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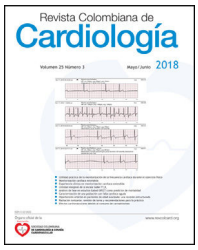

EDITORIAL

# *''To err is human. To cover up is unforgivable. To fail to learn is inexcusable.''*

## ''Errar es humano. Ocultar los errores es imperdonable. No aprender de ellos no tiene justificación''

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*Revista Colombiana de Cardiología*

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. . . .ωφελεειν η μη βλαπτειν. . . . (. . .to help, or at least do no harm. . .)

Hippocrates, Epidemics, Bk. I, Sect. XI, c. 400 B.C.

Very often, in dealing with our patients, colleagues or students, or simply gathering our observations to write a scientific article, we feel concern and frustration when considering adverse effects or complications.

In light of current medical practice, and particularly that of cardiology and cardiovascular surgery (the topic of the Revista Colombiana de Cardiología [Colombian Journal of Cardiology]), we constantly face increasingly complex patients. There are premature infants or the elderly, individuals with multiple morbidities (diabetes; mental, pulmonary, kidney, and liver diseases; fragility, etc.) and polypharmacy (diuretics, vasodilators, anticoagulants, proton pump inhibitors, antiarrhythmics, analgesics, etc.), those who have undergone several surgical re-interventions, diverse percutaneous interventions (pacemakers, defibrillators, stents, percutaneous valves, MitraClip implants, left atrial appendage closure, aortic endoprostheses, percutaneous closure of intracardiac defects, etc.), myocardial revascularization surgeries, and many others. In addition, we see the use of new medications, diets, and homeopathic products which are marketed for the treatment and management of special conditions. These treatments increase the possibility of adverse events and iatrogenic effects which put the patients'health and life at risk, increasing the length of hospital stays, the number of readmissions, and, ultimately, healthcare system costs.

Many articles speak of the efficacy of all these treatments, but very few describe their safety in depth. So-called ''adverse events'' are those which occur during clinical care and result from physical or psychological harm secondary to iatrogenesis rather than to the natural course of the disease or inherent patient condition. Iatrogenesis has been part of medicine from the beginning and will continue to be part of it as long as it exists as an art and a science.

Medical practice has made huge progress. However, it was not until the 60s that the effects of thalidomide and synthetic estrogens (diethylstilbestrol) were described and the Food and Drug Administration (FDA) in the United States

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warned of and described the adverse effects of these two medications. The progress in epidemiology and the development of clinical studies based on the scientific method, randomization and the use of control groups have helped determine the true efficacy and safety of multiple treatments.

The *Journal of Patient Safety* reported the real number of premature deaths associated with preventable injuries, estimated to be more than 400,000 per year. Serious injury seems to be ten to twenty times more frequent than lethal injury. According to the findings presented in the 2014 *National Partnership for Patients* (P4P) report, out of 11 areas considered, five reduced risks. This represented 15,500 fewer deaths and savings of 3.1 to 4 billion dollars, compared with the 2010 report.

Currently, the concept of iatrogenesis has been gaining interest and popularity in clinical research. While iatrogenesis has been a ''natural'' cause of disease since the beginning of medicine, todaýs society is not content with the situation, and, reasonably, demands compliance with a new culture offering a sense of ''patient safety'' as a commitment of all members involved in comprehensive health care. The use of risk scores, identification of complex patients, creation of comprehensive care groups and analysis of the causes of medical errors should lead to improvement processes.

Despite the explosion of scientific information, we experience many adverse conditions related to medications and devices which continue in real life and put our patients at even greater risk: most medications act through increasing or decreasing the dose rather than trying to normalize the disease, which is what they were created for. There is minimal or no consideration by physicians of the innate compensatory mechanisms of the body, and the effects of polypharmacy are not completely understood (especially with opiates, analgesics, sleeping pills, antidepressants and oral anticoagulants). In general, patients have a low adherence to medications and appropriate lifestyle advice. Over-the-counter dietary supplements, herb-based products, and non-traditional alternative therapies may interfere with prescription medications and there may be interactions between these medications. Finally, indiscriminate advertising aimed at consumers, especially on radio and television, encourages patients to request specific medications by name, thus creating a direct dialogue between the consumer and the pharmaceutical company, removing the physician from the ''equation''.

These few lines are merely a wake-up call for physicians, researchers and educators to consider the patientsśafety, do everything possible to reduce the chance of adverse events, include the topics of iatrogenesis and cardiotoxicity in training programs, insist on the proper indications for the use of medications and performance of invasive procedures and indiscriminate implantation of devices, conduct an exhaustive clinical follow-up, and compile and publish the information for the good of our patients and the protection of the healthcare system.

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