The David M Lawrence, MD, Chairman’s Patient Safety Award

By Arthur L Klatsky, MD
Associate Editor
Clinical Contributions
(pictured on page 10)

Dr. Oliver Wendell Holmes (1809-1894) famously and cynically commented a century and a half ago “… if the whole materia medica, as now used, could be sunk to the bottom of the sea, it would be all the better for mankind and all the worse for the fishes ….” He was probably substantially correct; most medical therapies of his day were likely to do harm. Fortunately, we have come a long way. The great physician/poet/philosopher could not have imagined the highly effective array of drugs, procedures, and preventive measures now available. However, the technologically complex nature of much modern therapy exposes patients to all sorts of potential injury. A stunning technical achievement can be nullified by an error, well exemplified by the widely publicized recent death in a heart-lung transplant recipient due to a blood transfusion mismatch. The rash of headlines about an “epidemic” of thousands of deaths due to medical errors may be exaggerated, but mistakes are always a risk. The Hippocratic-Galenic admonition applies as strongly as ever.

During his 11 years as Chairman and CEO of Kaiser Foundation Health Plan, Inc, and Kaiser Foundation Hospitals, David M Lawrence, MD, challenged Kaiser Permanente (KP) and the entire health care industry to pursue patient safety as an integral component of high-quality care. On the occasion of his retirement, the Chairman’s Patient Safety Award was established by the Board of Directors to recognize and honor projects that advance the quality of care by improving the safety of care. The goals are to: 1) create a culture of safety, 2) develop and standardize successful patient safety measures in KP facilities, and 3) define and implement an innovative and transferable regional intervention in patient safety.

In this issue, we publish the first (2003) David M Lawrence award winner. The award was given to the Southern California Orange County Preoperative Briefing Project. Designed by surgeons, operating room nurses, MD and RN anesthetists, scrub technicians, and administrative support personnel, the objective was to improve patient safety before and during the operating room procedure. The techniques involved were attempts to create a climate of improved communication, collaboration, teamwork, and situational awareness. Measurable results include elimination of wrong-site surgeries, a 19% increase in employee satisfaction, a 16% decrease in nurse turnover, and an increase from “good” to “outstanding” in the perception of safety climate in the operating room.

The Criteria and Guidelines state “Projects nominated for the Chairman’s Patient Safety Award should be evidence-based or experience-based and address significant patient safety issues through substantial, measurable, and transferable changes that positively impact the provision of safe care. Processes or interventions developed through the project may represent innovations related to the patient as a partner in safe care, clinical practices, support systems, safety culture, health care team performance, or the environment of care.” The criteria further specify that award selection will have a bias toward projects that demonstrate a change in outcomes and that preference will favor projects involving members from various disciplines (Health Plan/Hospitals, Medical Group, and Labor). It is desired that projects should be capable of replication interregionally, with a bias toward solutions that are practical, relevant, and cost-effective. It is expected that patient safety issues of considerable scope and magnitude will be addressed with substantial potential impact on the frequency and/or severity of harm.

After a compressed process in 2003, there are to be two annual awards, one to a region with a new project and the second to a region that most
effectively replicates the success of the prior year’s winner. There will be a call for abstracts in September of each year, and the announcement of the regions selected to submit full papers will occur during the December Award ceremony. The regional nomination should be signed by the KP Regional President and Executive Medical Director and submitted to the National KP Program Offices no later than July first. Regions will then have six months to submit full papers. Winners will be selected by the Board’s Patient Safety Award Committee during its September meeting, and representatives from all KP Regions will be invited to attend the annual Award Dinner during the Board’s December meeting.

There is no monetary reward, but substantial recognition. A limited edition of a blue and white plate with clasped hands etched in gold will be the perpetual trophy. Symbolizing partnership with the patient and commitment to provide trusted, safe care, it will be on permanent display in the Program Offices. Each year, a smaller version of the plate will be presented to the winning region, and individual awards are provided to team members. The winning project will be announced at the Board of Directors’ annual dinner in March.

The winning project will be featured on the Patient Safety Web site, in the Program’s Patient Safety Newsletter (STEPS), and on other appropriate programwide publications and venues.

Harmful treatment is now likely to be a more subtle matter due, for example, to failure to recognize individual risk/benefit aspects related to age/sex/ethnic disparities, cultural differences, or interactions with other therapy. It could be argued that avoidance of all these problems properly belongs to the concept of “patient safety” and that optimal patient safety is substantially synonymous with optimal medical care. In any case, it is gratifying that the culture of Permanente Medicine recognizes so strongly the importance of patient safety. Appropriate are some more upbeat words from Dr Holmes’ son, Oliver Wendell Holmes, Jr: “The great thing in this world is not so much where we stand as in what direction we are going.” ✦