EDITORIAL

Medical errors in reproductive health care

Medical errors, a much publicized problem in recent years, are believed to be a common occurrence in the reproductive health care. These errors occur not only in hospitals but in other health care settings, such as physicians' offices, nursing homes, pharmacies, urgent care centers, and care delivered in the home. Unfortunately, very little data exist on the extent of this problem in Thailand. One problem in assessing the frequency of errors is that we are deeply immersed in a blame culture, so it is hard to persuade people to report them. Many errors do not cause harm, but in many ways these are as important as those that do. They indicate a breakdown in the system or a wrong decision. If we are to learn from mistakes then we need to know about as many as possible so that corrective action can be taken.

What can be done about these errors? They cannot be ignored. Once errors are recognized their causes must be analyzed so that preventive interventions can be applied. Some of the mistakes are caused by systems failures, for example, with drug errors or wrong transfusions. Clear definition of clinical responsibilities is needed. Fatigue among the junior staffs may also cause problems. The main causes of adverse events relate to operative errors, drugs, medical procedures, and diagnosis. Each of these is amenable to prevention. Lack of surgical skills may be because of shorter training and tighter working hours, young gynecologists are less experienced than previously. Better training programs will also help with medical procedures. Drug errors remain a problem-no one can remember all the possible drug interactions that may occur, and incorrect dosages are also a recurrent problem. A computer linked pharmacology system sends warnings when incompatible or otherwise dangerous drugs are prescribed, and the introduction of such a system could prevent hundreds, indeed thousands, of errors. Diagnostic errors could be minimized by better training and wider use of protocols and diagnostic algorithms.

Errors can be prevented by designing systems that make it hard for people to do the wrong things and easy for people to do the right things. Cars are designed so that drivers cannot start them while in reverse because that prevents accidents. Work schedules for pilots are designed so they do not fly too many consecutive hours without rest because alertness and performance are compromised.

In reproductive health care, building a safer system means designing processes of care to ensure that patients are safe from accidental injury. When agreement has been reached to pursue a course of medical treatment, patients should have the assurance that it will proceed correctly and safely so they have the best chance possible of achieving the desired outcome. Special article in this issue entitled "Medical errors : an overview" will give an overview of medical errors which may be useful for the readers.

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Editors