

EDITORIAL

PREVENTING MEDICAL ERROR

Medical errors are now regularly reported in newspapers, shown in televisions and also in movies. Medical errors are claiming lives all over the world. Estimates show that in developed countries as many as 1 in 10 patients is harmed while receiving hospital care, the probability of patients being harmed in hospitals is higher in developing countries¹. According to the Institute of Medicine more than 1 million preventable adverse events occur each year in the United States, of which 44,000 to 98,000 are fatal and deaths due to preventable medical error exceed the number attributable to motor vehicle accidents, breast cancer or AIDS². Preventable medical errors can affect all patients irrespective of age, sex, gender or financial status.

An error is defined as the failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning). Medical errors may arise during diagnostic procedure (error or delay in diagnosis, failure to employ indicated tests, use of outmoded tests or therapy, failure to act on results of monitoring or testing) treatment (error in performance of an operation, procedure, or test (e.g., wrong-side surgery), error in administering treatment (e.g., wrong prescription), error in dose of or method of using a drug, avoidable delay in treatment or in responding to an abnormal test, inappropriate (not indicated) care, preventive care (failure to provide prophylactic treatment, inadequate monitoring or follow up of treatment) or due to system failure or equipment failure³.

An error may be active or latent⁴. Not all errors do harm to patients, but these are also important as they indicate a break down in the system. Health-care errors are often provoked by

weak systems and often have common root causes which can be generalized and corrected. Even today we do not have much information on epidemiology of medical error in hospital settings. Reluctance of health professionals to disclose errors and complexity of health care systems are some of the problems in assessing its prevalence. While errors are a part of every day practice, many errors are due to the complexity of health care organization and are preventable. Different studies show as much as 50 percent medical errors are preventable.

As medical error is a burden to the health system and recognized as a public health priority there is an urgent need to address this problem. Prevention of error in medical practice is essential to improve patient safety. WHO's World Alliance for Patient Safety has suggested several structures and policies that can help reduce harm to patients. These include national reporting and learning system (to report and analyze all types of medical error, to use the results of data analysis and investigation to formulate and disseminate recommendations for systems change, reporting and learning system should be non punitive, confidential, independent, capable of disseminating information on hazards and recommendations for changes.), taxonomy for patient safety(developing internationally acceptable data standards for collecting, coding and classifying adverse events and near misses), research for patient safety(improving tools and methods to measure patient harm in developing countries and defining a global patient safety research agenda), team-training and improved communication, teaching and training of health professionals on patient safety issues, patient empowerment and the adoption of evidence-based practices.

There have been very few studies on assessment of medical errors in the developing countries in general and India in particular even though medical errors and its consequences in terms of morbidity, mortality and financial losses are high. Medical errors should be identified,

cause detected and changes should be made in the system. Instead of finger pointing and playing the blame game, the system that is responsible for the failure should be analyzed. There should be both hospital based and community based studies with a standard method of documentation and investigation for better accuracy in getting data on medical errors. By being less judgmental, providing proper leadership and motivation necessary changes can be brought about in the health sector.

Health care services are not as safe as they are considered to be. If gaps in the health care delivery system are not properly identified, they cannot be corrected and continue unrectified. Adequate preventive measures and response systems can fill up the gaps. Thus, patient safety improves thereby reducing sufferings as well as expenditure of patient and health care provider. The need for safe health is obvious. The health care system should rise to the occasion and act quickly. The IOM report rightly says *“it may be part of human nature to err, but it is also part of human nature to create solution, find better alternatives, and meet the challenges ahead”*.

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1-WHO,10 facts on patientsafety, available at

http://www.who.int/features/factfiles/patient_safety/en/index.html. accessed on 10.08.2009

2-Kohn LT, Corrigan JM, Donaldson MS, Editors; To Err Is Human: Building a Safer Health System Committee on Quality of Health Care in America, IOM, NAP, 2000.pp26-26.

3- Leape, L. L., et al. “Preventing Medical Injury,” *Quality Review Bulletin*, 19(5):144–149, 19.

4- Jonathan A. Handler, "Defining, Identifying, and Measuring error in Emergency Medicine", *Academic Emergency Medicine* 2000; Volume 7, Number 11, 1183-1188)