



SPECIAL FEATURE

Everyone Has a Responsibility for Patient Safety, Part II: The Provider's Role

This article is the second installment in a three-part series on the roles patients, health care professionals and institutions play in patient safety in the health care process.

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Medicine in the 21st century has provided today's health care providers and patients with a myriad of sophisticated, effective treatment options. However, inherent in these advanced, potent and complex interventions is the potential for systemic side effects, treatment interaction, complicated relationships and communication and technical failure.

The days of a patient receiving care from a single general practitioner, one who supervised all facets of the patient's health in a local practice or small regional hospital are practically gone. Medicine in the 21st century has provided today's health care providers and patients with a myriad of sophisticated, effective treatment options. However, inherent in these advanced, potent and complex interventions is the potential for systemic side effects, treatment interaction, complicated relationships, and communication and technical failure. The first article in this series examined the patient's responsibility for his/her safety when receiving health care. This second part of the series will examine some of the health care provider's roles and responsibilities in the patient safety process.

Lead the way to patient safety in your practice, institution and specialty. Physicians carry clout in the health care environment. You can help influence policy and staff, directly affecting medical practice. You can help promote a culture of patient safety by:

- *Encouraging a blame-free environment.* When errors occur, it is important to determine why it happened and help change processes so it can't happen again. Don't look for individuals to blame, look for multiple systemic causes. If your institution has a non-punitive error reporting system—use it. If they are considering development of a reporting system, be an advocate for nonpunitive reporting. People who are afraid of being blamed for errors or being “outed” for reporting them simply won't, allowing them to go on unchecked.

- *Being supportive, cooperative and constructive.* Provide research and suggest changes in error prone areas. When new patient safety practices are implemented, be patient and constructive. All new processes take time to work out the kinks. Participate and give your administration constructive suggestions. Encourage your colleagues and staff to do the same.
- *Promoting a safe and comfortable environment.* All health care providers should feel safe and comfortable asking questions and discussing the patient. Miscommunication is one of the top reasons for medical errors. If you were about to operate or inject at the wrong level, wouldn't you want someone to speak up? No one should be afraid to ask the question that serves the patient's best interest. All providers you work with should feel equally responsible for the patient's safety and care. This will protect you as well as the patient in the long run.
- *Promoting multidisciplinary communication.* Spine patients are commonly cared for by a number of providers in different specialties and professions. For example, the number of people who might care for a trauma patient throughout the care process could include an emergency room physician and nurses, orthopedic surgeon, operating room nurses, radiologist, floor nurses, physical therapists, etc. The differences between caretakers make situations ripe for the opportunity for mis- or noncommunication. Think about who will need information and



what may need to be shared based on differences in perspective and training. Make sure that crucial information is conveyed to those people who will need it the most.

- *Using available patient safety tools and processes.* If your institution provides computerized physician order entry, standardization for abbreviations or wrong-site surgery tools, use them. Make it a habit to protect the patient from harm and yourself from liability.

It's important to inform patients when errors do occur. Although counter to current medical and legal practice, when an error occurs, it's important for providers to reveal this information to the patient. Besides being morally correct, patients want their providers to disclose this information. When patient attitudes about physician errors and disclosure were examined in a 1996 study, it was determined that patients want acknowledgment from their doctors that an error has taken place. The study also showed disclosure may reduce the risk of penalty. When a moderate or severe mistake occurred, patients were much more likely to think about legal action if the doctor didn't tell them about the error. These disclosures also engender trust and communication between provider and patient.

Disclosure also is becoming less a matter of choice. It was addressed in the supplementary patient safety standards for hospitals put into effect July 2001 by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Patient safety standard RI.1.2.2 states, "Patients and, when appropriate, their families, are informed about the outcomes of care, including unanticipated outcomes." The intent being that treatment outcomes should be explained when they are substantially different from what was originally anticipated. JCAHO may put into

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effect similar standards in all its programs. Now may also be the time to think about whether or not your practice has an error response plan in place.

Provide your patients with educational materials to help them protect themselves.

NASS and many other organizations and for profit companies provide patient education on an innumerable number of topics. Educate your patients about not only their condition, but on how to best look out for their own health and safety. On the spine patient section of the NASS Web site there are links to some materials that can help:

- NASS' patient education brochure, *Patient Safety Tips to Help You Safeguard Your Health*
- *Speak Up: Help Prevent Errors in Your Care* by JCAHO
- Patient fact sheets, *Five Steps to Safer Healthcare* and *Ways You Can Help Your Family Prevent Medical Errors!* by the Agency for Healthcare Quality and Research

Make continuing medical education a priority.

In order to provide your patients with the safest, most up-to-date care, it's important to make continuing medical education a priority for you and your staff. Some organizations provide their staff with a certain number of days annually to be dedicated to continuing medical education. Support your staff's efforts to continue their education as well. Relevant, carefully chosen CME credits should be a measure of your

medical knowledge and patient dedication, not just part of the re-licensing process.

Take advantage of tools that promote patient safety provided by professional societies and others. NASS, other specialty societies and various corporations have available a variety of tools to promote patient safety. Research and take advantage of them.

Sources

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Acknowledgment

Pamela M. Hayden, Senior Manager of Scientific Affairs at the North American Spine Society, contributed to this article.