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CHAPTER 1

Ensuring Patient Safety in Surgery— First Do No Harm

SYMON MESSIOS • KIMON BEKELIS • GEORGETTE BURKE • KADR ERSMEN

Primum non nocere—first do no harm. This oft-quoted phrase epitomizes the imperative for medical communities to avoid iatrogenic complications.¹ In the process of providing care, patients, physicians, and the entire clinical team join to use all available medical weapons to combat disease to avert the natural history of pathologic processes. Iatrogenic injury or simply “treatment-related harm” occurs when this implicit rule to “first do no harm” is violated. Both society and the medical community have historically been intolerant of medical mistakes, associating them with negligence. The fact is that complex medical care is prone to failure. Medical mistakes are much like “blow-by” incidents in which soldiers in the high-stress, complex fog of war mistakenly kill comrades rather than the enemy. Iatrogenic medical error and iatrogenic injury are associated with multiple latent conditions (contaminated, hazardous, unsafe, or obsolete, etc.) that prodigal first-line clinicians in care. This chapter will review the science of human error in medicine and surgery, the specific case of retrosigmoid brain surgery will be used as an illustration for implementation of emerging new strategies for enhancing patient safety.

The Nature of Iatrogenic Injury in Medicine and Surgery

The earliest practitioners of medicine recognized and described iatrogenic injury. Iatrogenic (Greek, *iatros* = doctor, *genic* = arising from or developing from) literally translates to “disease or illness caused by doctors.” Famous examples exist of iatrogenic deaths, such as that of George Washington, who died while being treated for gonorrhea with blood-letting. The Royal Medical and Surgical Society, in 1864, documented 123 deaths that “could be positively assigned to the isolation of chloroform.”² Throughout history, physicians have reviewed unexpected outcomes related to the radical care. They provided to learn and improve that care. The “father” of modern neurosurgery, Harvey Cushing, and his contemporary Sir William Osler modeled the practice of learning from error by publicizing their errors openly so as to warn others on how to avert future occurrences.^{3,4} However, the magnitude of iatrogenic morbidity and mortality was not quantified across the spectrum of health care until the Harvard Practice Study, published in 1987.⁵ This seminal study estimated

that iatrogenic failure occurs in approximately 4% of all hospitalizations and in the eighth leading cause of death in America—responsible for up to 100,000 deaths per year in the United States alone.⁶

A subsequent review of over 14,700 hospitalizations in Colorado and Utah identified 402 surgical adverse events, producing an annual incidence rate of 1.8%.⁷ The nature of surgical adverse events were categorized by type of injury and by preventability (Table 1-1).

These two studies were designed to characterize iatrogenic complications in health care. While not statistically powered to allow surgical subspecialty analysis, it is likely that the types of failures and subsequent injuries that this study identified can be generalized to the nonsurgical patient population. More recent literature supports the finding of these landmark studies.^{8,9}

The Institute of Medicine used the Harvard Practice Study as the basis for its report, which endorsed the need to discuss and study errors openly with the goal of improving patient safety.¹⁰ The Institute of Medicine report on medical errors, “*To Err Is Human: Building a Safer Health System*,” must be considered a landmark publication.¹¹ It was published in 1999 and focused on medical errors and their prevention. This was followed by the development of other quality improvement initiatives such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) Sentinel Events Program.¹²

One might argue that morbidity and mortality reviews already achieve this aim. The “M&M” conference has a long history of reviewing negative outcomes in medicine. The goal of this traditional conference is to learn how to prevent future patients from suffering similar harm, and thus incrementally improve care. However, frank discussion of error is limited in M&M conferences. Also, the actual review practices fell to support deep learning regarding systemic vulnerability.¹³ Indeed, since JHBM conferences do not explicitly require medical errors to be reviewed, errors are rarely addressed. One prospective investigation of four U.S. academic hospitals found that a resident vigilantly attending weekly internal medicine M&M conferences for an entire year would discuss errors only once. The surgical revision of the M&M conference was better with error discussion. However, while surgeons discussed adverse events associated with error 77% of the time, individual provider error was the focus of the discussion and cited

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