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Gaitán-Duarte, Hernando; Estrada-Orozco, Kelly
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Safety in healthcare services, a worldwide priority in women care

Hernando Gaitán-Duarte, MD, MSc.¹; Kelly Estrada-Orozco, MD, MSc, PhD (c).²

Patient safety has been defined by the World Health Organization (WHO) as the “*Management of processes that results in the reduction to an acceptable minimum of the risk of causing unnecessary harm in medical care*” (1, p.15). Acceptable minimum is understood to mean “*any harm that is inevitable in light of current knowledge, available resources and the context in which care is provided, which is in contrast with the risk of receiving no treatment or a different treatment*” (1, p.15). Harm to a patient is the undesired effect derived more from healthcare than from the underlying disease (2), and it is known as an adverse event or a reportable event with undesired effects –REUE–(3).

The Royal Spanish Academy defines a patient as the “*person who experiences bodily and physical suffering and, in particular, the person who is receiving medical care*” or “*person who is or will be medically examined*” (4). This concept includes both the person suffering from an illness as well as the healthy individual who comes into contact with healthcare services. It includes the widely researched concept of subjects with pathological conditions receiving care during hospitalization (5,6), as well as individuals receiving outpatient care (7) and people in good health such as children who are monitored for growth and development, or women in prenatal care.

The aim of prenatal care visits is to verify the normal course of pregnancy and ensure early detection of potential pathological conditions that may affect

the health of the pregnant woman or the product of gestation. For example, the pregnant woman or the fetus can be affected by disease conditions acquired before or during pregnancy, such as congenital syphilis (8), by situations that are inherent to pregnancy itself such as preeclampsia (9), or by complications from physiological events at the end of pregnancy, such as postpartum bleeding (10). All these conditions require timely recognition by the physician if risks are to be reduced to an acceptable minimum both for the mother and for the fetus. In the case of congenital syphilis, acceptable risk should not be greater than 5 x 10,000, in accordance with the goal of eliminating congenital syphilis (11); for pregnant women developing preeclampsia, the risk of dying from eclampsia should not be greater than 2% (12); and regarding postpartum bleeding, the risk of extreme maternal morbidity, and the risk of dying from this cause, should not be greater than 2.5% and 2%, respectively (13).

These numbers considered as the current minimum risks come from high income countries and may be deemed as the best achieved so far. How can it be explained that the risk for poor health outcomes are higher in low and middle income countries? Determinants of health (DH) could be part of the explanation. DHs are a set of factors of the individual, social, economic and environmental domains that influence the health of the individual or of a population. They are classified into two groups: 1) structural factors that are the multisectorial responsibility of states,

1. Editor of the Revista Colombiana de Obstetricia y Ginecología (RCOG), Bogotá (Colombia).

2. Invited Editor. School of Medicine, Universidad Nacional de Colombia, Bogotá (Colombia).

including political, economic and social determinants; and 2) intermediate and proximal determinants of health which have a direct influence on health and disease states. The latter include lifestyle and environmental factors, biological and genetic traits of the population, and factors related to health services such as healthcare process characteristics (14), namely, characteristics pertaining to the setting and nature of the work, characteristics of individual and teams providing the care, and patient characteristics (15).

For some sectors of the population, health services often fail in terms of access, quality and sufficiency. These failures affect certain groups to a higher degree, including women, indigenous and migrant populations, afro and diverse communities. These are groups that also suffer frequently from marginalization, discrimination and violations of their rights to education, drinking water, sanitation services, food and health, among others (16). Differences pertaining to health and care among populations and regions have been described in the literature for more than 30 years and occur regardless of the prevailing political or economic system. Health inequity is considered to exist when such differences are unnecessary, avoidable, arbitrary or unfair (17).

Health inequity contributes to higher maternal and infant mortality and is a factor of differences in health indicators not only among countries but also within a country itself. For example, health inequity related to ethnicity accounts for a proportion of maternal and infant mortality throughout the world (18). In Colombia, this phenomenon has been described in the Pacific region, where most of the people are of afro or indigenous origin (19). Other factors leading to health inequity have also been described, including the type of insurance coverage which has been associated with an increased risk of poor outcomes in pregnant women receiving care under the state-subsidized system, when compared to those covered by the contributive system (20).

Differences in undesired outcomes are not found exclusively in the pregnant population but also in

women requiring care due to gynecological conditions such as cervical cancer, sexually transmitted infections and urogynecological problems, including pelvic floor disorders, women suffering those conditions are also vulnerable to this type of inequity (21). In a broader sense, undesired outcomes in the care process do not always happen as a result of care-related actions such as inadequate interpretation of a diagnostic non-treponemal test in screening for gestational syphilis, or due to omissions like not offering a rapid test that can be interpreted at the point of care; they occur also due to lack of timely care not only for individuals afflicted by the disease but for those who seek to prevent disease or promote health. This omission may result in unintended harm as is the case when a pregnant woman does not access to antenatal care. In Colombia, the effect of this shortcoming and of preventive actions can be observed in congenital syphilis incident cases. This preventable condition, when treatment was offered to the mother during gestation, had an accumulated incidence of 1.54 for every 1000 live births by 2018, while the national average in 2021 is 2.03 cases for every 1000 live births. However, there are clear differences among regions; there are departments (states) with figures above the national averages, as is the case in Arauca and Casanare, with 3.78 cases for every 1000 live births (22). This problem of timely care is discussed in this RCOG issue, in the report of congenital syphilis cases in Bogotá. The study describes flaws in coverage or care provision to pregnant women, resulting in damage to the fetus or the newborn.

All these poor outcomes, which are ultimately reportable events, should be the target of clinical risk management programs as part of patient safety or healthcare safety, hence the need for all stakeholders in the health sector to strengthen activities aimed at reducing the risk of harm in individuals requiring health services at all levels of care. Those efforts must include promotion and prevention activities, primary and specialized care, outpatient or inpatient care. In this mission of ensuring safety in healthcare, all stakeholders have a role to play: national and local

government agencies, third-party payers (known as Health Benefit Plan Managers), hospitals, primary care centers, and even community centers, either private or public.

For this reason, starting with this issue of RCOG, a window is opened for the publication of primary or secondary research designed to increase safety in relation to reportable events with undesired effects in healthcare, which are the result of absence of services needed by the population, in our case the female population, or of their interaction with the care provided by health services. We seek to provide evidence to reduce to a minimum the risk of harm from action or omission for the furtherance of women's health throughout the different stages of life; evidence regarding methods used for surveillance of safety incidents, risk management and their effects in terms of implementation, safety and effectiveness outcomes; financial and ethical implications of interventions aimed at increasing safety; and actions designed to reduce barriers to their adequate implementation in health areas that can benefit women. The publication in this issue of the scoping systematic review on the structure and operation of rapid response teams in hospital settings marks the start of our dissemination of research studies on the topic of safety in healthcare services.

The intention is that, eventually, healthcare safety will become a common working goal in our health system. Not because resources are scarce should poor outcomes be accepted. We need to strive to prevent, recognize and tackle these issues from a systemic point of view so that the care process in all its dimensions can produce better health outcomes and bridge the inequity gaps existing in Colombia which, as was determined, notably affect women.

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