

“The Joint Commission first worked with p4ps founders ten years ago in the development of what became the seminal conference on patient safety in the United States. This first Annenberg Conference on patient safety – *Examining Errors in Healthcare* – was held in October 1996. People who attended the event well remember our shared sense of a new reality -- a whole new way of seeing the depth and breadth of risk and what needed to be done to address this risk.

“*First, do no harm,*” a principle derived from the Hippocratic Oath, enjoins doctors and other clinicians to pay the utmost attention to the profound consequences of their actions as healers. Nothing is more fundamental to healthcare than the patients who trust caregivers and institutions with their lives. And yet to truly appreciate the challenge posed by this principle, we in health care must come to terms with just how prone to failure the delivery of care has become and how unprepared we are to deal with it. How can we effectively fulfill our oath when “to err is human” and even the best doctors, nurses and pharmacists inevitably make mistakes? Is error tolerable? Do we expect too much? What should we expect?

Safety science infuses a new perspective on potential solutions to these problems. The core concept is that complex organizations fail as systems. This understanding shifts the emphasis away from whether the doctor, the nurse or the pharmacist are to blame for their errors to more comprehensive knowledge as to how a health care organization operates, delivers care and succeeds or fails as a system whose functioning relies on well intended, but fallible human beings. We are now called upon to apply this new understanding to achieve much higher levels of safety and reliability than we do now.

Our best chance for improvement is to work together as health care professionals, health care executives, patient safety officers, risk managers, safety experts and “policy makers,” among others, to develop strategies that will result in a real systems change. Together we can learn how patient care processes fail and what we can do to rescue patients when things begin to go wrong. Examination of attitudes that prompt the hiding of mistakes instead of learning from them is also an imperative. Health care organization cultures must ultimately be trusted to be just and be supportive of those who work within them. When that happens honesty in talking about and learning from error will become the norm. No job is more important, but our journey – ten years after Annenberg – has still only just begun.

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