EDITORIAL

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Medical Errors: Why Now and What's Next?

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It is said in many cultures that "to err is human". This was strongly reflected in Prophet Mohammed's (peace be upon him) hadith which said: "All children of Adam can make mistakes, and the most gracious of them are the ones who repent from their mistakes". This hadith reflects a basic physical, mental, and emotional concept that faces human beings: error.

Such a concept is also applicable to healthcare services, given the inherent limitations of human performance in terms of power, ability to deal effectively with large amounts of information and memory, and the complicated nature of healthcare systems. Interest in medical errors by all parties involved in healthcare services delivery has only gained momentum the last 15–20 years. This has led to changes in dealing with medical errors from a "see nothing, do nothing" approach to having an open discussion and investigation in order to identify the root cause of errors and search for preventive mechanisms.[1]

Such changes are attributed to various reasons. The first reason is the improved educational level of patients who have an increased awareness of their rights and responsibilities within the healthcare system, as well as increased expectations of receiving good quality care with secure safety. As a result, many healthcare systems consider patients a valuable source of information as they bring new ideas to the consultation room.[2] Some systems have gone even further by including patients' views in their planning.[3] This in mind, the Directorate General of Health and Consumer Protection in Europe launched a Eurobarometer survey on the perception of medical errors in the 25 Member States and in the pre-accession and candidate countries and the Turkish Cypriot Community in 2005.[4] The study found that almost four in five (78%) European Union citizens classify medical errors as an important problem in their country. The study also found out that 38% and 40% of respondents rank the issue as very and fairly important, respectively. Similarly, a study assessing community perception of medical errors in Oman showed that 79% of the respondents believed they knew what was meant by medical errors.[5] Of these, 35% were related to wrong prescribing of medication while 29% were related to wrong diagnosis.

The second reason for such high attention is the poor quality of care with high incidences of medical errors as shown by many studies.[6,7]

The third reason is the change in disease trends that has been witnessed by many healthcare systems from dealing with acute, mostly infectious diseases, which usually require few visits to the healthcare facility, to chronic diseases that require regular and frequent visits. The chronic nature of these illnesses exposes patients to multiple investigations and medications that ultimately carry the risk of exposure to errors or at least side effects or complications.[8]

The fourth reason is the hazardous and complicated nature of the healthcare system, compared to other industrial systems.[9] For example, delivering a single dose of medication is the end-result of a complicated process that involves 10–15 steps[10]; each step carries its own chance of error by the staff carrying out that step with higher chances of committing an error as the number of steps increases, thus placing patients at more risk.[11] Such nature has prompted many professional bodies to create solid sets of activities that assure patients safety.[12]

The fifth reason is the role of media in bringing medical errors to light and spreading stories of adverse events to community members.[13] However, community members may get misled by some of the stories they read or hear. Furthermore, people may leave the consultation without being made aware of either their diagnosis or their management plan. These may lead community members to misinterpret

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expected side effects or complications as medical errors.[5]

Eventually, the reasons outlined play a major role in bringing patient safety to the frontline of discussions by all those involved in healthcare services delivery in Oman.[14] However, there remains areas that needs to be considered in order to have an "error-proof" system, such as developing capacity building programs for healthcare professionals on patients safety as well as developing a supportive patient safety culture within our organizations.[15]

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