



## Patient safety in public health

In 1991 the publication of the Harvard Medical Practice Study gave a new light to the problem of patient safety.

Because of its rigorous methodology, its dimensions (more than 30,000 clinical records from 51 hospitals) and number and variety of the departments involved (medicine, surgeries, emergence, etc) the Harvard study represents a milestone in the patient safety research. It unequivocally demonstrated that errors happen in the hospitals, they can be life-threatening and most of them are preventable. A wide number of other reports have followed the Harvard study, most of them refer to hospitals while the rate of errors in primary care is less known. These more recent studies represent an important progress because the Harvard study is considered old in its approach describing errors as the result of negligence or misconduct and missing totally the problems of the medical environment (the *system approach*).

In the last few years relevant progress have been also made on medication errors, a substantial portion of medical errors. The Institute of Medicine estimated that preventable medication errors result in more than 7,000 deaths each year in hospitals alone, and tens of thousands more in outpatient facilities. This issue of the Italian Journal of Public Health aims to give an overview of some methodological problems linked to the patient safety activities, also under less common perspectives (as an Health Technology Assessment point of view). It also aims to describe some activities linked to patient safety in Europe and in the United States, some of these are well established activities others are more recent and in development.

Because of their relevance, their preventability and their cost to health systems patient safety problems should represent a typical public health concern and we hope our readers, mainly public health specialists, will find in this issue matter of interest.

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