CIRUGÍA y CIRUJANOS
Órgano de difusión científica de la Academia Mexicana de Cirugía
Fundada en 1933
www.amc.org.mx www.elsevier.es/circir

EDITORIAL

# To err is human, but to not put processes in place to avoid errors from becoming fatal is inhumane. 5th International Summit of the Patient Safety Movement (PSM), California, USA, 2017☆

## *To err is human, but to not put processes in place to avoid errors from becoming fatal is inhumane*. 5.º Congreso Internacional del Movimiento por la Seguridad del paciente (PSM), California, EE. UU., 2017

**Javier Dávila Torres**

*Spokesperson of the Executive Board of the Mexican Academy of Surgery 2017–2018; Representative in Mexico of the International Patient Safety Movement, Mexico City, Mexico*

Research into the study of healthcare and patient safety has been in place for decades and has led to the implementation of several programmes in the international field with operative application in both private and public medical centres.

In the United states, what the Americans term as medical errors have been reported as the third cause of death (Approximately 220,000 per year), and which specifically incorporate different elements of the health system, i.e. from the multidisciplinary team intervening in patient healthcare to the material resources and inputs used.

The physical, emotional, and even financial health repercussions of these errors on patients are key issues.

Hard work has been carried out in Mexico through the regulatory and academic institutions, which have also been linked to worldwide international organisations such as the world health organisation, the pan American health organisation, the joint commission, etc. Against this backdrop both the federal secretariat of health through the sub-secretariat of integration, together with the general health council, have promoted actions which the other public and private institutions initiated. These healthcare establishments have themselves also input great interest and creativity, even when resources have been limited, to dedicate themselves to risk prevention, reporting when inconsistencies in healthcare are detected, and correcting them. Notwithstanding, when precise data is requested for the various areas the information is scattered or unavailable.

If the numbers shown in united states are 220,000, which are ours, in Mexico and Latin American? I repeat, the information is diverse and not yet precise and on occasions it is

☆ Please cite this article as: Torres JD. *To err is human, but to not put processes in place to avoid errors from becoming fatal is inhumane*. 5.º Congreso Internacional del Movimiento por la Seguridad del paciente (PSM), California, EE. UU., 2017. Cir Cir. 2017;85:101–103.

*E-mail address:* jav_davilat@yahoo.com.mx

taken for granted that, among other issues, there is under-reporting. This does not mean that no work is being done in this respect, or that no advances have been made. On the contrary, since the 1999 ''err is human'' until now greater awareness on these issues and continuous improvement to the quality of services has been advanced. However, repeatedly in person-to-person conversations between colleagues which go beyond the keynote speech at a high level academic event, some people highlight and are frank about exposing the difficulties they face as managers when on occasions someone from their team for example refuses to understand the relevance of something as simple and universally acknowledged as hand washing, or does not use their identity badge. There are situations as simple as this or far more complex such as being assured of a diagnosis, being precise in diagnosis or in the prescription and administration of medication in paediatric patients, or being meticulous in different processes of the patient's hospital stay.

With regard to these ups and downs, another recurrent situation is the delegation of the entire responsibility of what happens in the medical centre regarding quasi defects or adverse events to the quality or epidemiological department heads, among others. Whilst on the subject, the overwhelming day to day life in hospitals and maelstrom of work involved means that on occasions information analysis, preventative and corrective measures in which all personnel involved participate sometimes fails to be so specifically important. By all personnel I am naturally including the highest level of staff, both from the medical centre and the ascending chain of command.

Leverage for the standardisation of procedures in line with regulations and with academic support has been the certification of medical establishments coordinated in Mexico since 1999 by the general health council. Several stages have been executed, with greater demands been met with training of auditors sent by all the public and private institutions involved and which have doubtlessly contributed to offering better healthcare. However, there are a considerable number of medical centres which should be recertified or certified for the first time (and private hospitals should also not stall here). Certification is highly desirable and consideration should also be made of the fact that certification regulations, designed in their day by the health protection commission, have now been modernised.

In Mexico, people examining this issue have consolidated arguments in academic meetings for several years, such as how to incorporate these concepts so that they become public policy and it should be noted that there has been a before and after since 1999. Many people have contributed, both to the law and to healthcare. This has not been easy for those who offer this service, for many reasons, which we will not go into at the moment.

Some time ago several organisation interested in this issue were created, including official ones such as the world health organisation and also non governmental foundations dealing with patient safety in particular. This is extensive, complex, multidisciplinary, infinite and universal and in this context there is not a single organisation capable of including everything. Therefore, without of course considering that this subject matter is new, or that a congress or council may resolve all problems, we need to identify what can help to benefit patients in the medical care they receive. Everything computes, and everything may be of use here.

In September last year during the annual surgical week, among other activities, the Mexican academy of surgery created a round table to talk about patient safety, with the valuable participation of the general health council, an academic expert who was a federal ex civil servant, the director general of a major public hospital, the medical director of a well known private hospital, and the founding chairmen of the international patient safety movement. The latter, who listened to the diagnosis and opinion exposed by previous speakers, talked about what the organisation he presided over had insured in hospitals, companies, academies and academic federations, etc.

The hospitals had been affiliated through the voluntary election of different strategies in which they determined their own scope, but committing themselves to the development of actions and building on quantifiable, measurable goals which represented improvement. In many of them a figure of lives saved was suggested as a hypothesis: for example if during the previous year a hospital had reported a figure of nosocomial infections in neonatal intensive care and this was to be reduced by 20% as a commitment for that year, the lives to be saved were quantified. This had considerable impact on the medical staff and the multidisciplinary team, who united to establish the right actions to achieve a goal which would unquestionably bring about more favourable outcomes for the patient.

As a follow-up of the above-mentioned session, several weeks ago, Mexico participated in a meeting in California USA, with the same international movement and was represented by directors of national health institutes of the highest level and one ex-secretariat of federal health. Its president Dr. Jesús Tapia Jurado spoke enthusiastically and with honour about the affiliation of public and private hospitals was spoken about, an academic federation and the Mexican academy of surgery.

They have all made several commitments to apply immediate actions relating to approaching and consolidating their staff towards a patient safety culture, healthcare associated with infections, mental health, anaemia and transfusions, medication errors, early detection of sepsis, sub-optimal neonatal oxygenation, deep vein thromboembolisms, the improvement of safe obstetric care, etc.

Keynote speech conference activities were dictated by, among others, the ex president of the USA, William Clinton, the ex-vice president Joe Biden (surprising to listen to him talk for 1 hour on the subject of cancer) and Richard Carmona (ex surgeon general 2002/2006, who moderated the speech form the UK ministry of health). Speeches from physicians and clinical nurses, academics, prestigious media, technological companies related to health and very importantly, testimonials from patients or family members of patients, with some highly impacting and emotional accounts (in some cases they even seemed familiar case histories).

Speeches from members of the USA senate involved in this subject were given, together with some from members of the who, joint commission, CDC of Atlanta and federal drug administration. The organisation had affiliated over 3,500 hospitals.

What is next? That each commitment given should have an outcome and accomplishments; that the issue should be promoted permanently in line with regulations and academic concepts; that experiences be shared for encouraging the improvement in patient safety and strongly achieve what this movement has set out to achieve which is: ''zero preventable deaths in 2020''.