

Indeed, Patient Safety has emerged as a Distinct Healthcare Discipline Supported by an Immature yet Developing Scientific Framework.

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Introduction

Patient safety is a discipline that emphasizes safety in health care through the prevention, reduction, reporting and analysis of error and other types of unnecessary harm that often lead to adverse patient events. The frequency and magnitude of avoidable adverse events, often known as patient safety incidents, experienced by patients was not well known until the 1990s, when multiple countries reported significant numbers of patients harmed and killed by medical errors. Recognizing that healthcare errors impact 1 in every 10 patients around the world, the World Health Organization (WHO) calls patient safety an endemic concern. Millennia ago, Hippocrates recognized the potential for injuries that arise from the well-intentioned actions of healers. Greek healers in the 4th century BC drafted the Hippocratic Oath and pledged to "prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone."^[4] Since then, the directive *primum non nocere* ("first do no harm") has become a central tenet for contemporary medicine. However, despite an increasing emphasis on the scientific basis of medical practice in Europe and the United States in the late 19th century, data on adverse outcomes were hard to come by and the various studies commissioned collected mostly anecdotal events. In the United States, the public and the medical specialty of anesthesia were shocked in April 1982 by the ABC television program 20/20 entitled *The Deep Sleep*. Presenting accounts of anesthetic accidents, the producers stated that, every year, 6,000 Americans die or suffer brain damage related to these mishaps.

In 1983, the British Royal Society of Medicine and the Harvard Medical School jointly sponsored a symposium on anesthesia deaths and injuries, resulting in an agreement to share statistics and to conduct studies. Attention was brought to medical errors in 1999 when the Institute of Medicine reported that about 98,000 deaths occur every year due to medical errors made in hospitals.

Effective and ineffective communication

The use of effective communication among patients and healthcare professionals is critical for achieving a patient's optimal health outcome. However, scientific patient safety research by Annegret Hannawa, among others, has shown that ineffective communication has the opposite effect as it can lead to severe patient harm. Communication with regards to patient safety can be classified into two categories: prevention of adverse events and responding to adverse events. Use of effective communication can aid in the prevention of adverse events, whereas ineffective communication can contribute to these incidences. If ineffective communication contributes to an adverse event, then better and more effective communication skills must be applied in response to achieve optimal outcomes for the patient's safety. There are different modes in which healthcare professionals can work to optimize the safety of patients which include both verbal and nonverbal communication, as well as the effective use of appropriate communication technologies.