

# focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION

## 'Let's Talk: Communicating Risk and Safety in Health Care' Draws 600 to St. Paul, Minn.

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More than 600 professionals—from physicians, nurses and health care administrators, to risk managers, attorneys, government policy makers and patient advocates—gathered from May 16 to 18 in St. Paul, Minn. for the third in the Annenberg series of conferences on patient safety. "Let's Talk: Communicating Risk and Safety in Health Care" focused on the role of communication in creating a blame-free health care culture that's accountable for patient care.

Here are just a few highlights of the three-day event. For more coverage of all conference speakers—or to order audiotapes and a conference syllabus, visit [www.mederrors.org](http://www.mederrors.org).

### Communicating in the midst of complexity

NPSF Board Member Richard I. Cook, MD, of the University of Chicago stressed that communication is often cited as a contributing cause of medical accidents. "There is a tendency to be very narrowly focused on communication," he explained. "There is actually a dense web of communications among nurses, residents, pharmacists, surgeons and other members of the health care team." Cook pointed out how communications can break down when there is a difference between the speaker's intention and the listener's interpretation.

### Communication: It's more than just talking

In a thought-provoking interactive session, presenters used option-finder machines to poll the audience on their judgment calls regarding disclosure in some health care case studies. Gerald B. Hickson, MD and James W. Pichert, PhD, of Vanderbilt University Medical Center led the audience through the pros and cons of sharing difficult information.

"Why do people file suit?" Hickson asked. "The single greatest error in health care is the failure of communication." He cited a study showing that 32 percent of patients' families who sue their doctors do so because they were advised to by someone influential, such as an attorney; 24 percent sue because they believe there was a cover-up; and another 20 percent sue because they feel they need more information. "Money is important, but families have to be motivated by something more," said Hickson.

Hickson and Pichert posed a series of actual situations and polled the audience to see how they would respond. Conference attendees overwhelmingly chose to handle patient situations by providing full disclosure to their families based on the information available to them at the time. And in a question in which a surviving family member asked who was responsible for his mother's death, 78 percent of the audience chose to say, "Anyone on the health care team might have saved her; we all bear the burden."

### 'Why do people file suit?'

The single greatest error in health care is the failure of communication.'

*Gerald B. Hickson, MD*

Vanderbilt Univ. Medical Center

### Making the best use of your most valuable resource

Mark R. Rosekind, PhD, President and Chief Scientist of Alertness Solutions, spoke about the role of fatigue in patient safety. The cost of fatigue is high. Studies using a virtual-reality surgery simulator compared the performance of surgeons who had gotten sufficient sleep vs. no sleep. The sleep-deprived surgeons made 20 percent more errors and performed 14 percent slower than those who had gotten enough sleep.

What's the solution? "Regulations are not sufficient," he said. Rosekind recommended an alertness management program incorporating education, strategies, scheduling and healthy sleep. But he recognized that history and economics are formidable barriers to change. "Success requires a cultural change that supports different attitudes and behavior," he explained. "If you don't deal with this issue, someone—presumably a regulator—will do it for you."

*For more detailed coverage of the Annenberg III conference, visit [www.mederrors.org](http://www.mederrors.org). Audiotapes of all sessions as well as the conference syllabus are also available.*

*The AMA video, "Health Illiteracy: You Can't Tell by Looking"—along with support materials—is available for \$25. Contact Joanne Schwartzberg, MD, at (312) 464-5355.*

### Lessons learned from aviation

The first day of the conference concluded with a performance of *Charlie Victor Romeo*, a dramatic work for the stage derived entirely from the "black box" cockpit voice recorder transcripts of six major airline emergencies. ABC News Aviation Analyst, author and NPSF Board Member John Nance, JD, introduced the theatrical documentary where the audience becomes observers to the tension-filled cockpit of real in-flight emergencies. Nance noted that pilots' relying too much on instrumentation in a crisis—even in situations where the instruments were clearly faulty—parallels over-reliance on diagnostics in health care.

### Health illiteracy: A patient safety problem

Joanne Schwartzberg, MD, of the AMA spoke about health illiteracy—the inability to read, understand and act on health care information. According to the 1992 National Adult Literacy Survey, 21 percent of Americans cannot read the front page of a newspaper; 48 percent (90 million people) cannot decipher messages with words and numbers, such as a bus schedule.

This translates into a major patient safety issue. If nearly 50 percent of patients can't understand messages with words and numbers, they can't interpret the instructions on prescription bottles, appointment slips, informed consent forms, discharge instructions or health education materials.

Schwartzberg showed the audience an emotionally charged video produced by the AMA featuring interviews with actual patients who described how their lack of reading skills greatly limits their understanding of written instructions from their doctors. Several patients also admitted the frustration and embarrassment they feel when they don't understand their physicians' verbal instructions.

"Low health literacy is a prescription for medication error," Schwartzberg warned. She encouraged health care providers to create a shame-free environment, use simple and direct language, and ask patients to repeat instructions in their own words to be sure they understand.

### An intercultural perspective on health care communication

Nagesh Rao, PhD, assistant professor at the School of Interpersonal Communication, Ohio University, explained that even when a physician and patient are from the same culture, they may view ill health in very different ways.

"In many cases, doctors take a scientific approach and focus on a person's disease, while the patient tends to focus on the subjective response to the disease," he explained. "This creates a need to analyze the physician-patient interaction as an intercultural encounter where two different world views meet."

### 'We made a mistake'

Daniel O'Connell, PhD, a consultant for the Bayer Institute for Health Care Communication, led a session on discussing medical errors—an excruciatingly difficult task for most health care providers.

"Revealing errors poses several dilemmas," he explained.

"While there is the protective power of acknowledging an error and apologizing, there is an increased possibility that patients and families—and the medical and legal worlds—will learn about errors that would otherwise go unnoticed. Humans rarely think it is smart to do what could really hurt them."

Steve S. Kraman, MD and Ginny M. Hamm, JD, of the Lexington, Ky. VA Medical Center discussed their organization's successful approach to patient disclosure. "What attracts investigative reporters and malpractice attorneys?" he asked. "Lies, cover-ups and secrets. We would rather see the facts about our cases accurately portrayed than speculated about."

Hamm cited the case of Mr. Holbrook, a long-term patient with a severe clotting disorder who died due to a medical error. Mr. Holbrook's daughter, Sandy Reynolds also shared her story with the audience. "Three weeks after Dad died, the VA called and they sent the nurse and Ginny Hamm to see me," she recalled. "Ginny told me, 'Sandy, you were right. We killed your dad.' I had not shed one tear from the day he died until that day," said Reynolds. "When she said that, it was like something was taken off of me. It makes such a difference when someone says, 'I'm sorry.'"

"I hope just one person who leaves this conference understands that it's not about money," said Reynolds. "It's about being able to heal, to be rid of the anger that eats at you like a cancer." The audience responded with a standing ovation.

### Mediation: De-escalating disputes at the lowest possible level

Leonard J. Marcus, PhD, of the Program for Health Care Negotiation and Conflict Resolution, introduced mediation as a way of resolving disputes at the lowest possible level. "Mediation is a face-to-face meeting, a voluntary process," he explained. "The mediator serves as a neutral, impartial guide, and the process is confidential and legally protected. With the mediator's help, the disputants craft and accept or reject a settlement which reflects their interests."

Why mediate? "Following an incident, patients and families want an understanding of what happened, an acknowledgement or apology, and corrective action," Marcus explained. "Money becomes less a form of revenge and more a matter of reimbursement. The process allows parties to derive meaning from the incident." **NPSF**

## From Annenberg III

# Patient Safety: Lessons from a Novice

BY DONALD M. BERWICK, MD, MPP

Conversations between health care providers and patients are always grounded in a context of knowledge and understanding—what we know and what we *think* we know. In the field of safety, I continue to regard myself as a novice. This is not false humility; it's a true confession. I came relatively new to this field of safety four years ago.

I'm still in an awkward state of personal development as I continue to discover that things I thought to be true simply are not. And things that I learned and then thought to be true aren't true either. This continuing evolution in my own understanding has affected the way I talk about safety. Here is a series of lessons that have caused me to change the way I think about safety.

### Lesson 1—I thought: The problem is errors.

#### I learned: The problem is harm.

If we believe our battle is against errors, we will lose. The problem is harm. Errors are inevitable; they will always be there. To some extent, what we call an error is an adaptive behavior in another context. Using the word "error" focuses our energies on changing people—virtually a bankrupt idea. There's also enormous toxicity in hindsight bias. Once the injury has happened, it takes no intelligence whatsoever to find what went wrong. I would like to see the vocabulary of patient safety focus more on the question, "How can we keep patients from being hurt in our hands?" and less on "How can we keep errors from happening?"

### Lesson 2—I thought: Rules create safety.

#### I learned: Rules and breaking the rules create safety.

Safety is a continually emerging property of a complex system—it's more like driving a car than baking a cake. People figure out the details if you let them. Breaking the rules is the adaptive response of an intelligent workforce involved at the sharp end of health care. In the violation of the rules is the next level of information about what to do to make a person safe. Rules should be more like instructions for driving a car—allowing the driver to adapt to current circumstances—than a point-by-point recipe for baking a cake. The people at the sharp end will figure things out if given guidance, but they will be guided wrong if the rules are over-enforced. Overspecification is a problem in safety.

### Lesson 3—I thought: Reporting is necessary to track problems and progress.

#### I learned: Stories are necessary to gain knowledge.

We're hooked on reporting now. Reporting for measurement contains almost no information. What we need are *stories*. Reporting that loses the story is mostly a waste. We need to harvest the knowledge. We need firesides, not spreadsheets. The question "How many?" isn't powerful. The question should be "What happened?"

### Lesson 4—I thought: Technology is the mainstay of safety.

#### I learned: Conversation is the mainstay of safety.

Every technology—even those for improving safety—has hazards. The world of technology has to be a world with dikes around it, or it will hurt us. Building technology for safety is crucial, but it must be supported by conversation—a human mechanism for getting control back. Technology without collective mindfulness will make things worse, not better. Safety requires the continual exploration of meaning.

### Lesson 5—I thought: Health care is mostly the same as other high-hazard industries. I learned: Health care differs a lot from other high-hazard industries.

There is so much to learn from other industries. But there are crucial, important differences between health care and other fields. The simple-minded adoption of safety practices from other industries is problematic because the range of risk levels in health care is extremely wide. No single answer can possibly do. It's important to know which level you're working on. The sharp end in health care is very local—and there's a tradition of secrecy in medicine. And we have to accept that we all die. If we regard death as the enemy, we've forgotten that our job is to *postpone* death. Other industries need not accept death as the outcome. We do. We also need to change the dynamics by making the public more comfortable with the stages of life approaching death.

### Lesson 6—I thought: What's important happens before the injury. I learned: What happens after the injury is equally important.

Part of our safety culture has got to focus on the healing side. We have to heal both people who are hurt—the injured person and the person who caused the injury. We need to get some energy back on the healing side of the table. The most important barrier may be skills—especially the ability to apologize. Some doctors are unwilling or unable to say how sorry they are. Apology begins the process of re-affiliation with the patient. **NPSF**

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## From Annenberg III

# Harnessing the Healing Power of Stories

BY DANIEL W. TAYLOR, PhD

A patient is more than a bundle of symptoms. And a medical person is more than a repository of skills. Both are characters living in stories, and they bring these stories to the medical relationship. Understanding that relationship as an intersection of stories has significant implications for the healing process.

All of us were born into a family of stories; we were further shaped by stories from school, places of worship and popular culture. Our stories help us answer the big questions in life. Whenever we have an important question—"Why am I here?" "Where did I come from?" "What happens after I die?"—we usually construct a story to help us answer it.

No one knows you unless they know your story. They may know your job, your title or your specialty—but if they don't know your story, they don't really know who you are. And so they aren't sure how to relate to you. They don't know what you love and hate, what motivates you. This lack of familiarity creates a greater chance that people will make some kind of mistake in relating to you. Or they may choose to avoid any mistakes by relating to you objectively, neutrally. And you will do the same to them. This also describes the medical relationship—but with the potential for much greater consequences.

Patients bring a story with them when they come to the hospital, clinic or doctor's office. Stories answer very important questions, such as "What happens to me when I go to the hospital?" For many people, the answer is, "You die." For others, the answer is, "They give you pain," or "They treat you like a body part—the gallbladder in room 206."

To *treat* patients as human beings—in both senses of the word—you need to know their story. The alternative is to treat them as objects. The medical relationship consists of an intersection of stories of the patient and the medical professional. The more we understand this and can shape our caregiving around it, the better healers we will be—and the less likely we will be to make medical errors that compromise the patient's safety. There is a direct correlation between seeing people as storied creatures and how we treat them, and medical error and safety.

Stories are never objective. Objectivity is often accepted uncritically in medicine as the friend of diagnosis and prescription, but objectivity can be the enemy of healing. You show you care for a person by caring enough to learn

their story. Care systems must grow out of, and reinforce, our humanity. Systems should be designed to meet the needs of staff and patients, rather than humans being sacrificed to meet the needs of the system. If the system tends to dehumanize the staff, the staff will tend to dehumanize the patient.

Some of the failures in medicine are the result of a failure to understand the storied nature of relationships. Being part of the story of medicine gives you something beyond price—the possibility that your life will be filled with meaning. This sense of meaning does not flow from titles or salaries or expertise. Meaning flows from relationships, and relationships get us into the realm of story.

I recently published a book with Dr. Ronald Hoekstra, a neonatologist at Minneapolis Children's Hospital. *Before Their Time: Lessons in Living from Those Born Too Soon*, tells the story of six premature newborns. One of those babies, named Lamarre, was born 18 weeks early. He weighed 20 ounces, and at 11-1/2 inches, he was shorter than a ruler. Lamarre was the first child of Jewel and Anthony. He made no sound when he was born, much to his mother's surprise. His lungs were not developed enough to make a sound.

Lamarre was immediately taken from the delivery room; his parents didn't see him for hours. The first time they saw Lamarre again was that evening when they were sitting in Jewel's hospital room. A nurse came in with a wheelchair and said, "You must come to the neonatal intensive care unit very quickly." There was obviously a crisis.

What they found when they got to the neonatal ICU was a furious symphony of care conducted by a doctor they had not seen before. Five nurses and two or three doctors hovered over the enclosed clear plastic incubator called an isolette. Bright lights illuminated it in the otherwise darkened room like an overnight construction zone. Lamarre had been brown and red when he was born; now he was totally white. His lungs were hemorrhaging. Buzzers were going off on the machines whose lines fed into the isolette. The nurses were handing things around; Dr. Hoekstra had his hands in the isolette through portholes in the side. He was examining Lamarre and looking above the baby's head at the monitors of the machines to which Lamarre was attached. And he was clearly frustrated. "Where is it? I need it now! Jewel and Anthony were spectators at this attempt to

rescue the life of their son. They were there to be witnesses, not participants. But that's not their style. They are people who act, not watch. At this point for Jewel, acting was praying, and for Anthony, it was talking to Lamarre. "A spirit came over me and said, 'You need to get down there and talk to your son; you can't just stand here and watch him die,'" Anthony recalls. "So I got down next to the isolette and I opened this little hole in the corner near his head and I started speaking to him. I said, 'Lamarre, you're not going anywhere. You've made it this far; you're going to make it. Just keep hanging on.' I was just speaking positive things into that isolette. I was speaking to my son."

Meanwhile, Dr. Hoekstra again said, "I need it now! Why isn't it here?" Whatever he was asking for finally arrived and he administered it to Lamarre. He kept working the dials on the respirator, calling out orders to the nurses, who responded instantly and precisely. It was a dance with death—or a dance against death. Everything seemed choreographed, but no one knew the final pass. For 10 to 15 minutes the doctor worked the machines like a pipe organ. He was focused intensely, directing all his mind and energy to the saving of one life for at least one more hour, one more night, perhaps for a lifetime.

Finally Dr. Hoekstra stood up straight and removed his hands from the isolette. "All right, he's stabilized." The color began to flow back into Lamarre like a spring rain into parched ground. Jewel was given a new room near the ICU; she and Anthony went to sleep. At 2:00 a.m., it all happened again. The entire scene was repeated. This would be the nature of their lives.

Lamarre's doctors—among the best in the world—wanted his parents to be realistic about his condition. Jewel and Anthony wanted to be realistic as well. The problem was they had a different definition and understanding of realism—a different story. Jewel and Anthony not only believe in miracles, but get up most mornings expecting one or two before breakfast. They live in a world in which what we see is only a small part of what actually is. For them, reality is primarily spiritual, not material. It is a battleground for souls, a contest between transcendent forces in which we are both participants and prize.

On that Saturday night, Dr. Hoekstra told them he would not be on duty for the next few days. His partner, Dr.

Vicksburg, would be following Lamarre's progress and doing a number of tests. Jewel and Anthony are not big fans of tests—especially when tests are seen as determiners of reality. They first saw Dr. Vicksburg on Sunday morning after Jewel had been discharged from the hospital. When they came into the ICU, Dr. Vicksburg had just finished examining Lamarre. After a brief introduction, she said, "I have x-rays, and it doesn't look very good at all. We have to talk."

Parent-doctor conferences are a fact of life in the rhythm of the ICU. The first one for Jewel and Anthony was going to set the tone for many to come. When they got into the conference room, Dr. Vicksburg began to recite a long list of problems. This led her to open a topic every doctor wishes were never necessary: "I think you should consider making a decision about what you want to do." She told them it was quite likely that Lamarre would not survive; perhaps the humane thing for their son would be to turn off the respirator and allow him to die in his mother's arms.

Jewel saw Lamarre and his situation not through the eyes of science and medical tests, but through the eyes of faith. "I told her about my belief and my faith in God. If a decision was going to be made, the Lord was going to make it," Jewel recalls. When it was suggested to Jewel that further treatment of Lamarre was futile and perhaps not in his best interest, she told Dr. Vicksburg, "As long as Lamarre will receive what you have to give him, you give it to him. And when he doesn't receive it, we'll know what to do."

Doctors and parents both want what is best for the newborn, but sometimes they pull in different directions. Sometimes it feels like war. "I saw us as advocates for Lamarre and her as an advocate for medical science," says Jewel. "She wanted to show us x-rays, but I didn't want to see all that. I wanted to speak for life, not for death."

The same objective facts can produce very different stories. For Anthony and Jewel, it was not a matter of whether Dr. Vicksburg was an excellent doctor; it was a collision of values, of ways of understanding what is real. They told Dr. Vicksburg they considered Lamarre's condition a spiritual matter. "We said, 'We're going to expect a miracle,' and Dr. Vicksburg said, 'Well, you're going to have to expect a great many of them.'" In Jewel and Anthony's eyes, a great many miracles did happen in the two years before Lamarre succumbed to a brain hemorrhage. Every day, every moment with their son was in itself a miracle, a gift from God. **NPSF**

*Daniel W. Taylor, PhD, is a professor of literature at Bethel College in St. Paul, Minn. His books include Tell Me a Story: The Life-Shaping Power of Stories (Bog Walk Press, 2000: ISBN 0970651104) and Before Their Time: Lessons in Living from Those Born Too Soon (InterVarsity Press, 2001: ISBN 0830822658), a book about premature infants.*

*Both books are available from Amazon.com, or by contacting the author at [d-taylor@bethel.edu](mailto:d-taylor@bethel.edu).*

*Taylor is co-founder of The Legacy Center, an organization dedicated to preserving and passing on life stories.*

# A Grieving Mother's Search for Answers Leads to Patient Advocacy

BY ILENE CORINA

The more I think about how society rules the way we think and act, the angrier I get. I could never admit I have no real anger at the doctor who performed the surgery on my firstborn child in 1990. I couldn't tell my friends or family that although he made a terrible mistake and my three-year-old son paid the ultimate price, it is not the thought of the surgeon who actually performed the tonsillectomy that makes my fists tighten.

The surgeon was a "nice" guy. That's why I chose him to do the surgery after my son endured two years of ear infections and high fevers. I continually took him to doctors and they always said his tonsils were so big, they must be removed. He needed tubes in his ears and his adenoids needed to be removed, too; it should all be done together. It was such common surgery—why would I even give it a second thought? My son would be able to eat ice cream and snuggle on my lap for hours. I would miss work and feel no guilt when we slept in the same bed during his recuperation. All the family would spoil him with presents and special milkshakes and ice pops. It's a memory we all have as adults—the endless ice cream.

I took Michael to three different physicians; they all gave the same diagnosis. I felt silly asking for more opinions for a simple tonsillectomy. It was, after all, one of the more common surgical procedures. How would I choose a doctor? The nicest? The youngest? The one who spoke fluent English and answered all my questions? The one who had a daughter my son's age and knew the fear I felt of being separated from my son for even the two hours of surgery? Yes, that is how I chose a doctor.

Michael was cleared for surgery and we prepared for every detail. He had the surgery on a Tuesday. We begged to go home that night; Michael was drinking and looking very good aside from the dried blood on his mouth and ears.

We were released that evening with instructions from the surgeon to call him with any questions or concerns. What a nice man he turned out to be. In the days that followed, we returned to two different hospital emergency rooms and the surgeons—as well as Michael's pediatrician—to report that there was blood on his teeth. On one occasion, the surgeon cauterized the area; another time Michael vomited so much blood that I was covered in it. Still, the

emergency physician sent us to call the surgeon, who couldn't be reached. I was instructed by the HMO to see Michael's pediatrician. She informed us that I was worrying over nothing and that Michael was fine.

After being made to feel like an irrational mother, I was forced back to an emergency room on a Sunday afternoon. Michael was swollen and covered in open sores. I informed this emergency physician of the last days' bleeding episodes; he sent us home with a salve for the open sores.

When we finally returned to the surgeon for a one-week follow-up visit, he informed me he had received no messages of any of our week's activities. After examining my son, the surgeon sent us home, advising that Michael stay off solids for one more day. Considering all that had happened, he wanted to be sure there would be no more episodes.

Mikey, as we lovingly called him, the bright and carefree toddler, would never get back to solid foods. He died the next day, eight days after surgery.

I planned a beautiful funeral, with roses for everyone who attended. We had a closed casket so family and friends would remember only the vivacious child Michael was. His face looked distorted because we had his eyes donated; they were the only parts of him that could be used. The hospital staff tried so desperately to save him that none of his organs were salvageable.

I stayed in contact with Michael's surgeon; he called a couple of times and spoke to my mother, telling her he didn't know what went wrong. He told me he was sorry and didn't know what happened. We discussed the possibilities and I told him I was waiting for the autopsy report. He offered to help me understand it. When the report arrived, we spoke one more time. I told him it said my son died from the tonsillectomy. He never called again.

Both my son and I had a relationship with this doctor. I liked him and felt he was "good." I thought he may be sad, angry and disappointed with what happened. I would never know that.

Soon I was hunted down by lawyers. They would wait in line at my job and ask to see me. I would get calls at

home at all hours of the day and night. I always refused to speak to them, yet it soon became apparent that without a lawyer, I may never know what really happened to my child. What did I have to lose?

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## **‘Finally, a friend found a sympathetic lawyer who would look at my case. His nurse explained that Michael died from blood poisoning. I would never had known this without the lawyer.’**

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No lawyer would take my case. My son was only three years old; he had no financial value. Although my family and friends would try to get me to consider using one of the lawyers who contacted me, I never would. Michael's death was private and sensitive, and I wanted someone with compassion.

Finally, a friend found a sympathetic lawyer who would look at my case. His nurse explained that Michael died from blood poisoning. My son was swallowing his blood and it was found in his stomach. I would never had known this without the lawyer. That is what Michael's open sores were; the swelling, the small amounts of blood I saw were really huge amounts dripping down his throat. If anyone, at any time, took his vital signs or did blood work, they would have caught this. No one did.

The lawsuit was not something I wanted to pursue, but to get these crucial answers for me, the lawyer needed payment. I couldn't pay him, and the small amount we settled on was enough to give me books and books of depositions with all the answers I needed.

Soon I was forced back in search of medical care when I became pregnant after numerous miscarriages and at the start of adoption proceedings. I searched for doctors with

“good” backgrounds. I needed a doctor I could trust—a physician who would respond to my need for emotional and physical attention. There was no place to go. I felt at the mercy of the health care system and I became an angry advocate, assuming all physicians had a right to do wrong, make mistakes and go into hiding. I actually felt sorry for my own health care providers.

I endured a terrible pregnancy. The young physician who stepped in over Mother's Day weekend was a doctor whom I refused treatment from weeks earlier. I thought he was too young and inexperienced, but I soon found that he was the only doctor who gave me choices.

“Do you want this baby?” he would ask me over and over. He explained the deformities the baby would have after going with no fluid for so long. (My water broke and fluid had been leaking for a week before labor began.) This doctor gave me many options of a simple delivery and a quiet death for this baby or years of struggle to save the child.

“If there is a heartbeat,” I told him, “I want this child.” He let me lead the way and he held my hand through a very difficult delivery. The medical professionals gave almost no hope. Even if my son did survive, he would have numerous problems—too many to name. After five months in neonatal intensive care and three years of home nursing, today my son Matthew is a vibrant, perfectly normal third-grader.

Matthew shows no signs of his early struggles. It was only the teamwork, cooperation and passion of a young “inexperienced” physician and a frustrated, distraught, grieving mother that gave life to what some say was just a fetus. This miracle was made possible with the help of a team of doctors who respected a patient's right to be part of the team.

To this day, I have an open relationship with all my children's health care providers and a deep respect for their job and knowledge. They, too, show a respect for my background and where I have been. It is this cooperative effort of education and communication that we teach at PULSE of New York (Persons United Limiting Substandards and Errors in Health Care), a support group I co-founded with Ralph Speken in 1998 for those who have been injured by medical error. [NPSF](#)

*Ilene Corina is Director of PULSE of New York, (Persons United Limiting Substandards and Errors in Health Care), a patient advocacy group based in Wantagh, NY.*

## Save the date!

Focus on Patient Safety (ISSN 1097-0673) is the official quarterly publication of the not-for-profit National Patient Safety Foundation (NPSF), in Chicago, IL. The NPSF represents an unprecedented initiative to improve health care safety by studying why errors in the health care system occur and implementing safeguards to prevent such failures from injuring patients. NPSF Board members represent every major segment of the health care system, as well as employers, medical ethicists, public health advocates and distinguished scientific research institutions.

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

To submit articles or publications for possible review in Focus, please direct materials to: Jay Callahan, PhD, Managing Editor, Focus on Patient Safety, National Patient Safety Foundation, 515 N. State Street, Chicago, Illinois 60610. Materials, inquiries and subscription requests for the publication will be accepted electronically at [npsf@ama-assn.org](mailto:npsf@ama-assn.org) or via fax at 312-464-4154.

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# Plan Now to Attend Partnership Symposium 2001 Oct. 10-12 in Dallas

The National Patient Safety Foundation has joined with VHA, Premier, and P4PS to sponsor "Partnership Symposium 2001," to be held Oct. 10-12 at the Fairmont Dallas. Mark your calendar and plan now to attend this dynamic meeting.

The conference will present patient safety success stories submitted by front-line clinicians, and offer a forum for exchanging information on patient safety solutions, strategies, and innovations. Attendees will sharpen their skills in addressing adverse drug events, medication errors, and other critical areas that impede quality health care delivery.

Sessions will show what it takes to become accountable to patients and the public for avoidable patient harm; promote a non-punitive environment; and create a culture of safety in health care organizations.

Patient Safety Theater will present an innovative drama bringing the theoretical to life. Actors will perform a series of case-based patient safety scenarios: a health care CEO learning of a catastrophic adverse event; the health care organization facing an angry and devastated family; the organization working with traumatized staff; and the health care organization publicly responding to many external demands for accountability.

The conference begins the evening of Wednesday, Oct. 10, and concludes at noon on Friday, Oct. 12.

Registration information will soon be available online at [www.p4ps.org](http://www.p4ps.org) or by calling (312) 543-5532. This partnership replaces NPSF's "Solutions" initiative for 2001. [NPSF](#)

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