The study by Mason et al.\(^1\) presenting the Imperial College Error CAPture (ICECAP) tool aims to provide vascular surgeons with a valid and reproducible tool for identification and categorization of common errors during vascular and endovascular operations. Despite some methodological limitations that have been properly addressed, six primary categories (communication, equipment, procedure independent pressures, technical, safety awareness and patient related) and 20 sub-categories were determined as the most frequent and important vascular procedural errors.

“To err is human”. This famous adage by Alexander Pope was used in a report issued in November 1999 by the U.S. Institute of Medicine in order to increase awareness towards preventable medical errors in hospitals that exceeded deaths by motor-vehicle accidents, breast cancer and AIDS.\(^2\) Among the report’s main conclusions was that the majority of medical errors were not a “bad apple” problem. They did not result from individual recklessness or the actions of a particular group, but mainly by faulty systems, processes and conditions that lead to errors or fail to prevent them. But are errors during surgical operations as complex and multidisciplinary as plane crash errors? Interestingly, ElBardissi et al.\(^3\) successfully adapted and applied in the OR the Human Factors Analysis and Classification System (HFACS); a universally accepted human error framework that was originally used by the US air force to investigate and analyze human factors and errors in aviation. This model illustrated that the organizational influence (climate, resource management and policies) impact supervisory processes (scheduling, training, and oversight), which in turn establish the preconditions (technological and teamwork related) that produce errors.

Another study evidenced that errors during surgical operations are sometimes more than venial.\(^4\) Anderson et al.\(^4\) recorded that disorganized care in terms of failure to think critically, to deliver disciplined treatment strategies, to recognize structural failures and to achieve situational awareness contributed to the morbidities after surgical operation. On the other hand, preoperative and postoperative briefings and standardized communication practices were of primary importance in minimizing surgical errors.\(^3\)

The effort by Mason et al.\(^1\) in implementing a new tool for collection, discussion and analysis of common types of errors during vascular operations seems promising towards the improvement of health care delivery. This pilot study presenting ICECAP may provide a novel starting point for further analysis and may add to the existing literature in identifying systematic factors impacting human performance and patient safety.

REFERENCES

2 Committee on Quality of Health Care in America. To err is human: building a safer health system. Washington D.C. 1999  