

That's the Patient's Right and Our Responsibility

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According to evidences, a new literature started considerably to appear about three decades ago, addressing medical errors, which was rising dramatically at the 90's. Obviously, the 1999's Institute of Medicine (IOM) report (To Err Is Human) has had an undisputable role in bringing health care events issue into the public and professionals spotlights which consequently followed by other studies in many states all over the world. This movement has led to highlighting a new term in health care glossary named "Patient Safety".

Publication of the report "To Err is Human" was associated with an increased number of patient safety publications and research awards. The rate of patient safety publications has increased from 59 to 164 articles per 100,000 MEDLINE publications following the release of the IOM report in a 10 years period.

Nowadays minding the Quality, Patient Safety is one of the two pillars under the health care services.

Regarding numerous papers, articles, reports, solutions and text books, issuing on patient safety, and health care events, some common words are repeated in most of them, expressions like "learning from errors", "an Organization with a memory", "patient safety research", "patient safety culture", "learn and share", and so on.

In the new view to health care events and considering expert opinions as prof. James Reason about nature of errors and role of human factors and system faults, it has been strongly suggested acknowledging these issues and finding solutions in order to minimizing adverse effects of above mentioned factors.

Finding infrastructural failures and predisposing factors, planning for re-engineering processes, or complying with quality improvement techniques as Plan, Do, Check or Study, Act (PDCA) are highly recommended.

The very important point is the similarity between infrastructural and predisposing factors as human attributes all over the health care centers. In other word, errors mostly occur in a similar manner among different health care settings. Health care

events happening in hospitals highly resemble each other, for instance, as for medication errors, eligible hand writings and "look alike, sound alike medications" are causes of many health care events. On the other hand, analysis' results, experiences, and solutions do not make that much difference in various health care settings. Then, experiences in one health care facility could be valuable for others if they would be shared.

"Learn and Share" is a key sentence in patient safety strategies which recommends health care units learning from errors either from what happens in their own unit or other organizations and reciprocally shares their experiments.

Here it would be worthy to address this valuable statement that: "To Err Is Human, to cover up is unforgivable, and to fail to learn is inexcusable."

That's why WHO report calls for increased ability to learn from mistakes through better reporting systems, skillful investigation of incidents, and responsible sharing of data.

On the other hand, research for patient safety is a key element to improve quality and safety in health care. Continuous researches are necessary for continuous improvements in the patient safety issues. Researches can be applied in all aspects of safety as leadership and management, measuring harms, incidents, and many other issues affecting patient safety any way.

Journals could provide a good room for addressing the above mentioned materials and sharing lessons learnt about patient safety, in which professionals and researchers would meet their needs and share their findings.

On the other hand, such a journal would highlight patient safety topics among researches and literatures in our country.

I wish the journal and its articles would be cited and used by researchers and professionals all over the World.

The final benefit would be for patients and health care providers in any settings in different levels regarding minimizing harm to patients.

By now, in our country, patient safety experts, professionals, and researchers used to feel the lack of a specialized journal for patient safety in the country as there are not so similar journals all over the world. Then publishing "Patient Safety Journal" sounds very good NEWS for people who are interested in patient safety, even in overseas and is

an honor for our country, ministry of health and the above mentioned people.

My colleagues and I in Patient Safety Department of MOH feel pleasure for this great event in our country, and I hereby acknowledge and congratulate our colleagues in Mashhad University of medical science.