

focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION

Commitment to Patient Safety: A Personal Journey

BY GORDON SPRENGER, PRESIDENT AND CEO, ALLINA HEALTH SYSTEM

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There is a tremendous amount of work that patient safety champions must do to make error elimination a front-burner issue on health-care provider agendas today. We need commitment, passion, and stamina to tackle this complex problem and bring about the cultural changes our health care industry must have to become a safer place to give and receive care.

My own journey started about two years ago when I was asked to participate in the Harvard Executive Session (HES), where I joined my colleagues from health care and other industries to learn more about medical error and patient safety. We were part of Harvard's new focus on medical error. These sessions afforded me close contact with some of the leading experts in safety, many of whom are referenced in the Institute of Medicine (IOM) report, *To Err is Human*. This experience had an intense impact on how I look at patient care, quality, and my own role in error prevention.

My first "aha" was about my own complacency. I suspect many of us, like me, have always paid attention to incident reports, but didn't get overly concerned unless the incident resulted in a major accident, caused a crisis, or produced a lawsuit. We compared the incident reports to national and local benchmarks, and as long as they were within range, we did nothing.

While some industries find a 5% error rate acceptable, we are not some industries—we are health care delivery systems. Any error rate is simply too high. It wasn't until I attended the HES that I was hit with this reality. We must start talking of managing to zero defects, not reducing errors by some percentage. If you are the patient, one error is too many.

Errors cost our patients' trust, yet silence continues to surround this issue. Most consumers believe they are protected. Media coverage has been limited to reporting anecdotal cases. Licensure and accreditation confer, in the eyes of the public, a "Good Housekeeping seal of approval." Providers also perceive the medical liability system as a serious

impediment to systematic efforts to uncover medical errors. Even though error rates are substantial, serious injuries due to errors are *not* part of the everyday experience of physicians and nurses. Errors are often seen as isolated and unusual events. In other words, that doesn't happen here—except when it does. Then patients and families lose trust in the system, providers are often pitched into a sea of blame, and too often, management only puts a Band-Aid on the problem without searching for systemic causes.

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Most errors do not result in harm—they are intercepted, there is good recovery, or the patient's defenses prevent permanent injury. One important reason physicians and nurses have avoided reporting errors and talking more openly about prevention is that they have a great deal of difficulty in dealing with error. The reasons are found in the *culture* of health care.

Lessons learned are shared privately. There is a powerful emphasis on perfection, both in diagnosis and treatment. And every day in our hospitals, our messages have been clear: mistakes are unacceptable. Professionals are expected to function without error, which is translated into the need to be infallible. One result is that health care professionals, like test pilots, come to view an error as a character failure—you weren't careful enough, you didn't try hard enough.

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This kind of thinking lies behind a common reaction, “How can there be error without negligence?” Many of our caregivers have been emotionally devastated by serious accidents that harmed or even killed a patient; our caregivers are often isolated by these emotions. The individual may learn to never repeat that error again, and the hospital may even change some practice patterns—but most of the time, the adjustment takes place in a vacuum.

We need to create a just, accountable culture that does not look first at the person at the sharp end for blame. Each of us is accountable when an error occurs. The many internal, external, individual, and systemic mechanisms and causes of errors dictate that there cannot be a simple or universal means of reducing errors. Instead, creating a safe process—whether flying a plane, running a hospital, or performing cardiac surgery—requires attention to reducing errors at each stage of system development: design, construction, maintenance, allocation of resources, training, and developing operational procedures.

In health care, building a safer system means designing processes of care to ensure that patients are safe from accidental injury. When agreement has been reached on a course of medical treatment, patients should be assured that it will proceed correctly and safely so they have the best possible chance of achieving the desired outcome.

Not long ago, a young Minnesota boy fell through the risers while sitting at a hockey game, hit his head on the concrete floor and was taken to one of our hospital's emergency rooms. He had serious brain damage. One of our ER nurses called the on-call pediatrician for drug and dosage levels to help reduce the brain swelling. Unfortunately, in the verbal order, several zeros were inadvertently added to the dosage level. If the boy had not died from the head injury, the drug overdose would have been fatal.

Did the nurse who took the order intend to make an error or give the boy an overdose? Absolutely not. Yet with all the technology we have today, why do we rely on verbal orders?

Accident prevention has not been health care's primary focus, and incident reports are often perceived as punitive. It's not that errors are ignored. It's that often the investigation is superficial, focusing on the individual and events immediately surrounding the incident—not the *systems* that contribute to error. Non-injurious errors (near-hits) are rarely examined at all. And when reports are filed, employees perceive that nothing changes, so there is no motivation for them to report incidents.

We need to think about communication and our influence as role models. Every member of our care teams—including the patient—needs to be empowered to speak up and work collaboratively. A team is only as strong as its weakest link.

I recently spoke with a group of physicians about aircraft-carrier takeoffs and landings, which are high-risk maneuvers. When I explained that we can learn from these events, a surgeon in the group interrupted, saying, “The important factor is that there is a well-known leader—the captain—who can call the shots.” This statement points to the type of culture change we need in health care.

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The element that makes the airline team effective is collaborative, non-intimidating communication. Anyone on the team can stop a takeoff or landing if that person assesses it to be unsafe. Likewise, during high-risk medical procedures like emergency room events or surgeries, every team member must be able to frankly question procedures.

We need to start with the board of directors and senior management, developing their buy-in on the importance of patient safety. Top management must understand the need to develop a blameless organizational culture to reveal the near-hits. Incidents that result in injury are already reported. It's the near-hits we need to study carefully so they never become an incident report. Because near-hits have not been reported or calculated for leadership, near-hit reporting will increase numbers. But bringing near-hits to leadership's attention will put a greater focus on curing systemic problems.

Allina Health System has more than 22,000 employees, and it is difficult to get everyone on the same page, but I've learned how simple gestures or symbols communicate personal and organizational priorities. In 1999, when the head injury/overdose experience with the boy occurred in one of our hospitals, I called the administrator to offer my support and advised him to talk honestly and immediately with the parents. The next important step was to have the administrator immediately talk with the nurse to find out

what we had done wrong in not supporting her to get the correct dosage. We emphasized that this is *our* problem, not just hers. This was a terrible incident, but we took responsibility with the family, the community and our staff. We must do this each and every time to establish a blameless culture, where the question is “What happened?” not “Who was involved?” unless, of course, the act was egregious.

We need to see patient safety aligned with the ethical imperative to do no harm and the economic realities of error costs. It makes good business sense to be concerned

about patient safety. Our customers' trust and confidence are built on our reputation, and our market share reflects our patients' trust in our hospitals and clinics.

At a time when we have a widening gap between resources and demand, the cost to redo work, pay for extra procedures, increase length of stay or pay significant liability claims cannot and should not be tolerated.

More importantly however, ensuring our patients' safety is simply the right thing to do. **NPSF**

Gordon Sprenger is President and Chief Executive Officer of Allina Health System, the largest health system in Minnesota. He is past-chairman of the American Hospital Association board of trustees and is a member of the Hospital Research & Development Institute. He chairs the Midtown Community Works, the Medtronic Board of Directors and is co-chair of the Phillips Partnership.

What we need from health care leaders

- **Listen and learn from stories about error.** Shared understanding supports cultural change. We first must mobilize our resources—obviously in different ways within our respective organizations—but we must develop precise business plans to make it happen. It helps to have flexible people working toward a common goal. Sometimes you may get resistance from legal or risk management in surfacing errors in your organization. At Allina, legal, risk management and pharmacy leadership worked together to develop a legally safe newsletter for distribution across our hospitals and clinics. The reader-friendly newsletter—ready to post on employee bulletin boards and put in mailboxes—shares alerts, warnings, near-hits, and successes in an easy-to-use form for managers in all clinical areas.
- **Remember that people create safety.** In our system, I am called whenever there are sentinel events. People who have received my calls consistently report how supported they felt and particularly pleased that I asked the appropriate questions (“How is the staff doing?” “Do we know what systems didn't work?” etc.) I've learned this is the single, most powerful action the CEO can take to move patient safety toward the top of the list for people with hundreds of compelling demands.

I have also learned it is crucial to have rapid-cycle teams across the organization to act on locally identified safety issues. As CEOs, we must express a high level of interest in our safety teams' work. For example, I spent time with the safety team at one of our hospitals to learn about their efforts and help them remove barriers to success. The symbolism of the CEO being so concerned with safety that you would take time to spend with the safety teams is essential.
- **Create a just cultural norm.** Insist that blame be limited only to egregious misconduct or impairment. At Allina, we have a number of unions. Our nurses' union council of chairs collaborated with us to modify our approach to sentinel event analysis, particularly because we did not have a stellar history of nurturing providers involved in error incidents. Now our risk management systems have changed to help leaders complete multi-disciplinary sentinel event reviews.

For example, an operating room director told me about a sentinel event in which a surgical tech's assessment was weighted as important as the surgeon's. She congratulated the total team for the courage to give their views of the story, to hear one another and to successfully improve care for the patient.
- **Be a role model; leaders will be closely watched during this cultural change.** Just as we started with the board, Allina has had special education for our executive leaders before moving to other leaders. The leadership of the organization must carry the lantern for others to follow. At Allina, we did this through patient safety culture workshops for all senior officers to begin building the understanding, moving away from denial and prioritizing error reduction as a front-burner issue.
- **Ask for help.** Plans are under way to replicate the Harvard Executive Session in the Twin Cities to mobilize a community-wide commitment. Competition centers on execution of best safety practices—not in identifying safety practices that lead to error reduction. Safety is not something we compete over. There should be no best-kept secrets when it comes to patient safety. **NPSF**

'For My Brother'

A heartfelt story of one family's devastating loss,
and the struggle to understand what happened BY ROXANNE GOELTZ

On September 22, 1999 my 39-year-old brother, Michael P. Lange, died due to a medical error. I want to share with you the human side of what happens in the desert of medical safety.

The only thing Mike wanted from life was to have a family, spend weekends with them, cook great meals and watch the Green Bay Packers. Unfortunately Mike never found a person with whom to share his dreams. In March 1999, he bought a Harley-Davidson motorcycle and rode it every spare moment he had. He told our mom he never realized how beautiful his world was.

I last saw Mike that August, on his way through Minneapolis with friends going to the Sturgis Motorcycle Rally. We sat on the deck eating homemade pizza and drinking beer.

Watching Mike, I was amazed at how much my son Derrick is like him. My heart filled with pride knowing if my son was to be half the person my brother was, he would be a decent human being. The next morning I meant to get a picture of the guys on their bikes, but forgot. I expected to get one later. Little did I know there was never going to be a later.

Mike was gone on his motorcycle trip for two weeks. Happiness filled the air when he stepped into my parents' living room in full riding gear and with a big grin on his face. "It was great, Mom, so beautiful," he said, giving her a big hug. That memory now tears at her heart every day.

My journey into this nightmare began in El Paso, Texas, where I was doing some evaluating for my job with the

Federal Aviation Administration. I called my husband at 6:00 a.m. ... "Hi Babe, how is it going?" ... "Not good Roxanne, Mike has passed away." ... "What? NO! What happened?" ... "You need to call your parents."

The pain this message brought to my heart was too familiar. It shredded my heart into strips of memories and tore it into pieces of loss that clogged my throat.

My God! My parents! The anguish I felt could not compare to theirs. They had now lost both their sons. How does one begin to fathom the loss of a child? I screamed, I can't do this again, how are my parents going to cope? I began to cry uncontrollably as I punched the numbers on the phone.

By the time my father answered, I was screaming and blubbering unrecognizable words. He understood the horror on the other end of the line as he said, "This must be Rox; I'll get your mother." When I heard the pain of loss in my mother's voice, I realized I had to be strong for her. My hysterical crying stopped abruptly.

Mom said, "They let him die, Rox. He went into the emergency room with a gut ache. They admitted him and gave him morphine without knowing what was causing his pain. He was put into a room and left unchecked and unmonitored for more than four hours. He passed away. They did not even try to help him!"

I hung up the phone and fell to my knees, crying and trying to keep the strips and pieces of my heart that were caught in my throat from coming up. If I let them out I may never have pieced them back together. As his big sister, I apologized to Mike for not protecting him, for not being there, for this awful thing that has happened to him—this ultimate injustice. He was a good man, a loving son, an adoring brother and a true friend.

There was no compassion from those whom my parents trusted to care for their son. My parents were called at 4:00 a.m. and told to come to the hospital, that Mike was not doing so well. On the way to the hospital, they made plans to take him to another hospital, not realizing it was too late. No one met them at the front entrance; they rode the elevator to the second floor. The doors opened and the whole staff was standing there, whispering. They stopped abruptly and looked at my parents.

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Roxanne Goeltz is an air-traffic controller who lives and works in Minnesota. She is married and has a son.

Her late brother, Michael P. Lange, lived in nearby Wisconsin.

My mom knew as she looked into their eyes and turned to Dad and said, "He is dead, Ray!" Screaming, she ran down the hall to Mike's room. In the doorway she saw Mike lying there, his arm hanging over the side of the bed with the IV still in it. My mom and dad traveled from the doorway to their son with a horrific feeling of failure, the failure all parents fear—that they will not protect their child from harm. They felt guilty for trusting someone else with this task, the ultimate mistake that cannot be undone.

My parents were in shock and grief, their hearts being ripped from their chests, surrounded by a profession that should have helped Mike, that should be helping them at that moment. An airliner crashes and 250 people die. The families are brought to see parts of the wreckage, to help with closure, and grief counselors are available. My parents were led to the body of their dead son, not a seat from a plane, but there was no one there to help them. My father saw death in two wars, but has suffered no greater trauma than seeing his healthy, loving son alone in a room, in a hospital, in a community he trusted. There is no physical pain greater than the loss of a child.

Later, my parents were called to the hospital again. I was not there yet and they had to go without me. The family doctor told them Mike died from blood in the sac around the heart. My parents asked how it got there. No answer, then excuses; there was another emergency.

Someone made the choice not to care for Mike—not even to check on him for more than four hours. "If you were too busy, why not get help, why not tell us so we could have taken him somewhere they would have cared for him?" my parents asked.

Mike was misdiagnosed; the doctor made a mistake. A mistake! He never even tried to help him. Mike called my mom at home at 8:30 p.m. and said they wanted his family medical history. My mom called and talked to the duty nurse, telling her of two uncles who died of aneurysms. The nurse said the information was not pertinent to Mike's case.

Mike, who had high blood pressure, smoked and was a bit overweight, was now back in the hospital with severe pain radiating to his back. My mom requested an ultrasound, but it was not done. She called Mike and told him the nurse didn't think the aneurysm history was significant. "Dad and I will be by to see you in the morning," she told him.

The family medical history was not passed on to the doctor. What would it have cost the nurse to talk to the doctor about an ultrasound just to make sure it was not pertinent? It cost my brother his life. My parents left the hospital still in shock over the fact they actually trusted their son to these people.

'My parents were educated the hard way. The price of the lesson: the death of their son. We can no longer blindly trust. We must become educated in our role as patients and the part we must play in our safety.'

My parents were chastising themselves for leaving Mike alone, for taking him to that hospital. They were unable to comprehend how the trust they had for the hospital to care for Mike could be ripped from them. It was a trust ingrained in them by their upbringing, by a society that teaches blind trust of doctors—doctors who must work in a system that fails them, too.

My parents were educated the hard way. The price of the lesson: the death of their son. We can no longer blindly trust. We must become educated in our role as patients and the part we must play in our safety.

The community was in shock. Mike had so many friends, and they wanted answers too; they were angry. Those who could give some answers hid behind the hospital doors. The hospital administrator, who attends church with my parents, would not even acknowledge their existence. Is this the kind of person in charge of caring for a community's health? We are able to forgive mistakes but not indifference, not denial and hiding.

So many people were calling and stopping in to see my parents, trying to understand, to offer condolences and support. Mike was gone and we couldn't understand what happened. The hospital had no explanation, no apology, no condolences, and no help in dealing with the loss.

Mike did not need to die. In an age of medical miracles, he was not even given a chance to fight what was happening to him. He was quieted with a drug and left alone to die. My parents have talked to a lawyer; why do we need to do this just to get answers? Why can't we just be told the truth?

More than 200 people came to Mike's funeral. Many lives were affected and changed forever in a small community now distrustful of its hospital. After the funeral, I rode with my friend Pat on Mike's Harley back to the church. We sped

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NPSF National Consensus Process Guides Joint Initiatives

A key objective of the National Patient Safety Foundation is to bring key stakeholders together to develop a collaborative action agenda on key issues such as the safe use of pharmaceuticals.

NPSF has found the CogniScope™ process and instrument—developed by Alexander Christakis, PhD and CWA Ltd.—to be an excellent tool in developing cross-functional teams and groups to resolve complex problems by helping them process information. CogniScope is based on 20 years of experience and more than 200 applications, including pharmaceutical discovery and development approaches and revisions to the FDA drug review process (Center for Drug Evaluation and Review), and many business applications.

The four major steps in this systematic process are:

- 1. Input.** The process begins with a literature search and survey of content experts and key thought leaders.
- 2. Analysis.** This step identifies the problem and develops a trigger question. Participants prepare a white paper to pose the pivotal question aimed at catalyzing action from stakeholders; the paper also presents and analyzes the common understandings and viewpoints gathered from interviews and a literature search.
- 3. Stakeholder Workshop.** A two- or three-day workshop is a highly structured, disciplined inquiry system that: (a) allows every voice to be heard equally; and (b) produces a collaborative action plan identifying the most highly leveraged actions to produce the desired outcome.
- 4. Follow-up Delphi Survey.** This step refines the plan and identifies the level of stakeholder commitment. Within two weeks after the workshop, the participants are surveyed to fine-tune the plan and identify resources, as well as to clarify the strength of their commitment to the collaborative action plan.

The four-step process takes four to five months to complete.

For more information on the Patient Safety Consensus Process, please contact:

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Pharmaceutical Initiative Addresses Safe Drug Use

The NPSF has organized a Pharmaceutical Safe Use Initiative to develop consensus on stakeholders' accountability and responsibility for pharmaceutical safety and design. In June 1999, NPSF convened a stakeholder workshop including patient advocates, pharmacists, nurses, physicians, members of the media, pharmaceutical industry representatives, pharmaceutical safety researchers, and Food and Drug Administration (FDA) officials.

In the two-day workshop, the stakeholders defined the challenges to improving pharmaceutical safety, examined how these challenges related to each other, identified means to address them, and developed a strategic action plan. The participants created a national steering committee to facilitate, monitor and report on the action plan's implementation. Two major projects have been completed; others are in various stages of development.

NPSF and the FDA co-sponsored a workshop on March 27-28, 2000 in Bethesda, Md. The workshop, *Safe Medical Treatments: Everyone Has a Role*, was designed as the first step in informing consumer and patient groups about pharmaceutical safety and getting their feedback. The group drafted a manuscript, *Promoting Safe Pharmaceutical Use: A National Public Health Priority*, and submitted it to a peer-reviewed medical journal for publication. When published, the article will communicate the workshop's findings to the medical community.

NPSF Announces Joint Initiative on End-Stage Renal Disease Patient Safety

In June 2000, NPSF, the Renal Physicians Association (RPA) and the Forum of ESRD Networks (Forum) announced a new End-Stage Renal Disease (ESRD) Patient Safety Initiative. This initiative is focused on reducing health care errors and measurably improving patient safety.

The NPSF, RPA and Forum will identify and address the key issues affecting patient safety in ESRD care. Louis Diamond, MB, ChB, Chair of the NPSF Applications and Learning Program, NPSF Board Member, and RPA and Forum Past-President, said, "The NPSF has developed a solid methodology for improving patient safety among specific communities of health care specialists. We're certain that by using such a learning model, we can really make a difference." The NPSF plans to launch similar work with emergency physicians and ophthalmologists in the near future. **NPSF**

Leaders Discuss Their Role in Patient Safety

Nearly 150 stakeholders in patient safety—from physicians, health care professionals and CEOs of health care systems to medical device manufacturers, trial attorneys, consumers and policy makers—convened May 7-9, 2000 at the Wyndham Drake Oakbrook Hotel in Oakbrook, Illinois. The mission: to produce an action plan addressing the recommendations of the Institute of Medicine (IOM) and the Quality Interagency Coordination Task Force for building a safer health care system.

“We have to face the inevitable: humans make mistakes,” said NPSF Board Chair Henri R. Manasse, PhD, of the American Society of Health System Pharmacists. “We need to work together to create better medical equipment and devices, design better systems for error prevention, early detection and mitigation—and consider the human factors.”

Manasse said the NPSF's diverse partnership has been crucial in elevating patient safety to national importance and in producing significant achievements in understanding and reducing errors in our health care institutions. “The NPSF was designed with the belief that all stakeholders in health care—including patients—must participate and collaborate to bring about improvements and new thinking in patient safety,” he said.

Leadership Subteam Tackles Issues

Participants broke into several subgroups to address specific patient safety issues. The leadership subteam, a heterogeneous group of 41 led by NPSF Board Member Jim Conway, COO of Boston's Dana-Farber Cancer Institute, and facilitated by Robert Hill, agreed that leaders need to take ownership of patient safety issues rather than passing the buck.

There were a few CEOs in the group, but many who received invitations had apparently passed them along to their quality-control people—a too-common symptom of some CEOs' thinking that patient safety isn't their direct responsibility. Echoing the sentiments of the Annenberg Conferences, participants said leadership's role is to be vigilant around safety: visible, verbal and valid.

The group agreed that health care leaders need to model the way and mobilize the effort toward improving patient safety. Support from the very top is needed to drive out the culture of fear, blame and shame. Leaders need to establish an open, non-punitive environment where people feel free to come forward to talk about accidents and

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near-hits. Another job of leadership: make a business case for safety, prioritize the issues and move beyond crisis management to a centralized approach to patient safety.

Top leadership needs to show an absolute commitment to patient safety, and continually raise the bar through safety standards, processes and communication. Leaders should make patient safety an ongoing effort. Continual monitoring and a centralized approach will help weave patient safety into the fabric of health care organizations.

Patient safety needs to be a key component of training—as well as continuing education—for everyone from physicians to nurses to pharmacists and administrative staff. Leaders can also advance patient safety by planning more effectively, including adequate staffing for patients' needs.

How can success be measured?

- A dramatic increase in event reporting.
- Making safety a part of all management decisions.
- Board and organizational understanding of the importance of patient safety.
- Proactive identification of danger through risk-assessment approaches.
- Clarifying the system-based patient safety model and the individual's role in it.
- Leaders serving as active liaisons with professional boards.
- Consumers being seen as partners in care.
- Consumers seeing the health care system as safer.

Much data and resources are needed to achieve these objectives, including: model curricula; standard definitions and taxonomy; best practices and process maps; standardized formats for sharing data; consumer education materials; and having a safety content expert or point person.

NPSF

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The opinions expressed in this publication are not necessarily those of the National Patient Safety Foundation or of its board of directors.

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down the highway, the warm autumn air blowing my hair back; I imagined my two brothers riding side by side, warring angels for God's purpose.

I believe my brother Mike is OK, all right and happy, but my life as I knew it is gone. I ask Mike every day to show me what to do. He tells me in my heart that he would not want this to continue happening to others. It was Mike who showed me the National Patient Safety Foundation and gave me the courage to ask to attend the Wisconsin forum.

I kept wondering, what qualifications do I have compared to the doctors, nurses, pharmacists, lawyers, and insurance representatives? I found that mine is the most important qualification: my brother died of a medical error. My love for him leads me in my drive, not to seek vengeance, but to bring meaning to his death and forgiveness in our hearts so we can prevent this from happening to others. It is difficult when no one will face us whom we can forgive.

The medical community needs to take ownership of its mistakes with the people who place their lives in its care. Medical professionals need to embrace the cultural shift their system needs to increase patient safety. Consumers must become active partners working with the medical community to ensure quality care.

Mike died of a medical error. We ask the medical professionals in the system who were caring for him to be accountable, honest, compassionate and to do the right thing. Talk to us. We may never have an answer, but I want to bring some meaning to my brother's death so we can prevent this question from continuing to devastate lives.

I believe in my heart that no one deliberately let my brother die. The system in which these people work failed them and us. These errors have been driven underground for too long; it is time to bring them to light so they can be eliminated.

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