Surgical Patient Care

Improving Safety, Quality, and Value

Juan A. Sanchez
Paul Barach
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wsage@law.utexas.edu

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Editors
Juan A. Sanchez
Department of Surgery
Ascension Saint Agnes Hospital
Armstrong Institute for Patient Safety & Quality
Johns Hopkins University School of Medicine
Baltimore, MD, USA

Paul Barach
Clinical Professor
Children's Cardiomyopathy Foundation and Kyle John Rymiszewski Research Scholar
Children's Hospital of Michigan, Wayne State University School of Medicine
Detroit, MI, USA

Julie K. Johnson
Department of Surgery
Center for Healthcare Studies
Institute for Public Health and Medicine
Feinberg School of Medicine
Northwestern University
Chicago, IL, USA

Jeffrey P. Jacobs
Division of Cardiovascular Surgery
Johns Hopkins All Children's Heart Institute
Johns Hopkins All Children's Hospital
Johns Hopkins University
Saint Petersburg, FL, USA

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A Quiet Revolution: Communicating and Resolving Patient Harm

38

William M. Sage, Madelene J. Ottosen, and Ben Coopwood

"Truth never damages a cause that is just."

—Mahatma Gandhi

Imagine falling ill or being injured, but with a curable condition. You are referred to a successful, confident, and experienced surgeon. He presents a clear, compelling plan of treatment, which you gratefully accept. Imagine entering the hospital for your operation: the majestic facility, the cutting-edge technology, and the skilled, compassionate personnel there to care for you. Afterwards, however, things are not as you had been led to expect. But what went wrong, why it happened, or how to make things better again are withheld from you. There are whispers but no answers. Some people don't look you in the eye; others have simply vanished. Now imagine the same thing happening to your parent, spouse, or child.

W.M. Sage, MD, JD (✉)
School of Law and Dell Medical School, University of Texas at Austin, 727 E. Dean Keeton St., Austin, TX 78746, USA
e-mail: wsage@law.utexas.edu

M.J. Ottosen, PhD, MSN, RN
Department of Family Health, UTHealth-Memorial Hermann Center for Healthcare Quality and Safety, 6410 Fannin, Suite #1100.45, Houston, TX 77030, USA
e-mail: madelene.j.ottosen@uth.tmc.edu

B. Coopwood, MD, FACS
Department of Surgery and Perioperative Care, Dell Medical School, University of Texas at Austin, 1501 Red River Street, Austin, TX 78712, USA
e-mail: ben.coopwood@austin.utexas.edu

Fortunately, serious injuries from errors in surgical care are uncommon. Unfortunately, they happen more often than should be the case for an industry that aspires to high reliability in safeguarding patients' lives and health [1–3]. Inexcusably, their occurrence not infrequently leads to the nightmarish scenario of abandonment described above, a through-the-looking-glass experience reminiscent of buying cheap consumer goods or taking fraudulent investment advice far removed from how health professionals see themselves and their work. Surveys of physicians confirm that many medical errors, even those causing significant injuries, are not disclosed to patients [4–6]. But that is finally changing—a significant trend in medical practice and professional ethics that this chapter describes, explains, and celebrates.

Consider the following not-so-hypothetical cases:

Case #1 A right hepatic lobectomy for hepatocellular carcinoma. The OR shift change occurs during the uneventful, 3-h case, and a new scrub tech and circulating nurse relieve the original team. Once the specimen is removed and hemostasis achieved, the attending surgeon scrubs out to start another case while the surgical fellow closes. Sponge and instrument counts are performed and documented as correct. However, a

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