After being inundated with patient safety information over the past four years, you might not think of picking up a book on the subject.

But *Internal Bleeding* (Rugged Land, 2004), a new book by two doctors, carries you along. You find yourself turning the pages as you read about Joan Morris, who, while waiting to go home after a treatment for a brain aneurysm, ends up having an electrophysiology procedure because she is confused with another patient, Jane Morrison. You feel your stomach tighten as you read about Duke’s renowned pediatric transplant surgeon, James Jaggers, MD, receiving the news in the OR that he has just given Jesica Santillan new organs that didn’t match her blood type. And you read about a patient who is resuscitated despite a DNR order—only for the code team to find out after they stop the code that they have been working on a different patient, who actually is on full code status. The code is resumed, but the patient dies.

The stories are compelling, heartbreaking, and make you realize once again why patient safety deserves so much attention. The book has won favorable reviews from the *New York Times* and the *San Francisco Chronicle*, among others.

*OR Manager* interviewed Kaveh Shojania, MD, who wrote the book with Robert M. Wachter, MD. Both are at the University of California, San Francisco.

**Why did you get interested in patient safety?**

Dr Shojania: It was a combination of personal experience and general research interests.

I actually was involved in a very serious error that we talked about at the beginning of the book that affected me tremendously. I even considered dropping out of medicine.

[The case took place in the emergency department while Dr Shojania was a beginning resident. He sent a 29-year-old man with chest pain home after a review by the attending physician only to learn the patient was readmitted later with a massive heart attack.]

That was filed away at the back of my mind when the Institute of Medicine report, *To Err is Human*, came out in 1999. It seemed like this was a natural thing for a general physician or internist to do research on because it requires broad clinical interests and familiarity instead of focusing just on a specific disease.

**OR managers and directors have heard a lot about medical errors and patient safety in the past few years. Why do you think they should read your book, and what do you think they would gain?**

Dr Shojania: I think it is easier to explain why a health care worker would read it than a regular person. Usually, when people write for nonclinicians, they feel they have to give an easy answer. What the book tries to do is to show that it is a lot more complicated than that. That often is not a fun message to hear.

I think for an OR manager, this is really important stuff. It is also complicated.

You can say, “sign the site,” to take an obvious type of error that affects OR managers—avoiding wrong-site surgery. But if all you have done is to introduce a protocol that requires physicians and patients to sign the site—if everything else about the system stays the same, you have just added a bandage to an already not-very-well-run system.

That’s the message from a lot of other industries. With Three Mile Island, for
example, the actual error that gave rise to the accident was related to a safety protocol they had put in place. Whenever you take a complicated system and add apparently straightforward fixes, you often make the system no better and sometimes worse.

That is an important message for people within health care to hear—it’s not as simple as saying, “Write neater,” or “Pay more attention,” or “Ask the patient their name.” Of course, those things are helpful, but we can’t expect some sort of miracle cure unless we dive in and pay attention to everyone’s different perspective—the surgeons, the nurses, the anesthesiologists, the patients. That is going to take time. It is not an overnight fix.

**Q If you were going to speak to an OR committee today, what would you say are the key things they could do to make surgery safer?**

**Dr Shojania:** There are certain things like standardization, which your readers know more about than I do. There are variations in the way surgeons do things, but you have to balance allowing them a certain zone with the fact that unnecessary variation produces quality and safety problems.

Every time the tray is set up a little differently or, say, they like to give their own local anesthetic in the incision before final closure—all of these can give rise to errors.

Just like in internal medicine, people have their own idiosyncratic way of doing things. If your way of doing things is not clearly based on evidence and is not the same as the way other people are doing things, there are bound to be problems at some point.

So standardization is a theme in patient safety. That is why hospitals are trying to make sure all wards have the same type of programmable IV pump and the same kind of defibrillator—so people don’t have to learn to do things five different ways.

I think the same applies in the OR. A given hospital should decide, “This is how we do this procedure. These are the appropriate things to have on hand and what to expect.”

The other general lesson is not to try to do too many things at once in improving safety. A lot of times people get the idea that here are the five or 10 things JCAHO is talking about, and we are going to try to fix all of them. What ends up happening is you don’t do a really good job at any of them. But if you sink your teeth into one area, maybe wrong-site surgery, postoperative infections, or something that came out of a recent event, you may have more success.

It is better to pick one or two things and succeed at them than to pick five or 10 things and not succeed at any of them.

**Q Toward the end of the book, you say this whole fight against medical errors is kind of like the aftermath of the war in Iraq—it seems like it’s going to go on and on.**

**Dr Shojania:** This is a problem we will always have with us—it is not going to suddenly be won one day. We’ve had errors for thousands of years—that’s why the Hippocratic oath says, “First do no harm.” They realized back then that there are collateral effects to everything we do.

I think the answer to, “Is this a war we are going to win?” is, “I think it depends what you mean by that.” What we want to do is to say there are certain problems right now we really want to reduce, and I think we could succeed in that. It may take five to 10 years to make wrong-site surgery a thing of the past. But for every success, I am sure there will be some new problem. That is true every time we invent a new technology. In surgery, the main example in the 1990s was laparoscopic surgery. It was an incredible advance in technology, yet we found there were learning curves and adverse events as patients, surgeons, and
nurses tried to become more familiar with the new techniques. There is going to be something like that every decade.

So the watchword of safety is “always vigilant.” We can’t ever get complacent and think we have won the war on error, because that is exactly when safety problems start happening again.

Someone wrote an interesting book on the Challenger disaster in the 1980s. In interviewing people a number of years after the event—this was before Columbia—she found some people at NASA were already admitting confidentially that people were going back to the way things were. Initially, there was the shock, and everyone was being so careful, and there were new attitudes, but then sure enough, things went back a little to the way they were before, and there was another disaster. Now that’s not necessarily cause and effect, but I think it is an important lesson for health care—we can’t stop being vigilant. We can’t look at patient safety as a fad or as something that we’ll fix and move on to the next thing. This is always going to be with us, and it is always going to have to be a priority for us.