



Editorial

[Translated article] Is patient safety still a strategic priority?

¿Sigue siendo la seguridad del paciente una prioridad estratégica?



In 2023, Donald Berwick published an editorial in the *New England Journal of Medicine* in which he warned, with concern, that the “constancy of purpose” in the field of patient safety seemed to have been lost.¹ Drawing on W. Edwards Deming, he recalled that improvement in complex organizations is only possible when there is visible, sustained, and coherent commitment from leaders. He also noted that, after more than two decades of the patient-safety movement, many healthcare organizations appeared to have moved this objective out of the foreground, absorbed by other clinical, economic, and organizational priorities.

This reflection is particularly relevant at the present time. Healthcare systems are simultaneously facing problems of accessibility and sustainability, population aging, workforce shortages, accelerated digital transformation, and demands for equity. In this scenario, it is worth asking whether patient safety still occupies a central and explicit place on strategic agendas or whether, on the contrary, it has come to be regarded as an assumed value rather than a true priority.

It is worth recalling how the modern patient-safety movement emerged. In the 1980s, the *Harvard Medical Practice Study* analyzed more than 30,000 medical records of hospitalized patients in the state of New York in order to estimate the magnitude of medical negligence, in the midst of a malpractice insurance crisis.^{2,3} However, its results revealed something unexpected: only a minority of adverse events were due to negligence, while a very large proportion were related to errors in care processes and were therefore potentially preventable. This finding led Harvard researchers, and especially Lucian Leape, to embark on a path that would transform the way healthcare harm was understood.⁴ Inspired by high-risk industries, they introduced safety sciences into healthcare and laid the foundations of the systemic approach to error that would crystallize in the Institute of Medicine report: *To Err Is Human*.⁵

Since then, patient safety has come to be understood as a fundamental property of complex systems, requiring leadership, organizational culture, robust processes, safe technology, and continuous learning. During the early years of the 21st century, this approach was translated into national strategies, reporting and learning systems, quality standards, and the progressive deployment of safe practices. Safety was placed, at least formally, at the center of institutional discourse. In the Spanish context, this orientation was reflected in the National Health

System Quality Plan⁶ and later in the National Health System Patient Safety Strategy,⁷ which defines safety as a priority strategic line and establishes a common framework expressing an explicit will for leadership and alignment among administrations and organizations.

However, more than two decades later, the data call for critical review. The contemporary replication of the *Harvard Medical Practice Study* carried out in Massachusetts hospitals identified at least one adverse event in 23.6% of hospital admissions, of which 22.7% were considered preventable.⁸ Nearly 4 out of 10 corresponded to medication-related adverse events, which constituted the most frequent group of harm. These results, far from suggesting substantial progress, point instead to stagnation in the reduction of avoidable harm.

In the field of medications, the World Health Organization (WHO) has repeatedly warned that medication errors continue to represent one of the main causes of avoidable harm in healthcare systems worldwide.⁹ For this reason, the 74th World Health Assembly approved in May 2021 the *Global Patient Safety Action Plan 2021–2030*,¹⁰ which includes a specific strategy aimed at implementing measures to improve medication safety, in line with the recommendations set out in the third global patient safety challenge: *Medication Without Harm*.⁹ More recently, in its report *Global burden of preventable medication-related harm*, the WHO noted that approximately 1 in every 20 patients receiving healthcare experiences some form of preventable harm associated with medication use, and that a clinically significant proportion of these events results in severe harm, permanent disability, or even death.¹¹ Similarly, the Organization for Economic Co-operation and Development (OECD) estimates that up to 1 in 10 hospital admissions may be associated with medication-safety problems, that around 1 in 5 hospitalized patients experiences some harm related to pharmacological treatment, and that the costs derived from avoidable admissions and prolonged hospital stays exceed 50 billion dollars annually in its member countries.¹²

It must also be considered that, at present, the risk associated with medications is amplified by the growing complexity of both processes and therapeutics: fragmentation of clinical information, transitions between levels of care, cognitive overload of professionals, polypharmacy in frail patients, dependence on digital systems that are not always well integrated, sustained workload pressure, and so on. In this context, small deviations can pass through successive barriers and translate

into serious harm if systems and technology are not designed with high-reliability criteria.

Within this framework, adverse events such as the one recently reported in the media in our setting must be approached with the utmost prudence and respect. Beyond the specific circumstances and the analyses that may be required, such incidents remind us that even in highly specialized environments, with advanced technology and highly qualified professionals, systemic vulnerabilities persist. These are not incomprehensible anomalies, but rather expressions of the inherent fragility of complex processes when system defenses fail.

All of this raises a fundamental question that connects with Berwick's warning: is there still a real and tangible constancy of purpose regarding patient safety, and in particular medication safety, or has it become diluted among multiple competing priorities? The epidemiological, clinical, and economic magnitude of preventable medication-related harm, consistently documented by the WHO and the OECD, reinforces the idea that safety in medication use must remain a central axis of healthcare system strategy and of leaders' agendas—not as a declarative principle, but as a defined objective that is measurable and sustained over time. Far from competing with access, efficiency, or sustainability, safety is an indispensable condition for achieving them. Adverse events prolong hospital stays, increase costs, erode trust, and generate a human and reputational impact that is difficult to bear.

From the perspective of healthcare management teams, patient safety cannot be understood as the sum of individual good intentions, but rather as a shared, explicit, and sustained responsibility. To lead means to prioritize, assign clear responsibilities, guarantee the necessary resources, and maintain a constancy of purpose that permeates the organization and is translated into coherent decisions over time.

In the same vein, it is difficult to justify that medication safety continues to be a diffuse responsibility, distributed among multiple actors without clearly identified leadership. Organizations such as the National Quality Forum pointed out more than a decade ago that effective leadership of structures and systems related to medication use should fall to the pharmacy service, explicitly recognizing the pharmacist as responsible for promoting and integrating safe medication-use practices within healthcare organizations.¹³ This consensus and evidence-based vision anticipated the need to establish formal and stable structures for medication-safety management.¹⁴ The designation of a Medication Safety Officer (MSO) does not mean creating a new function, but rather providing coherence, continuity, and accountability to an activity that the profession has been carrying out for years. Formalizing this role is not only consistent with the evolution of Hospital Pharmacy and with the strategic challenges defined by the Spanish Society of Hospital Pharmacy,¹⁵ but also represents an opportunity to strengthen professional leadership in one of the areas with the greatest impact on quality of care. It is probably time to demand that this recognition not be deferred to the future, but realized now.

Patient safety is not a completed stage in the development of healthcare systems. Without a real constancy of purpose, it risks becoming a formally acknowledged priority lacking transformative capacity. Its presence in strategic documents is not enough if it is not translated into concrete, measurable objectives maintained over time. Patient safety will only be truly strategic if it remains an explicitly led priority, provided with resources and evaluated through indicators, and not merely a shared principle.

Let us continue working to ensure that this is the case.

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Conflict of interest

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References

- Berwick DM. Constancy of purpose for improving patient safety – missing in action. *N Engl J Med.* 2023;388(2):181–182. doi:10.1056/NEJMe2213567.
- Brennan TA, Leape LL, Laird NM, et al. Incidence of adverse events and negligence in hospitalized patients. Results of the Harvard Medical Practice Study I. *N Engl J Med.* 1991;324(6):370–376. doi:10.1056/NEJM199102073240604.
- Leape LL, Brennan TA, Laird N, et al. The nature of adverse events in hospitalized patients. Results of the Harvard Medical Practice Study II. *N Engl J Med.* 1991;324(6):377–384. doi:10.1056/NEJM199102073240605.
- Leape L. Making healthcare safe. *The story of the patient safety movement.* Springer International Publishing; 2021.
- Institute of Medicine. In: Kohn LT, Corrigan JM, Donaldson MS, eds. *Committee on Health Care in America. To err is human: building a safer health system.* Washington (DC): National Academy Press; 1999.
- Ministerio de Sanidad y Consumo. *Plan de Calidad para el Sistema Nacional de Salud. Marzo 2006. Madrid: Ministerio de Sanidad y Consumo; 2006.*
- Estrategia de Seguridad del Paciente del Sistema Nacional de Salud. Periodo 2015–2020. Madrid: Ministerio de Sanidad, Servicios Sociales e Igualdad; 2015.*
- Bates DW, Levine DM, Salmasian H, et al. The safety of inpatient health care. *N Engl J Med.* 2023;388(2):142–153. doi:10.1056/NEJMsa2206117.
- World Health Organization. Medication without harm. Policy brief. Geneva: World Health Organization; 2023. License: CC BY-NC-SA 3.0 IGO. Acceso 3 de febrero de 2026. <https://www.who.int/publications/i/item/9789240062764>.
- World Health Organization. Plan de acción mundial para la seguridad del paciente 2021–2030: hacia la eliminación de los daños evitables en la atención de salud. Geneva: World Health Organization; 2021. License: CC BY-NC-SA 3.0 IGO. Acceso 3 de febrero de 2026. <https://www.who.int/es/publications/i/item/9789240032705>.
- World Health Organization. Global burden of preventable medication-related harm in health care: a systematic review. Geneva: World Health Organization; 2023. License: CC BY-NC-SA 3.0 IGO. Acceso 3 de febrero de 2026. <https://www.who.int/publications/i/item/9789240088887>.
- De Bienassis K, Esmail L, Lopert R, Klazinga N. The economics of medication safety: Improving medication safety through collective, real-time learning. *OECD Health Working Papers No. 147.* Paris: OECD Publishing; 2022. Acceso 3 de febrero de 2026. https://www.oecd.org/en/publications/the-economics-of-medication-safety_9a933261-en.html.
- National Quality Forum (NQF) safe practices for better healthcare—2009 update: a consensus report.* Washington, DC: National Quality Forum; 2009.
- Ford EH, Michalek C. Medication safety officers: a pillar of patient safety in hospital pharmacy. *Farm Hosp.* 2025;49(6):392–395. doi:10.1016/j.farma.2025.05.017.
- Sociedad Española de Farmacia Hospitalaria. Proyecto SEFH 2030. 20 retos para 2030. [Internet]. https://www.sefh.es/bibliotecavirtual/sefh2030/20231025_INFORMECOMPLETOSEFH_VF.pdf.

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