**Healthcare safety**

BY FA I S A L B A R I 2021-11-12

A FRIEND maintains that her father died as a result of catching an infection in the operation theatre when he was there for surgery for an unrelated issue. The hospital in question, a very expensive private sector provider of healthcare in Lahore, never acknowledged anything and my friend did not have access to the means through which she could have the matter investigated.

Another friend feels her daughter was forced by the hospital and her gynaecologist to accept the caesarean option rather than have a natural birth, (even though there was no real medical reason for a C-section) so that the hospital could charge her for a longer stay and for the operation as well.

A 1999 study of the American Institute of Medicine reported that between 44,000 and 98,000 Americans died each year due to preventable medical errors. A separate study estimated that a million patients are `injured` by errors during hospital treatments in the US each year. A 2013 study puts the number of preventable deaths due to errors of allsorts at400,000 ayear.

For the UK, a National Audit Office report said that 34,000 people died per year due to human errors. The total number of patient errors that resulted in death or injury were put at a whopping 974,000.

Providing healthcare is complicated and difficult. There are so many diseases and so many procedures and protocols to follow. Human errors are inevitable. The numbers reported above are not small though. And these happened in countries that have the most advanced healthcare facilities, and have very developed protocols, procedures and systems and plenty of internal system checks as well.

What must the situation be like in a country like Pakistan where there are scant internal system checks and almost, no checl(s from outside of the system? In the US and, to an extent even in the UK, people have recourse to the law that provides a lot of protection in reasonable time and, in manycases, at reasonable cost. In Pakistan, even when the laws are on the books many a time they are not implemented. And, perhaps more importantly, when laws and procedures are violated, effective remedy, through access to courts, is hardly ever available. Time delays and the cost of litigation allow the richer and stronger parties to get away with violations.

Most interactions between medical personnel and patients take place in private or only in front of other medical personnel. This lends a lot of opacity to the process so that finding out if there was an error or mistake is not straightforward. In addition, since we are in the domain of expert knowledge, separating errors from judgement calls is not easy for non-medical personnel either.

Developing detailed protocols for interaction is one way of ensuring compliance and reduction of errors. In most countries, the medical fraternity itself creates bodies that ensure compliance and set standards of behaviour and care. In many places, medical insurance companies provide another layer of checks. Then the regulatory framework of government, working from local to the nationallevelprovidesfurtherlayersofchecks.

And if all else fails, citizens have the right to invoke the legal system and the courts for justice.

For Pakistan, protocols are not well established in most places where medicine is practised. Barring a few larger hospitals, there is too much discretion and rule breaking that goes on at all times. Even reported cases clearly establish the lack of protocols and adherence to them. The medical fraternity does no self-policing and enforcement: how many doctors have been barred from practising or censured by the medical fraternity? The regulatory structure only exists on paper and is hardly implemented. And, as we have already said, the legal system is too expensive to invoke and get a hearing from. Cases stay in courts for too long and this works against the less powerful party which, in most cases, happens to be thepatient or her/his family.

The issue of C-sections has been mentioned in the beginning. Some recent papers have shown that almost one in five children in Pakistan is born via C-section. This is way above what WHO thinks is average for most populations (around 10 per cent). C-sections can have health and other consequences for the mother. So, it is not a neutral switch.

In addition, it is also very expensive and a major drain on the financial resources of most families.

But this makes it more lucrative for private health providers. Most research suggests that the financial incentive is likely to be the main reason we have so many more C-section procedures than expected.

I have not talked about excessive diagnostic testing and giving excessive medications and so on as problems. But they are problems as well. All of these at some point will need to be thought through for better protocol development, for better selfregulation, for better regulation through the medical fraternity itself, and for a more effective statecontrolled regulatory system. One does not know if the provision of justice will get better in Pakistan and when but if and when it does, it will help outcomes in this sector too.

A first step in this area might be for the medical fraternity to start developing better protocols and to ensure their implementation in more formal and documented medical establishments, and to keep much better data on compliance. This means being able to undertake inspections in order to check compliance. The inspections can generate good data on compliance and violations as well. If we take the first step, the pathways to the next steps will open up too. In the meantime, citizens have no choice but to live with healthcare provision that has almost no effective regulation at any level. The writer is a senior research fellow at the institute of Development and Economic Alternatives, and an associate professor of economics at Lums.