

PRIORITIZING PATIENT SAFETY IN CARDIOLOGY PROCEDURES

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The eye opening report, 'To Err is Human' by National Institute of Medicine in 2011 revealed that more than 90,000 persons succumb to medical errors in USA alone, incurring a cost of 8-9 billion dollars. The number of deaths reported claims a higher mortality than deaths due to accidents on roads, breast cancers and AIDS.¹ Similar scenario was painted by other reports.^{2,3} WHO declared patient safety as a priority in 2002. Most medical students, even trained in developed countries, admit to inadequate exposure to the concept of patient safety.⁴⁻⁷ Some of the developed countries have included 'patient safety' in their medical curriculum. But there is a wide variation between the content, time allocated from 4 hours to 30 hours, modes of instruction consisting of eight formats and method of evaluation.⁸ WHO has formulated guidelines for medical curriculum consisting often modules. One of the modules is dedicated to patient safety in invasive procedures.⁹

Patient safety should be an integral part of all postgraduate programs but most importantly of cardiology fellowships. Depending on the infrastructure, number of faculty members and trainees, level of computerization and diversity of procedures performed every unit and institution has to develop a tailor made program for patient safety.¹⁰ Common errors have to be defined, frequency recorded, contributory factors identified and ways and means explored to prevent these errors being translated into accidents. This should entail offering expert services in outpatient clinic, routine caring for an indoor patient, conducting non-invasive tests and performing interventional procedures. Proper patient identification, in time administration of evidence based treatment and performance of diagnostic procedures according to evidence offered by the latest guidelines are the basic ingredients of patient safety. Proper application of non-invasive and invasive tests for optimal information is important. Awareness about potential errors in performing the tests, limitations of investigations and their expert interpretation is of paramount importance.¹⁰

Practice of cardiology has transformed in the last two decades. Non-invasive investigations have been perfected to offer more accurate and reliable information reducing reliance on invasive investigations. The role of cardiac Catheterisation laboratory has changed from diagnostic to therapeutic. Interventional procedures have obviated the need for open heart surgery for many indications in both adult and paediatric population. Patient safety has to be re-emphasized in the current scenario. 'Oculo-dilating' reflexes of interventional cardiologists have to be reigned in with application of common sense and evidence based guidelines. Of course all lesions do not need to be opened up - just because a lesion can be opened is not an indication for angioplasty. Judicious and ethical application of modern technology is very important. Patient safety and benefit should be the guiding principles.^{11,12}

Careful selection of patients for maximal benefit for implantation of newer devices like ICD, CRT and CRTD according to the ever emerging newer guidelines has to be essential part of basic protocol. In resource restrained economy as ours more care is required to identify patients who may derive optimal benefit from the new technology.

In conclusion, in the modern cardiology there is potential of great patient benefit employing non-invasive investigations for maximal information on disease pathology and still broader prospects of patient benefit utilizing newer technique and devices for improving patient symptoms and outlook. Patient safety must be considered as the first priority and this should be ingrained in undergraduate medical curriculum but more importantly in Cardiology postgraduate fellowships as an integral part of training.¹³

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