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LETTER TO EDITOR

Medical Errors in Emergency Department; a Letter to Editor

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Cite this article as: Asadi P, Modirian E, Dadashpour N. Medical Errors in Emergency Department; a Letter to Editor. Emergency. 2018; 6(1): e33.

Dear Editor:

Medical error is the third leading cause of death in the United States of America and almost 100000 patients lose their life due to medical errors every year (1).

Studies show that the number of medical errors is increasing annually. Various factors such as weak communication between medical staff and patients, the activity of the press and other mass media, insurance companies, lawyers and legal advisers, reposition of the doctors, economic problems of the health care team, and etc. have an important role in this increasing trend (2-5).

Medical errors are generally considered from two perspectives, which include individual approach (traditional) and systemic approach (holistic).

In individual approach the initial encounter with an error is finding the guilty person and blaming him/her. In this approach, each individual is responsible for their actions, individually. This approach has a long background in the world of medicine and aims to improve performance with actions like compulsory education, warning, legislation, and punishment. The problem of this approach is that the system is ignored, so it does not reduce medical errors, because the error is influenced by several factors; therefore, blame or even abandoning those who are guilty does not change anything.

The systemic approach is an unavoidable phenomenon that can be used to enhance the performance of the system. Actually systemic approach is to change the system, so that the probability of error is reduced. When an undesirable event occurs is not important to find out who has made a mistake, but we must examine what has caused the failure of defense mechanisms against errors. System sets of elements (human

and inhuman) are independent and interact with each other to achieve a common objective. Man acts as a part of the system and the last of the cycle and the final performer of the system. For this reason, root causes of medical errors should be managed.

Overcrowding, shortage of personnel and equipment, and admission of patients with life-threatening diseases has made the emergency departments prone to higher incidence of medical errors.

Poursina Hospital is an educational Hospital in Rasht, Guilan province, North Iran, with about 30000 to 35000 admissions per year. Performing a cross sectional study, we analyzed the registered cases of medical errors in the hospital during one year. 396 (1.24%) cases of medical errors were reported and emergency department with 134 (33.7%) cases had the highest incidence of medical errors among hospital wards. Diagnostic errors with 173 (43.5%) cases and medication errors with 100 (25.1%) were among the most common reported errors. Most of the people were not informed regarding their error and there was the possibility that they repeat the same errors.

It seems that experienced personnel should be used to reduce the occurrence of medical errors in the crowded wards, which have to support patients with life-threatening diseases. People should be aware that the error registry system has been launched to identify and resolve system errors and it doesn't aim to identify the offender.

1. Appendix

1.1. Acknowledgements

None.

1.2. Author's contribution

All the authors of this article met the criteria of authorship based on the recommendations of the international commit-

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tee of medical journal editors.

1.3. Conflict of interest

Hereby, the authors declare that there is no conflict of interest regarding the present study.

1.4. Funding and support

None.

References

1. Donaldson MS, Corrigan JM, Kohn LT. To err is human: building a safer health system: National Academies Press; 2000.

2. Schenkel S. Promoting patient safety and preventing medical error in emergency departments. Academic Emergency Medicine. 2000;7(11):1204-22.

3. Sandars J, Esmail A. The frequency and nature of medical error in primary care: understanding the diversity across studies. Family practice. 2003;20(3):231-6.

4. Schwappach DL, Koeck CM. What makes an error unacceptable? A factorial survey on the disclosure of medical errors. International Journal for Quality in Health Care. 2004;16(4):317-26.

5. Tamuz M, Thomas E, Franchois K. Defining and classifying medical error: lessons for patient safety reporting systems. BMJ Quality & Safety. 2004;13(1):13-20.