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Building On 'First Do No Harm'

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To state the obvious, patient safety—the theme of this edition of *WMJ*—is a concept of utmost importance in medical practice. It is not a new notion: for centuries doctors have functioned by the credo to “first do no harm” to their patients. Unfortunately, this fundamental issue has not received adequate systematic attention for many decades. It is a difficult problem to address, as many factors appear to be involved, reflecting the complex technology, interactions and systems that characterize modern medicine.

At the University of Wisconsin Medical School, we are active participants in work that is designed to bring patient safety to the forefront of awareness and improve the systems that ensure good patient outcomes. We believe we have an obligation to give physicians of the future learning experiences that will help them deal effectively with patient safety, as well as all the other aspects of care that constitute “quality.” The school shares this responsibility

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with partners like the State Medical Society of Wisconsin. Hopefully, the partnership that exists between us, which currently features efforts to more deeply involve students in the medical society, can be expanded to include safety issues.

One of the leaders of our efforts at UW Health is Dr. Jeffrey Grossman, Senior Associate Dean for Clinical Affairs and newly appointed President and Chief Executive Officer of UW Medical Foundation. Grossman and representatives of other Madison health care providers formed the Madison Patient Safety Collaborative, a group whose purpose is to enhance patient safety in the Madison community and beyond. The local leaders took up the initiative in response to a 1999 report on hospital medical errors by the Institute of Medicine. Titled “To Err is Human,” the report motivated providers across the country to review current safety practices and determine ways to improve them.

The Madison group came together with the philosophy that patient safety should not be an arena in which to compete, but rather to cooperate. Group members believe that by transcending the barriers to communication and knowledge-sharing

that commonly exist between competitive health care organizations, the entire Madison community can become a safer place to be a patient. In the tradition of the “Wisconsin Idea,” the group will readily share its data and experience with other organizations throughout the state.

The Collaborative, which Grossman chairs, began its work by using a tool called the “Patient Safety Improvement Framework,” developed by the National Quality Forum. Using the tool, they created an inventory of the current status of safe practice in Madison. In line with the group’s philosophy, data were collected in an anonymous format and analyzed on an aggregate basis. Based on this work and other data, the group developed a “Patient Safety Agenda” that describes its goals for patient safety improvement. The group has initiated several city-wide projects that address such issues as reduction of errors in the writing of medication orders, improved documentation of prescriptions and medication lists, and standardized institutional policies for the disclosure of medical errors and complications.

The group also plans to develop a “Patient Safety Center” that would act as a

repository and clearinghouse for patient safety data—a place to share “lessons learned.”

There is also a vision for the development of a patient safety teaching center that could be a common resource for health care providers in this community and beyond.

The group believes that by working in full partnership it can accelerate the accumulation and application of knowledge about patient safety. To that end, the Collaborative has also formed alliances with campus scientists to help make the Madison community’s care delivery system a “laboratory” for defining and applying knowledge about patient safety.

As the patient safety initiative gains momentum, however, it is

important not to sensationalize the issue. Making care systems safer takes the same methodical and rigorous approach that is used so successfully to solve other problems in science and medicine. The need for action is apparent, but it must be embedded in knowledge of how to change behaviors and processes in extremely intricate organizational systems. Recent advances in understanding disease—and the concomitant pharmaceutical and technological treatments that have developed—have improved healthcare outcomes immensely, but they have also produced many more complexities that challenge our dedication to ensuring patients’ safety.

Finally, we must keep in mind that patient safety is but

one piece in a larger universe of quality issues that we all work with continuously. These other issues include communication, continuity and coordination of care, and process and outcome improvement—all of which contribute to shaping a patient’s experience with the healthcare system.



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