Foreword

Patient Safety: Examining Every Aspect of Every System to Improve Outcomes

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This issue, Volume 101, Issue 1, marks the beginning of the second century of Surgical Clinics. I would be hard-pressed to think of a better topic to begin this new century of sharing information than with Patient Safety. After all, everything we do, everything we learn, everything we teach, and everything we should aspire to, should be for the benefit of the patient. This is why our profession exists.

Safety has become a loaded word in recent years. Its meaning has become somewhat obscured and, in some cases, even coopted. One now not only has to consider whether an action, process, or environment is safe but also consider whether it feels safe—and to whom does it feel safe or not. The sociologic discussion of differences of opinion on what constitutes safety and who will be the arbiter of that meaning is beyond capacity and the desire of this foreword. What is necessary for us to examine in our series is what efforts and understandings can we use to make the paths that surgical patients take safer for them to travel. I would like to say that this is a completely objective goal but, there will inherently be some subjectivity, as safety in our context always involves humans, and some of those humans will have differing goals and opinions.

Our concept of safety in the world of surgery has evolved tremendously over the past century. It has not, however, evolved in a vacuum. Nearly every aspect of our lives has evolved its own safety issues as well. Commercial and private transportation, food and water, building codes, clothing, toys, pretty much everything we consume or come in contact with, have some element of scrutiny for safety. Even going to war—arguably one of the least safe things one might contemplate—is replete with safety briefings and equipment (at least in the US Armed Forces).
Safety on some level is a concept, but on another level is a study. The study of what we do and how we apply the knowledge learned from that study in a systematic fashion should allow us all to function in a safer manner. Historically, the concept of surgical practice was that one learned from his/her own mistakes and over time became safer. Beyond that we have Morbidity and Mortality conferences and other meetings that allow us to review our local results and, it is hoped, make improvements, in essence, learn from our own mistakes as well as those of others. A significant category of literature exists on the benefits and drawbacks of learning safety in surgery in this manner.

Improvements in communication and the ability to rapidly transfer and analyze data have allowed us to not only expand our discussions of safety and failure analysis beyond our own walls but also to share concept and techniques with other disciplines. We have been able to share with our colleagues in the flight safety and safety at sea communities to learn very valuable processes. We have been able to share analytical skills and methods with our colleagues in the actuarial and statistical fields. Our colleagues from project management and logistics backgrounds have been able to help us see process issues that have been hindering our best efforts. The list goes on and on.

While the amount that we surgeons can learn from other nonmedical disciplines is nearly limitless, there will always be a major distinction between what we do and what, say, the airline industry must do: in the field of medicine, the end goal is not always agreed upon. If we want to safely fly an aircraft from Logan International Airport in Boston to SeaTac Airport in Washington, we can most assuredly agree on whether the plane took off, traveled, and arrived safely. We may have differing opinions on the comfort of the flight. We may even have room to argue about the safety of the conduct of the crew during the flight in some rare cases, but we almost always could agree on what it meant to have a safely completed flight in terms of moving the aircraft—an aircraft leaves under safe conditions, operates in a safe manner, lands safely at designated destination, and is usable to perform additional flights. When it comes to medicine, we may not be able to agree on the goals of therapy or what constitutes safe performance by the crew, or for that matter when the “flight” is complete. Individual patients and their families ultimately retain the power to make or execute many of the decisions in medicine. In aviation, the passengers don’t have that authority. In addition, in the aircraft world, if the plane is unsafe, you can get another one if needed. In the patient care world, that really isn’t an option; you have to work for the patient who presents.

Even with the above differences taken into account, there is still much that we have learned from other industries to help us improve safety in medicine. Perhaps among the most important lesson, in my opinion, is that the concept of safety in surgery requires examining every aspect of every system and element that bears upon the patient outcome. None of us exists in isolation, and we are all interdependent on all of our other colleagues and facilities. It has been said that “success has a thousand fathers and failure is an orphan.” I would posit that when we have a failure that our failure too has multiple parents, as it is usually an error chain that leads to truly bad outcomes.

In order to understand where and how we fit into a system of safety, we must first learn the vocabulary and tools that allow us to function more safely. Becoming facile with human factors, pathways, processes, and risk-mitigation as well as understanding the concepts of improving teamwork, analyzing data, and creating a culture that values safety, is critical to creating an environment that will minimize unnecessary bad outcomes. We are deeply indebted to Dr. Zheng and her colleagues for compiling an excellent set of reviews that will allow the reader to develop a sound basis for continued education.
At the end of the day, those who work in our profession will not likely eliminate all bad outcomes. That said, we can do a great deal to create platforms that will allow us to minimize unnecessary risk. That journey to greater safety begins with a single step for all of us, and each of us needs to take that step; none of us can do this alone. It by definition requires a collective effort.

Looking back at the changes chronicled in Surgical Clinics series over the past 100 years, one may be struck by not just how much has changed but also by how much has stayed the same. We do live in an era with a sound foundation upon which we can build. We should neither feel as if we have made no progress nor should we feel complacent. We at Surgical Clinics greatly look forward to working with our readership and our contributors to generate the best and most useful information we can for the next century and more.

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