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Lessons from the Anesthesiology Department Can Improve Patient Safety • Patient Safety Movement

By: Dr. Michael Ramsay, Chairman of the Board, Patient Safety Movement Foundation

3-4 minutes

I am an anesthesiologist by training, and have just retired as chairman of a very busy anesthesia department in Dallas, Texas. I trained in London in the late 1960s. Back then, continuous electronic monitoring was not available in every operating room. Instead, we remained in contact with our patients via a mono-aural stethoscope, listening to breath and heart sounds, and keeping a finger on the temporal pulse. We did not tape patients' eyes closed, as pupils were used to monitor the depth of anesthesia. Back then, the estimated preventable mortality rate that was directly related to anesthesia was approximately 1 in 10,000.

In 1985, the Anesthesia Patient Safety Foundation (APSF) formed with the goal of reducing preventable harm to patients undergoing anesthesia. The APSF applied a systems approach to anesthesia safety to get to zero preventable harm. Their approach involved all entities that played a role in anesthesia safety: from industry to patients, health care professionals to administrators. The APSF applied research into "High Reliability Organizations" to improve

patient safety, which was met with great success.

Preventing patient harm as a result of anesthesia has resulted in improved safety equipment, monitoring equipment, and proven best practices. The preventable mortality rate is now in the range of 1 in 250,000 to 1 in 500,000. What's more, thanks to the improvements in anesthesia patient safety, much sicker patients are undergoing extremely complex surgeries these days.

While there has been much progress, there is still plenty of work to do to get to zero preventable harm in anesthesia. The number one Perioperative Patient Safety Priority for 2020-2021 is "Creating a Culture of Safety, Inclusion and Diversity."

The tremendous success of the APSF must be applied to the whole health care system. Here at The Patient Safety Movement Foundation (PSMF), our moonshot goal is to get to zero preventable patient harm by 2030. We can achieve this goal the same way the APSF is – by making our health care systems into High Reliability Organizations, where the right process is done every time.

The PSMF is teaming up with all the safety organizations, hospitals, hospital and health care administrators, health care workers, patients, industry and medical organizations, and politicians, to create blueprints for safe medical care. These blueprints, which we call Actionable Patient Safety Solutions or APSS, are the proven best practices that have been developed that will prevent patient harm. They are available at the PSMF website for everyone. APSS are living documents that may be updated by proven data submitted to us at www.patientsafetymovement.org.

Many health care facilities have signed on to institute all these safe practices to create a culture of safety and become High-Reliability Organizations.

If we all work together to institute the best practices, we can reach the goal of “Zero Harm by 2030.” We can do this, but it will take a team effort of all the parties involved, from politicians to industry to health care systems.

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