with punishment, since it is often offered to small-time offenders as an alternative to fines or jail time..
- However, community service can also be **altruistic** –unselfish-, and it is a vital part of many small communities.
- Basically anything which benefits the society in any way can be considered as a community service project or activity.
- In all cases, community service work is performed by volunteers who are not paid for their time.

Mention some examples of community service?

- Visiting and spending time with lonely elderly.
- Tutoring needy students in their studies for free.
- Helping out at organizations such as libraries.

Why to carry out community service?

- Benefits the community
- The volunteers in the activities also gain a sense of accomplishment
- Better social communication skills
- Exposure to new peoples and cultures
- Overall improved mental health. *"When you cease to make a contribution, you begin to die." - Anna Eleanor Roosevelt*

What is the Concept of Volunteering?

- Volunteering is generally considered an altruistic activity, intended to improve human quality of life.
- Volunteering can be daily ,for hours ,weekly or when needed .
- It can be done through: money, donations, work effort, or relations

Why do some people volunteer? ★

- For their own skill development.
- To solve problems when needed
- To make contacts for possible employment.
- To help others and earn respect and favor.
- Get benefit of spare time.

Mention the types of volunteer work?

- **Skill –based volunteering:** e.g. special skills required.
- **Micro & virtual- volunteering:** e.g. off-site tasks done by internet . Completed in certain time .May need application process or training, eg. telemonitoring, teletutoring.
- **Environmental volunteering:** e.g. Protecting animals, education about natural environment.
- **Emergency volunteering:** e.g. During natural disasters..
- **School volunteering:** e.g. Additional teaching for students.
- **Community volunteering:** e.g. for orphanages, widows, mosques, blood donation, during Hajj and Ramadan,..etc.
- **International work –camps:** e.g. Environmental conservation, rural developments.

Doctors are to be committed to:

Integrity, Compassion, Altruism, Continuous improvement, Excellence & Working in partnership with members of the other health care teams.

Physician and the community

- Physicians are members of the community, they affect it and are affected by it.
- Responsibilities of physicians are not limited to those within the hospital and clinical care.
- Although the focus is usually on the physician-patient relation, the broader sense of responsibility of physicians is *towards their community.*

Physician's role in the community extends to:

Public Health, Prevention of illnesses, Educational roles, Improving healthcare access, Setting policies, Assurance of competence, International Aid & Fundraising.

Who are health stakeholders?

Many entities in the community that share the responsibility of maintaining and improving its health. e.g.:

- Health care providers
- Public health agencies
- Community organizations
- Government agencies
- Schools
- Social services organizations

Health depends **not** only on medical care but also on other factors including:

- Individual behavior
- Genetic makeup
- Social, psychological, environmental **and economic conditions**

10 Essential services of stakeholders:

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

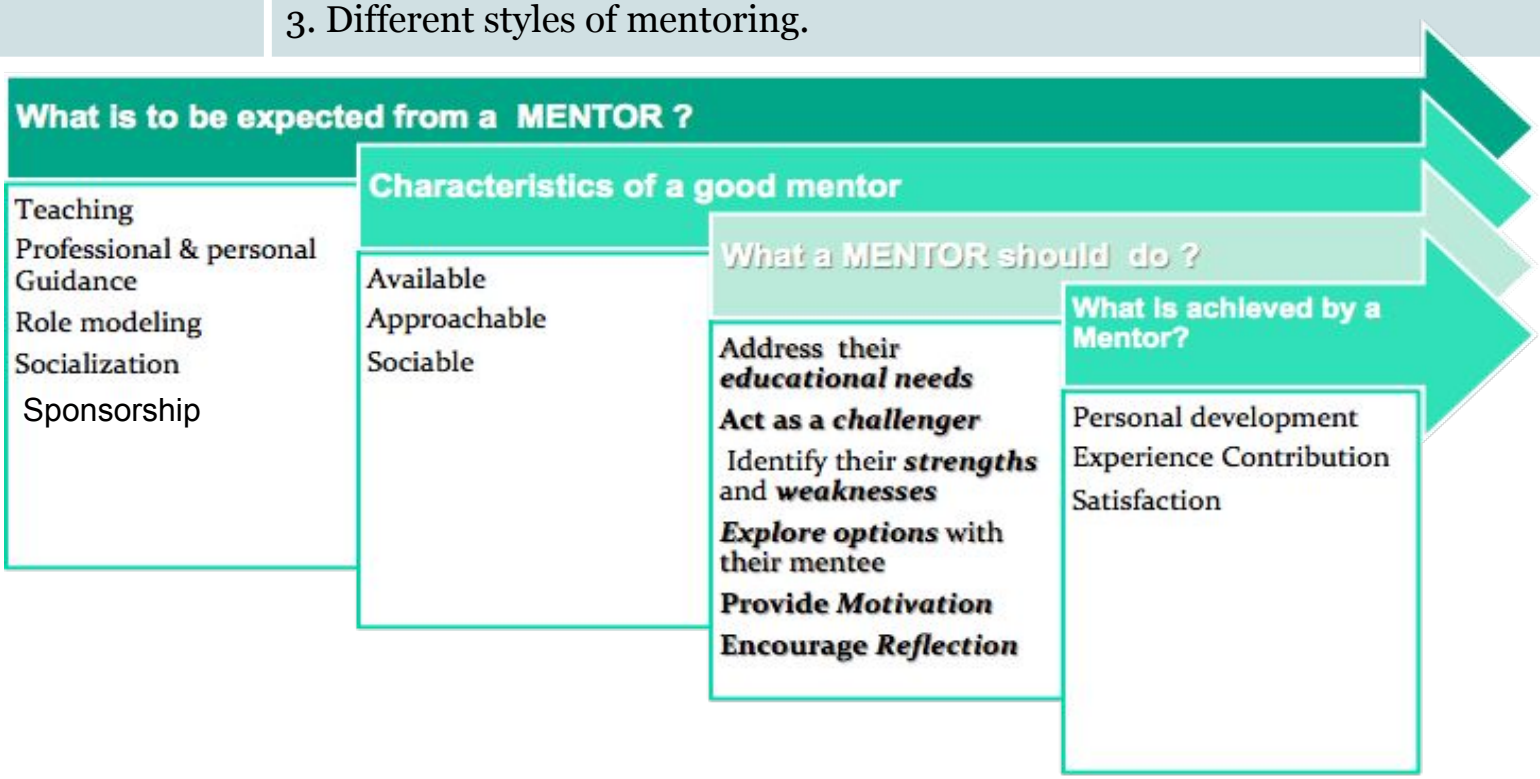
Physician's' role in the community extends to:

A-Public Health	Public health is the science and practice of preventing diseases and promoting health in populations. • It depends largely on epidemiology. • Largely performed by governmental organizations. **Traditional objective:** **• To control communicable diseases** **• Safety of water and food supply** **• Response to national disasters**
B-Educational roles	Educating the public about: • Causes of illness **• Preventive measures** • Predisposing factors **• Changes in lifestyle**
C-Improving healthcare access	Improve the level and ease of access of individuals to health care services by reducing inequalities.
D-Fundraising	• May not apply locally since health care services are provided by the governments. • Funds may be raised to help those individuals who cannot afford to purchase medications or medical equipments.
E-International Aid	• In some areas of the world, health care is very limited and almost non-existent ,most people suffer from diseases such as Malaria, Tuberculosis, Typhoid, and AIDS. Many of the illnesses can be improved or eliminated by basic medical care and other measures. ***International community services done through:**

General Organizations	Medical Organizations :	Governments
Organizations providing humanitarian needs: • Clean water supplies • Clothing • Education	**• Medical care** **• Medications** **• Immunizations** **• Medical supplies** • Teach communities about nutrition and preventive measures • Training of local health care providers	Aid to other countries during time of need. May include sending: • Medical professionals • Medical equipments • Medications

10 Professionalism through mentoring

what is mentoring	- "It is a professional *relationship* built within an organization that is intended to target and focus the *training* of individuals" - Mentoring is to support and encourage people to manage their own learning in order that they may maximise their potential, develop their skills, improve their performance and become the person they want to be."
mentoring involves	Interaction (relationship) between two people: • Mentor (Teacher, Adviser, Role model and friend) • Mentee (student, learner) who are normally working in a similar field or sharing similar experiences
benefits of mentoring	- Significant benefits are associated with mentorship - it is a career development tool, Develop your skills and help others learn, grow, and improve their skills. - Effective mentorship is crucial to career success in academic medicine
good mentoring	The nature of a mentoring relationship varies with the level of students and Mentor *"One size doesn't fit all"* 1. Different human relationships. 2. Different learning needs. 3. Different styles of mentoring.



What a MENTEE should have?

1. **Respect:** Mutual respect is the starting and sustaining aspect of a successful mentoring relationship.
2. **Responsiveness:** Your willingness to learn from your mentor and your mentor's willingness to respond to your learning needs are important for successful collaboration.
3. **Accountability:** Once you and your mentor establish mutually held goals and expectations, keeping your agreements, strengthen trust and helps maintain a positive relationship.

What a *MENTEE* should consider?

Students are obliged to recognize the multiple demands on a mentor's time.

What a MENTEE should be?

Strategic: what / why
Tactical:How

Who is MENTEE/PROTÉGÉ

Protégé (male), a protégée (female)
Now a days MENTEE (both male & female)

The characters you should have for effective mentoring

Characteristics of GOOD mentoring

Mentoring flourishes behavioral, motivational and career outcomes. It is an effective way of helping people to progress in their careers.

1. Establish an open communication system with reciprocal feedback
2. Set standards, goals, and expectations
3. Establish trust
4. Care for and enjoy each other
5. Allow mistakes
6. Participate willingly
7. Demonstrate flexibility
8. Consider constraints to mentoring
9. Learn from others
10. Work on common tasks
11. Be open and comfortable

Picture 12-1 who is involved in mentoring

Summary

AS A MENTOR YOU SHOULD HAVE:

- The desire to help – you should be willing to spend time helping someone else, and remain positive throughout.
- The ability to challenge the mentee in a non-threatening way & Provide Feedback.

AS A MENTEE YOU SHOULD HAVE:

Motivation to continue developing and growing, and Listen actively

Professionalism in a cultural context

Characteristics of Professionalism:

- Competency.
- Attitude.
- Responsibility.
- Conduct on the job.

Attitudes Central To Medical Professionalism In Cultural Context

- Humility تواضع
- Sensitivity
- Empathy تعاطف
- Curiosity
- Respect
- Awareness of all outside influences (including cultural) on patients health

Cultural context	
Knowledge	Skills
1.It is important for a medical student or post graduate trainee to learn about the surrounding community in which he/she practices or trains. e.g. Socio economic status, patterns of housing nutritional habits, healing practices and disease incidence and prevalence. **2.The knowledge taught has specific evidence-based impact on health care delivery.** e.g. How Ramadan fasting affects Muslims who are diabetic.	It is crucial to understand **health beliefs** of those who come from different cultures or have different health care experiences.

Three fundamental principles of medical professionalism:		
Patient welfare	Patient autonomy	Social justice
Patient Welfare (Including Autonomy): 1.Professional competence 2.Honesty with patients -- integrity 3.Patient confidentiality 4.Caring attitude 5. Scientific knowledge 6. Maintaining trust 7. Setting and maintaining professional standards		1.A just distribution of resources 2.Managing conflict of interest 3.Improving quality and access to care 4.Respect for colleagues

Cultural influences - The Centrality Of Patient-Physician Relationship To Medical Professionalism

Four Possible Consultation Models:

PATERNALISTIC MODEL Physician as a PARENT, IMAM or priest.	Dependent on community's social values and moral norms • Physicians are in the best position to judge what is best for their patients. In a strong form of this, physicians authoritatively order patients to assent (with coercion if necessary). • Culturally applicable in Chinese culture and partially in other Far East and South Asian cultures.
DELIBERATIVE MODEL Physician as a MENTOR	• Physician objectively knows and prioritizes patient's personal and medical values. • The physician mentor's grip on decision making is more relaxed than the physician / parent model but autonomy-conscious patients find it unsatisfactory. • Culturally this is an option for some of the patients in Eastern countries
INFORMATIVE ENGINEERING MODEL Physicians as TECHNICIANS or contractors	• Physicians only provide value neutral medical information and leaving patients to make decisions independently based on personal values (total patient autonomy) • Physicians treat diseases rather than patients, and sick persons are "Consumers". • Culturally applicable To certain sections of Western and relatively less eastern population.
INTERPRETIVE/ COLLEGIAL MODEL Physicians as FRIENDS OR COUNSELLORS	• Physician's medical facts and patients personal values contribute to balanced medical decision-making. • Upholds patient autonomy without undermining the physician's duty of beneficence. • Shared decision making • Culturally popular in the West • Increasingly accepted in the East .

While providing professional care physician must not impose his / her view on a patient's:

- Life style, culture, beliefs, race.
- Sex, age / sexuality.
- Social status / economic worth.

Physicians must be prepared to explain and justify his / her actions and decisions.

CONFIDENTIALITY

Confidentiality concept may not be the same in the East as in the West.
However its principles are applicable in most settings.

Special Cultural Issues In Professional Care In Different Parts Of The World:

- Insistence on eye contact?
- Uncovering of face in some females
- Undressing of female patients?
- Sharing of confidential information with spouses, relatives?
- History taking of female adults from parents or husbands?
- Giving information to patients in a way they can understand
- Physicians must **not** exploit patient's vulnerability or lack of medical knowledge.

Accepting gifts or other inducements

➔ You should not ask for or accept any material rewards, except those of insignificant value from representatives of pharmaceutical companies.

➔ Help with conferences and educational activities may be acceptable

RESEARCH:

- Research should not be contrary to the patient's interest e.g. exploitation of developing countries patients.
- Research protocol should be approved by a research ethics committee. This committee may be non existent in many settings.
- Your conduct in the research must not be influenced by payments or gifts.
- Record your research results truthfully.

Cultural Context In Under-graduate Medical Education Curriculum:

- The goal of the curriculum should be to prepare students to care for patients from diverse social and cultural backgrounds including racial, ethnic and gender biases.

Professionalism in Different Cultural Contexts - CRASH

CRASH is a mnemonic for the following essential components of culturally competent health care:

- Cultural Competency
- Respect
- Assess
- Sensitivity/ Self Awareness
- Humility

The goal of the CRASH-Course in Cultural Competency is to build confidence and competence in the clinician's ability to communicate effectively with diverse patient populations.

Professionalism in Different Cultural Contexts -PEARLS

- Partnership: Working with the patient to accomplish a shared outcome.
- Empathy: Recognizing and comprehending another's feelings or experience.
- Analogy: Being willing to acknowledge or express regret for contributing to a patient's discomfort, distress, or ill feelings.
- Respect: Non-judgmental acceptance of each patient as a unique individual; treating others as you would have them treat you.
- Legitimization: Accepting patient's feelings or reactions regardless of whether or not you agree with those perceptions.
- Support: Expressing willingness to care and be helpful to the patient however you can.

Culture is directly related to health promotion, disease prevention, early detection, access to health care, trust and compliance

CONCLUSION

Patients are entitled to good standards of professional practice and care in all cultural settings. **The essential elements of this medical professionalism are:**

1 - Professional competence.

2 - Good relationship with patients and colleagues.

3 - Observance of professional ethical obligations.

Medical teachers should be a role model' in application of these essentials .

We must learn to demonstrate our respect to individual patients in ways that each person will receive or perceive as being respectful.

12 Unprofessional behavior

Professionalism :

- Attributes and behaviors that serve to maintain patient interests above physician self-interest.
- It is the unconditional caring of the patient, putting others before self.

IT IS NOT WHAT WE DO BUT HOW WE DO IT THAT DEFINES MEDCIAL PROFESSIONALISM.

professional Attributes: quick review

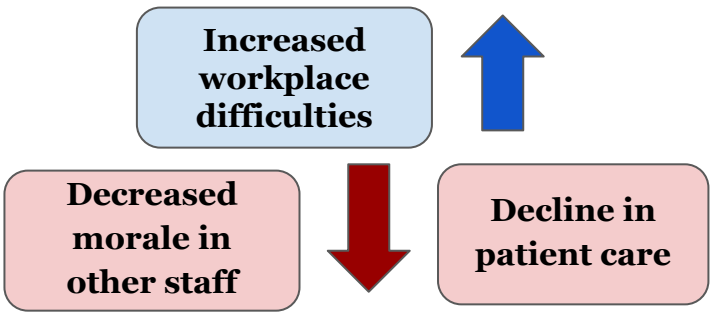
Honesty/integrity. Openness. Reliability. Responsibility. Respect. Presence. Compassion/empathy. Competence. Commitment. Confidentiality. Autonomy. Self-improvement. Communication /collaboration. Self-awareness / knowledge of limits. Altruism/advocacy. Morality and ethical conduct. Self regulation. Teamwork.

What is Unprofessionalism? Not pertaining to the characteristic of a profession.

Medical Unprofessionalism:

Do not have to wait until patient dies to determine that medical care suffered.

Unprofessional behavior is a broad term which results in:



Categories of unprofessional behavior :

1. Illegal or criminal acts :

A physician may be disciplined and lose his medical license based solely on the fact that he was convicted for a crime or offense.

2. Immoral acts:

Fall into the limited category of sexual activity with individuals that may be patients.

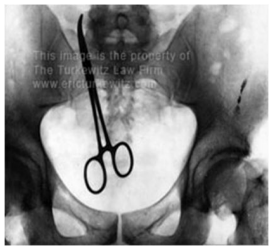
3.Business related acts:

These acts are related to the operation of the business, not the quality of the care.

Obtain, maintain, or renew a license to practice medicine by bribery, fraud or misrepresentation

4. Acts that violate acceptable medical practices: 3 categories

4- Negligent practice :



- Failure to maintain records of a patient, relating to diagnosis, treatment and care.
- Altering medical records.
- Failure to make medical records available for inspection.
- medical erorrs.

Categories of Medical errors :

- **Harmful medical errors.**
- **Near miss medical errors:** An event that under slightly different circumstances could have been an accident, either because the error was detected and corrected in time or because the patient was just lucky.

Actions to be taken?

- **Reporting it to the health care system.** What to report? Report both types and labelling a near miss medical error as "near miss ME"
- **Disclosing it to the patient involved.**

Common types of medical errors:

Surgery related	Ob/gyn, General surgery, Orthopedic, Cardiac, Plastic surgery.
Medication related	• Mismanagement and possibly incorrect medication. • Wrong prescription. Wrong dosage. • Inadequate instructions to patient.
Body fluid related error	• Blood transfusion administered too quickly, which resulted in congestive heart failure and death. • Transfusion of contaminated blood.
Diagnostic errors	• misdiagnosis leading to an incorrect choice of therapy. • Failure to order necessary diagnostic test. • Misinterpretation of test results. • Failure to act on abnormal results.
Equipment failure	• Defibrillators with dead batteries. • Intravenous pumps whose valves are easily dislodged bumped which cause increased doses of medication over too short a period.

Why do we need to disclose medical errors?

- Promote public trust.
- Prevent further harm to a patient and to other patients.
- Respect personal autonomy.
- Support principle of justice.
- Improve the safety of medical practice.
- Be able to trust the physicians and the system.

Non-disclosure of errors:

- Undermine efforts to improve the safety of medical practice.
- Block efforts to identify the faults and weaknesses in the health care processes and procedures.

Legal obligations:

- Having an efficient system for disclosures of our own medical mistakes, and those of higher authorities.
- Having written policies and procedures that fully support patients and their rights.

What do we disclose to patients?

- Full disclosures of all the errors that result in harm
  What has happened and why.
- How the problem occurred.
- Implications.
- How to prevent it happening again.

how to disclose medical errors? Using the (Practical Disclosure Approach).

❖ **Practical Disclosure Approach** :

- Disclosure should be at the right time and setting, when the patient is medically stable enough to absorb the information.
- A physician should take the lead in disclosing errors to patients and their families.
- They should avoid being defensive or evasive, but rather explain what happened in an objective and narrative way.
- Avoid reacting to the response that such disclosure might generate.
- A proper acknowledgement and empathy accompanied by apology may be appreciated by the patient. Thus it may strengthen, rather than undermine, the physician-patient relationship.
- Support should be provided.

5. Plagiarism :

Is an unethical, dishonest act whereby an individual uses the work of another, commit literacy theft, or present work as an original idea without crediting the source or stating that it is derived from an existing source.

Types of plagiarism:

Direct copying	Copying someone else's work using the exact words and putting it as your own. This is the most common type of plagiarism.
Word switching	Putting someone else's writing as your own by changing words without showing that you are using someone else's ideas.
Working with others	• Copying all or part of another student's writing is plagiarism. • Sharing an assignment is plagiarism. • Group work on individual assignment is plagiarism. • Writing in Arabic and asking some else to translate your work is plagiarism. What is acceptable when working with others? • Group assignments. • Discussing your work and ideas with other students. • Getting advice on sources of information from other students, lecturers or professionals. .
Concealing sources	Hiding the sources of your work and not revealing them. This includes: 1. Putting someone else's ideas on your words without referring to them. 2. Using a reference more than one time, but only pointing it out once.
Buying assignments	Buying an assignment is the worst kind of plagiarism and may have serious consequences.
Self plagiarism	Re-using all or part of an assignment or a project that you have used before without making it clear is considered as plagiarism.

Unprofessional physician :

- Impaired
- Disruptive behavior
- Dishonest
- Greedy
- Abuses power
- Lacks interpersonal skills
- Conflict of interest
- Self-serving

Impairment :

Impairment means more than making incorrect diagnosis.

1. Avoidance of patients and their psychological needs.
2. Dehumanized care.
3. Inappropriate treatment.

Disruptive behavior :

➔ Include repeated episodes of:

- Sexual harassment.
- Racial or ethnic slurs.
- Intimidation and abusive language.
- Persistent lateness in responding to calls at work.

Early warning signs:

- Late or incomplete charting.
- Delayed or no responses to call or pagers.
- Abusive treatment of staff.
- Unkempt appearance and dress.
- Inability to accept criticism.
- Gender or Religious bias bias.

Complaints as indicators of unprofessional behavior:

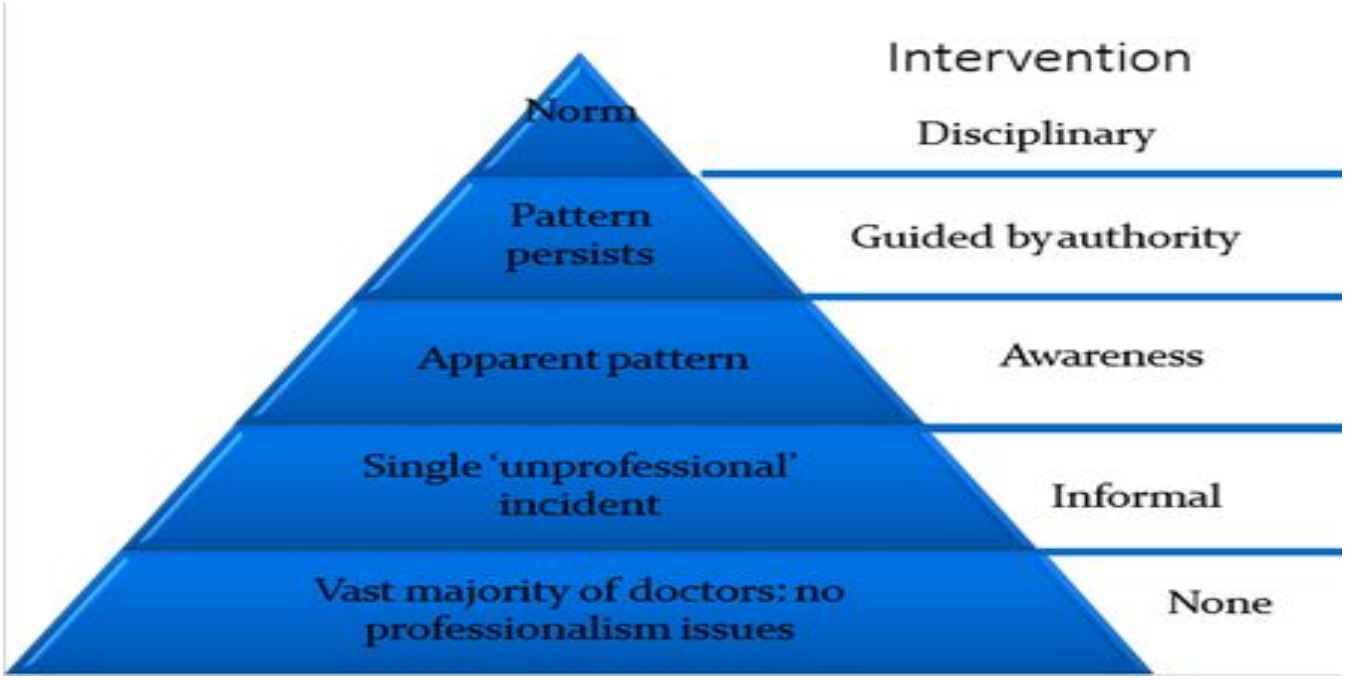
20–25% apparently disappoint their patients

More than 2/3 of physicians never or very rarely generate patient complaints (Hickson et al. 2002, 2007a,2007b). A total of 6% of doctors, however, received 25 or more complaints over a 6-year period Nurse surveys suggest that 4–5% of physicians display such behavior.

The eyes and ears of patients, visitors and healthcare team members are considered to be the most effective surveillance tools for detecting unprofessional behavior

Dealing with unprofessional behavior:	
Surveillance	Registration

Disruptive behavior pyramid:



What does formalizing a response need?

It needs cost + time.

Cases :

Scenario 1 :

A senior doctor, head of a high profile department, is known to bring in research dollars, to be very hard working and adept at specialized medical procedures. S/he is well known for shouting at nurses, throwing instruments back at them, and humiliating junior medical staff. S/he is often absent from department, Complaints are made to hospital administration from staff members; increased numbers of "critical incidents" and staff resignations are noted.

Scenario 2 :

A general practitioner is consistently late or absent for pre-scheduled sessions. S/he gives no explanation, leaving the partners to fill in and make excuses. When confronted, s/he becomes abusive in front of office staff and patients.

Scenario 3 :

A final-year medical student has caused disruptions throughout the course by monopolizing time in tutorials, behaving inappropriately with patients and being unwilling to heed advice. Many patients refuse to be interviewed by her/him and have complained to staff. S/he has not failed any exams, but several tutors and nurses have raised concerns about the student's "attitude" and ability to work as an intern.

Scenario 4 :

A 54 year old male patient is admitted for the fourth time in two months for complaints of severe ridiculer pain following several attempts at decompressive back surgery. His pain has been sub-optimally controlled with very high-dose narcotics and other adjuvant pain-management medications. The nursing staff take his vital signs at the start of every shift but otherwise only appear when his medications are due or he rings the call bell. The pain waxes and wanes but is so severe at times that he cries out. The medication orders for breakthrough pain is ineffective. When he tells one nurse this, she responds, sighing, :you have had your medication and you'll just have to wait three hours for your next does. I'm going on break, so don't bother me by ringing the bell"

Summary

1) Not pertaining to the characteristic of a profession.

2) Unprofessional behavior fall into five categories:

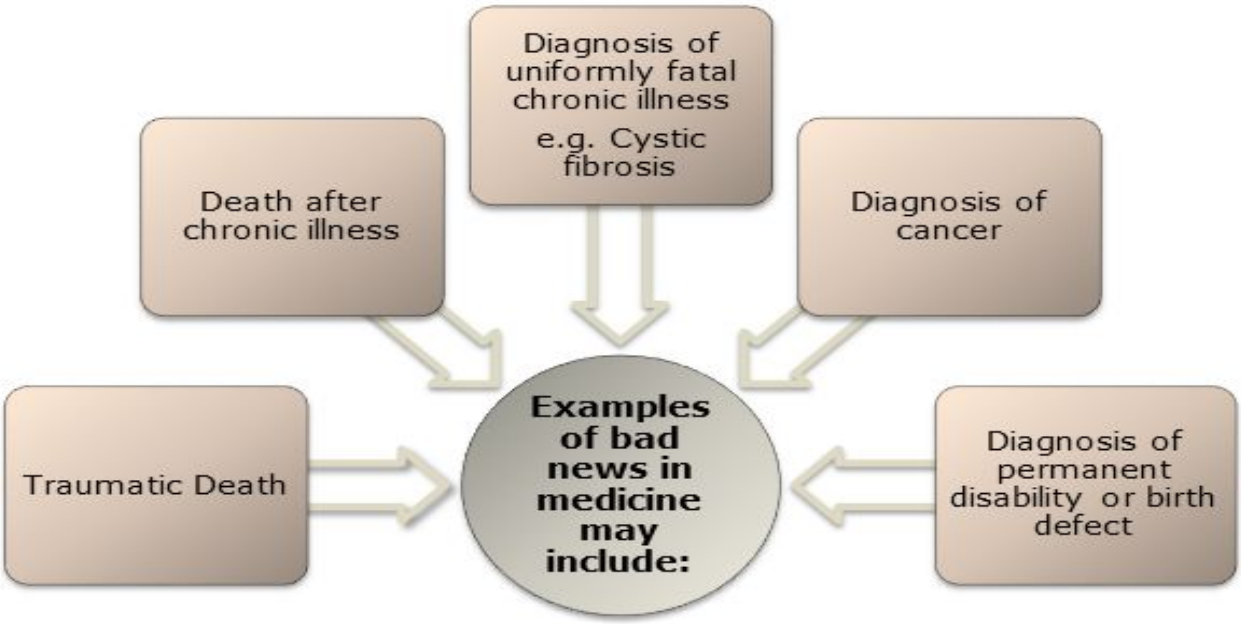
- Illegal or criminal acts
- Immoral acts
- Business related acts
- Acts that violate acceptable medical practices
- Plagiarism

3) Do not have to wait until patient dies to determine that medical care suffered.

What are "Bad News" in Medicine?

Information that produces a negative alteration to a person's expectation about their present and future could be deemed Bad News.

- Your Bad News may not be my Bad News.
- Bad News doesn't have to be fatal.
- Bad News doesn't have to seem so bad to the medical practitioner.



➔ **To some patients or to their families "Bad News" may also include :**

- Unexpected admission to ICU.
- Long bone fracture.
- H1N1 influenza.
- Need for surgery e.g. Hernia or Appendicitis.

Breaking Bad News "Options"		
Nondisclosure	**Full Disclosure**	**Individualized Disclosure**
-	Give all information As soon as it is known	Tailors amount and timing of information Negotiation between doctor and patient As soon as it is known

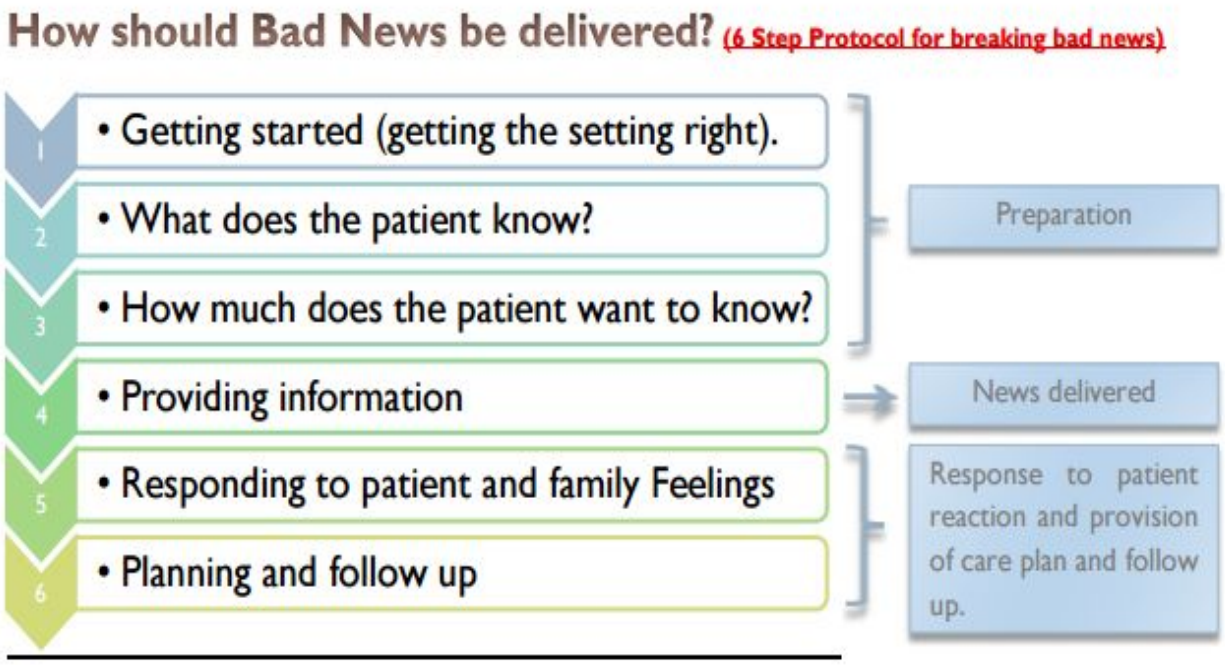
"Bad News" Consensus :

- Ensure Privacy and Adequate Time.
- Encourage Patients to Express Feelings.
- Arrange Review.
- Provide Information Simply and Honestly.
- Document Information Given.
- Discuss all the available Treatment Options.
- Provide Information About Support Services.

Basic Principles	
When to be informed ?	• As soon as information is clearly known. • Don't pass on unsure information too soon.
Where to be informed ?	• Private setting. • In person, not on phone.
Support persons present?	• Both parents. • Other support people, family, friends, hospital support.
Challenges. It's a difficult task because:	• It is frequent and stressful. • Most patients want to know the truth • The truth is unpleasant and will upset the patients • We are anxious and fear negative evaluation

The spikes protocol:

1. S= "setting"
2. P= "perception"
3. I= "invitation"
4. K= "knowledge"
5. E= "empathizing and exploring"
6. S= "strategy and summary"



Steps 1,2,3 : Preparation

A. Prepare Yourself	B. Prepare Your Setting	C. Prepare Your Patient
1. Review the patient's history and know about possible management. 2. Practice the interview for possible questions and answers. 3. Relatives can be present, but , follow the patient's wish.	1. Arrange to meet in a quiet room. 2. Make sure that you are not going to be disturbed. 3. If recently examined allow him/her to dress before the interview	1. What do they know already? 2. What do they want to know? 3. Some patients do not want detail 4. Build up gradually

Step 4:

- Use basic communication skills: use simple language, listen, follow up verbal and non-verbal cues.
- Start at the level of comprehension and vocabulary of the patient.
- Avoid excessive bluntness, as it is likely to leave the patient isolated and later angry.
- Set the tone. "I am afraid I have some bad news".
- Give the information in small chunks
- Avoid using hopelessness terms
- Be truthful, gentle and courteous.
- Offer hope.
- Emphasize the positive.
- Allow questions.

Steps 5 and 6 : ★

1. Respond to Patient & Family Feelings:

Acknowledge and identify with the emotion experienced by the patient. When a patient is silent use open questions, asking them how they are feeling or thinking. "How are you feeling now?"	Do not say "I know how you feel". Empathy can be shown by using terms such as, "I think I understand how you must be feeling."	Allow the patient time to express their emotions and let the patient know you understand and acknowledge their emotions	Unless patients' emotions are adequately addressed it is difficult for the doctor and patient to move on to discuss other important issues but remember the patient's crisis is not your crisis - Listen.

2. Providing Care Plan :

- Don't leave the patient confused
- Provide a clear care plan with treatment options
- Identify support systems; involve relatives and friends.
- Offer to meet and talk to the family if not present.
- Make written materials available.
- Summarise.

3. After the Interview: Follow up

- Make a clear record of the interview, the terms used, the options discussed and the future plan.
- Inform other people looking after the patient what you have done.
- May need to have a number of meetings
- Follow up the patient.

Always DOCUMENT every step taken to notify the patient of the bad news.

What Not to Do ?

- Don't Break bad news over the phone.
- Don't Avoid the patient.
- Don't Leave patient in suspense.
- Don't Lie to the patient.
- Don't Tell patient if he or she doesn't want to know.
- Don't Interrupt excessively.
- Don't Use jargon.
- Don't Give excessive information as this causes confusion.
- Don't Be judgmental.
- Don't Give a definite time span (just say "days to weeks" or "months to years" etc.
- Don't Pretend treatment is working if it isn't.
- Don't Say "Nothing can be done".
- Do not say "I know how you feel".

Instead "I think I can understand how you must be feeling."

Breaking Bad News "in the Emergency Department":

<table>
<tr><td>It is a difficult task because</td><td colspan="2">• Families do not have time to prepare for the bad news.
• Practitioners do not have a prior relation with patient or family.
• A stressful situation for practitioners.</td></tr>
<tr><td rowspan="2">Death notification</td><td>BE READY FOR:
• Initial reaction of eruption of grief
• Reactions are varied and Culturally determined
• Very rarely yet chances of hostile reaction towards the staff</td><td>WHAT TO DO?
Physician should stay in room with family:
• As a resource
• As a silent presence
• Remind family members (especially other children) that it was not their fault.</td></tr>
<tr><td colspan="2">Follow the GRIEV-ING Protocol</td></tr>
<tr><td>The GRIEV-ING Protocol</td><td colspan="2">• G: Gather the family.
• R: Resources : call for support to assist the family.
• I: Identify yourself , identify the deceased patient by name and the knowledge to be disclosed to the family.
• E: Educate family about the event that occurred for their deceased in the emergency.
• V: Verify that their family member has died (dead).
• -: Space ; give the family personal space and time for emotional moment and absorb the information.
• I: Inquire ; ask if there are any questions, answer them all.
• N: Nuts and bolts; inquire about organ donation and other issues as applicable.
• G: Give them your card or contact information. Offer to answer any question that may arise later.</td></tr>
</table>

Scenario :

Practice For Breaking Bad News:

Mr. Abdulla was seen in the clinic last week, for the complaint of constipation and bleeding per rectum. Colonoscopy was requested with the suspicion of colorectal carcinoma. The colonoscopy was performed and he was advised to follow up in the clinic Today patient has come to get his results. You review the results in the record which clearly indicates: Colorectal Cancer with involvement of lymph nodes.

Conduct BBN with the use of 6 Step Protocol.