

## Why are patient care errors still so frequent?

Without a doubt, for thousands of years now, it has been known that errors are typical of human nature, a part of it. Therefore, errors are inevitably frequent, and will continue happening, in all of our everyday activities. We routinely undertake multiple actions, mostly common and usual, and make decisions and use our clinical judgment; however, at the same time, and for different and complex reasons, we make several errors in aspects or actions that we assume we have mastered. When someone makes an error, they believe their action, judgment or hypothesis is usually correct and, therefore, such belief will remain until they realize that such error will invariably happen again. That is the appropriate time to change our erroneous belief and admit that after making a mistake, it is important to learn the reason for it and, this way, we may not repeat it. Unfortunately, not many people share this behavior because they assume they will not repeat the error, but it will undoubtedly happen again. If we do not cultivate a critical attitude towards patient care, errors will continue increasing and leading to more potentially serious adverse events, including death.

Several studies in different fields have focused on this issue, but still many questions remain about the reason for such frequent errors. Those studies were mainly targeted at two topics: the human factor and cognitive psychology.

Human factors have been studied especially by engineers working with aviation and nuclear power plant control. Cognitive psychologists have focused on developing the human cognition model. The advances made in neuroscience have improved the knowledge of the different physiological aspects of cognition. In addition, it has been determined that several errors are the result of a cognitive dysfunction or alteration. This has produced reasonably coherent theories of why humans make frequent errors. Strategies should be designed based on these theories in order to reduce or minimize their occurrence.

In the field of medicine, the high frequency of errors is the result of different and complex aspects. One of the actions leading to a higher incidence of medical errors is that both physicians and other health care providers have problems facing and accepting human errors. In most schools of medicine and in residency or fellowship training, as well as in schools of nursing and pharmacy,

students do not discuss errors and are therefore not prepared once they have to deal with patient care. Several articles have shown that medical errors are more common during residency programs.

In order to reduce the number of mistakes in medical practice, it is critical to take a first step towards a change in the traditional culture of how medical errors are approached. Such culture, which is still unfortunately very common in health care facilities, is based on hiding the error and punishing or disciplining those responsible for it. This is a degrading and dishonest model which has been present in the medical field for a long time. If it continues to prevail, without a doubt, errors will not be reduced. The current evidence shows that, unless there is a major cultural change, errors will continue to increase.

Still, the traditional culture persists even in developed countries, which, therefore, have not been able to reduce errors and the associated adverse events, not being able to achieve the desired reduction. In the United States, errors in relation to hospitalized patients are the third most common cause of death every year, after heart disease and cancer. In recent years, approximately 300 000 patients have died annually in hospital settings due to errors leading to a serious adverse event. No other cause worldwide has resulted in such a large number of deaths.

Lucian Leape, M.D., from Harvard University, first established an excellent team to study the causes of death among hospitalized patients in New York City, whose work was published in 1991. A few years later in an interview, Leape raised the question "How hazardous is health care?", and compared it to various situations that humans may go through in their lives (earthquakes, floods, accidents, etc.); he concluded that "*the most dangerous risk for death for any person is being hospitalized.*"

In October 2004, the World Health Organization (WHO) launched a special initiative called the World Alliance for Patient Safety, for the purpose of establishing the necessary policies to improve patient safety, including a cultural change. Then, in 2007, the WHO published a text requesting more investigations aimed at improving patient safety. Likewise, it pointed out that more than 10 million patients die or suffer severe disorders each year as a result of "unsafe medical practices."

The WHO initiative under the World Alliance for Patient Safety brought about several advances in actions and special programs to reduce patient care errors resulting from the inadequate systems in place at health care facilities.

The second topic handled by the WHO was the safety of patients who undergo surgery. Under the slogan "Safe surgery saves lives", a worldwide program was implemented to reduce surgery errors; in 2008, the WHO Guidelines for Safe Surgery were published. Surgery errors are common, even when their actual prevalence is unknown, and affect millions of people. It has been estimated that at least 250 million major surgeries are performed each year worldwide, so the possibility of a mistake is much higher.

Therefore, it is absolutely necessary for health care providers to continue on the path towards a new culture, where errors are admitted and their cause is studied in order to reduce them. Such culture will lead to better hospital systems through the implementation of error prevention measures aimed at preventing errors from reaching patients.

Unfortunately, most hospitals in Argentina do not deal with errors and do not even have a Patient Safety Committee (PSC). For this reason, the multiple systems remain unimproved and, thus, the marked deficiencies that increase error frequency persist.

Most likely, this is because many health care facilities have made no progress in relation to patient safety given that they do not recognize nor implement the new culture for approaching errors. Besides, in general, they do not consider that errors are mainly the result of deficient hospital systems and not of individual responsibilities.

We should continue advocating for the improvement of care for hospitalized patients; only this way, we will be respecting the "first, do no harm" principle.

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