

## **When will health care pass the orange-wire test ?**

**By Sir Liam Donaldson  
Chair of the WHO World Alliance for Patient Safety**

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Imagine that a Boeing 757 aircraft engine contained an orange-coloured wire essential to its safe functioning. Imagine that an airline engineer doing a preflight inspection spotted that the wire was frayed in a way that suggested a systematic fault rather than routine wear and tear. Imagine what would happen next. It is likely that most 757 engines in the world would be inspected—probably within days—and the orange wire, if faulty, renewed.

Like airlines, hospitals take charge of people's lives many times a day. Yet, health care has lagged behind other industries in putting safety first in dealing with its consumers. A systematic fault that put patients' lives at risk discovered in one country would not surely be rapidly and simultaneously corrected by health services across the world. That harm can come to recipients of health care is not a new idea. Studies as early as the 1950s and 1960s reported on adverse events. A body of observational studies started to accumulate from the early 1990s with the publication of the results of the Harvard Medical Practice Study.<sup>1,2</sup> Since then other studies have investigated the extent of adverse events in different places.<sup>3-9</sup> It is now estimated that one in ten patients who receive health care will suffer from preventable harm.<sup>10</sup> Today we know that medical error causes up to 98 000 deaths annually in hospitals in the USA and that an estimated 850 000 adverse events occur in UK hospitals each year.<sup>10,11</sup>

Adverse events cause untold human misery to both patients and staff. They also exact a high financial toll. In the UK alone additional hospital stays cost about £2000 million a year and paid litigation claims are estimated to be £400 million annually.<sup>10</sup> The litigation costs are in addition to a potential liability of £2400 million for existing and expected claims.<sup>10</sup> At present there are few comparable data from developing countries and those in economic transition. The indications are that the problem of patients' safety is just as much of an issue there, although the potential sources of harm may be different. WHO figures suggest that developing countries account for around 77% of all reported cases of counterfeit and substandard drugs.<sup>12</sup> At least half of all medical equipment in

most developing countries is unusable or partly usable, thereby subjecting patients to increased risk of harm.<sup>13</sup>

The key to addressing these challenges is recognising that adverse events are not a series of unconnected and parochial one-off's.<sup>14</sup> Rather, error is provoked by weak systems and can have common root causes which are generalisable and also correctable. In 2002, the World Health Assembly recognised the rapidly escalating global problem of patients' safety when it passed a resolution asking all its member states to address the problem.<sup>15</sup> Since then WHO has witnessed unprecedented interest and willingness by countries rich and poor to tackle the challenge of making health care safer. In response, on Oct 27, WHO launched a World Alliance for Patient Safety.<sup>16</sup> The World Alliance will be very important in facilitating the development of patients' safety policy and practice in WHO's 192 member states. The Alliance will deliver several core functions and short-term initiatives, which will be set out in an annual work programme (panel). In delivering these programmes WHO will bring together its technical experts from all parts of the world. The Alliance will be supported by senior policy-makers and international experts with a common objective to stop health care causing harm to patients.

The creation of the World Alliance for Patient Safety provides a unique opportunity for coordinated action across the globe, sharing knowledge, expertise, and experience to reduce the impact of medical error. Safety should be a core value for any modern health service. Systems thinking should be at the heart of the design of its practices and processes. To continue to fail to learn from mistakes made in the delivery of care—as has been the case in the past—is fast becoming inexcusable.

Among many other opportunities created by the launch of the World Alliance for Patient Safety is the hope that one day the learning from the inadvertent death of a patient in a hospital in one country could save the lives of many others around the world. When that comes to pass the health-care industry truly will have passed the orange-wire test.

*Liam Donaldson*  
Chairman, World Alliance for Patient Safety, WHO,  
CH-1211 Geneva, Switzerland  
philipp@who.int

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