To the mothers and fathers who have lost children due to medical error, to the husbands and wives who have lost spouses, and to all of those who have lost trust in our ability to recognize the privilege of caring for you or those you love.

And to Anie, my daughter, who despite a challenging year, taught me that hard work, focus, humor, and love is really what makes for a good and meaningful life.
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Tackling the second edition of *Patient Safety Handbook* initially seemed like a relatively simple proposal. The first edition, which was released in 2004, was actually conceptualized shortly after the landmark IOM report *To Err Is Human* made public what many clinicians, administrators, and patients already knew: that healthcare systems were poorly designed, preventable errors occurred frequently, and people who entrusted their lives to providers and systems that promised a great outcome were too frequently harmed or killed.

The science of safety was relatively nascent. Early leaders in the field such as Dr. Lucian Leape and James Reason helped us all to begin thinking differently about why the healthcare system was so prone to error and how the science of safety (borrowed from other high-hazard industries) might be applied to healthcare to better understand the root causes of error and to identify potential solutions for solving specific safety problems. Early on, one of the recommendations offered by the drafters of the IOM report—to fund research to advance the science and study of safety—took root, and research into the most common types of errors and to their etiology flourished. I would guess there are very few healthcare providers who are not familiar with the common causes of medication errors, the reasons wrong-sided procedures continue to happen, and the economic and emotional impact that preventable errors have on our healthcare delivery system.

Yet the ability or the willingness to translate this knowledge into strategies that yield positive change seems to lag far behind.

I have read the many articles and commentaries on safety since the release of the IOM report: some suggesting that great progress has been made and others (probably equal in number) lamenting the fact that little progress has been made. In fact, both are probably true. We know a great deal more about the complexities of the healthcare delivery system that predispose individuals to err; we know that leadership is key in setting an agenda for change and in aligning safety with the core vision and values of the organization, and we know that change (even some of the seemingly simple things) is extremely hard to bring about and sustain in a culture steeped in tradition and hierarchy.

Many providers continue to demand more and better data and fail to appreciate that they probably already have more than is necessary to begin the process of change. We have all learned that you can avoid the inevitable for a long time by simply asking for more proof. In my work with many hospitals, it is clear that it is far easier to continue to study the problem than to actually fix it and it is also easy to justify the limited effort to focus on safety by describing the current conditions and challenges faced by the healthcare industry, which often seem to compete with the safety agenda.

Clearly, many individuals and organizations have provided great leadership to stimulate the
safety agenda, but far too often the impetus for change is yet another tragic event, another loved one lost, and another group of providers devastated by their role in, or proximity to, an event where significant harm to a patient is the result. We must do better, and real and lasting change will occur only when healthcare providers and organizations acknowledge that they must hold themselves and their peers accountable for safety, they must stop making excuses as to why safety is not a priority in their organizations or within their practices, and they must be willing to change practices and behaviors that we now know are counterproductive to a culture of safety.

As both a clinician and a lawyer, I have been intrigued by how often I still hear the excuse offered that “we can’t be more transparent . . . we can’t share information about our own errors and best practices . . . we can’t hold our peers accountable” because the legal system is “so unfair,” “so punitive,” so “likely to deliver an unfair or unjust verdict.” This excuse continues to inhibit progress in many areas. It also has the impact of allowing providers to blame someone or something else for the problems that really are under the control of the caregiver and the caregiving organization. It seems somewhat obvious that most patients enter the legal system only after harm has occurred or information has been withheld. So undoubtedly a better strategy would be to take control of the environment that is under our control and recognize that the only way to not be put at risk by the legal system is to develop strategies for keeping patients free from harm. For over 30 years, doing the opposite has not proven to be the solution.

Some looking at the table of contents of this book might be concerned that there are no specific chapters representing the patient’s responsibility or the patient’s role in patient safety. This was actually intentional. My position on patient safety is that once again it is first and foremost the responsibility of the provider and of healthcare organizations. It is a responsibility that we cannot pass off to a patient or a concerned family member or advocate. Of course, patients must be the reason we rededicate ourselves to changing the unsafe and overly complex systems that often give rise to error, and we must listen to them so we know what things are of greatest concern to them. But we cannot make patients and family members responsible for patient safety. I find it unnerving when campaigns are launched asking patients to “speak up” to ask their caregivers if they have washed their hands or to challenge patients to know how to escalate a concern when their loved one seems in peril. It is once again an attempt to shift responsibility away from those individuals who are responsible and in the best position to lead the change to someone who is vulnerable, frightened, and oftentimes too ill or too timid to be an advocate. My fear is we might further harm patients and their loved ones after an error by intimating that, if only they had been more assertive or more demanding of their care providers, they could have avoided or prevented the error. This shifting of our responsibility onto others adds insult to injury and often fails to allow providers to uncover the true root cause of the problem. Patients should expect that when they entrust their care to a provider or an organization, reasonable, safe, and effective care will be provided and that preventable errors will indeed be prevented, without their needing to maintain constant vigilance to protect their loved ones. The fact that so many people now state they would never leave their loved ones alone in a hospital is a testament to how little faith the public has in us, and this needs to change.

In addition, providers should know that their role in advocating for patient safety and their efforts at creating and sustaining personal and collective accountability will not only yield benefits for their patient but also for them. Errors are devastating to those experiencing them and to their loved ones, but the toll they take on the providers involved is also devastating. Working as a provider in our current healthcare delivery system is physically and emotionally exhausting, and providers
change the way we educate physicians and nurses so that they develop the competencies needed to be safety champions. This recognition of the need to create a measureable curriculum around safety is reinforced by the tools available with this second edition, which include specific learning objectives for each chapter, questions to test whether the most salient points were understood, and Microsoft PowerPoint slides to review the highlights of each chapter and to teach colleagues specific aspects of the topics presented.

It is my hope that the material provided in the second edition will enable you to see that while we are not yet where we need to be in making our systems safer, we are making progress toward achieving safer and more transparent health care for all.
For those outside the medical profession—and to a large extent, those inside it as well—the reasons for becoming involved in patient safety are most often personal, and not in a good way. For my husband and I, this involvement was precipitated by the loss of our brilliant, vibrant 15-year-old son, Lewis, who died from a cascade of medical errors following elective surgery.

I will not go into detail, but suffice it to say that a boy we regarded as one of the outstanding young men of his generation was casually sacrificed to medication error, hierarchy, and misplaced arrogance—in short, to all the shortcomings of the teaching hospital. Lewis entered the hospital a healthy, athletic teenager wearing shorts and sandals in the last days of a late South Carolina autumn. Four days later, we emerged without him into the first bright, cold days of winter. His path in those few days can be traced in half a sentence: two hours in surgery, two and a half days in recovery, and a day and a half in calamitous decline before he died, unrescued, in his hospital bed. Through all this, our concerns and pleas for help had gone unheeded.

As we worked through Lewis’s medical records to reconstruct the decisions that had been made, we were taken aback by what we found. Most chilling was the gradually dawning realization that despite their ultimately lethal mistakes, most of our son’s caregivers had acted strictly by the book, even down to the language used when speaking to us. But the standards they were following came with cavernous wiggle room, enough to accommodate even the most egregious errors and then nothing was done to catch them after they had occurred. Not just the process but the structure was rife with potential for harm. In this context, James Reason’s Swiss cheese metaphor—an other piece of our new knowledge—seemed little more than a euphemism. The system, so implicitly trusted by so many, was simply not set up to accomplish its goal. From our perspective, there were more holes than cheese.

We saw only one way forward from this experience—to bring some good out of the disaster that had befallen us. That was the beginning of a journey of advocacy that has yet to end. In many ways, we were typical of families affected by medical harm. Like most, we sought to bring hope out of despair, and we thought that the legacy of our son and thousands of others would be the immediate reform of the system that had taken their lives. Our aspirations seem almost quaint from our current perspective. But we believed that a system so out of sync with its own mission could surely be brought back to its intended path by a small group of determined people bent on doing the right thing.

This all took place at the end of 2000, a year after the Institute of Medicine’s report To Err Is Human. Hope was high in that moment. The problem had been delineated, and
we had both the will and the outline of a plan to change it. Rereading parts of the 2004 edition of Patient Safety Handbook, one can still feel that hope. And yet, there and elsewhere, many people were already expressing dismay at the slow pace of reform. The fifth anniversary and then the 10th passed with much soul-searching. Few thought we had shown significant change to be proud of.

No one can say we have not made many advances. We have put to rest—in most circles, at least—the idea that patient harm is not a problem. We have meaningful support from government entities. We have dedicated champions both within and outside of the system. Thanks in large part to the path blazed by consumer advocates in many American states, we have the beginnings of a system of transparency that has the potential of giving patients a clearer idea of benefits and risks. And yet we still do not have a real-time picture of the extent of patient harm, and we do not know to what extent our efforts in the past few years may or may not have helped reduce it.

Patients overwhelmingly see patient harm as an ethical issue, and those who think about it see transparency as the essential underlying principle of reform. They are not mistaken in this. The industry of health care has been allowed to function with too little accountability to its patients, its practitioners, and its communities and in the process has often lost the virtues of openness, honesty, and altruism that the public thinks should be its hallmark. Patients will also tell you that fragmentation and high-volume medicine—lack of time with their providers—are among the most significant drivers of patient harm. The patient voice is essential to solving these problems. Left unaddressed, these difficult, overarching questions have the potential to negate all that is achieved through other patient safety programs.

The bottom line is that much remains to be done. Patients and families continue to entrust themselves to systems that are fraught with risks over which they often have no power. Technical solutions, standardization, teamwork, improved communication, culture change—these all are necessary, important, and transformative. But they are only parts of a larger solution. Above all, we need to take on patient safety as an ethical challenge, one that pays careful attention to patient concerns and aspires to broad and innovative change at a fundamental level. I urge you to read this volume with that in mind.
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