Editorial

The End of the Beginning: Complexity and Craftsmanship and the Era of Sustained Work on Patient Safety

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The three patient safety articles in this issue of *The Joint Commission Journal on Quality Improvement* come from well-established groups, and each reflects a particular point of view. Weeks et al[1] tell us about the impact of catastrophic events on the organization, Kuperman et al[2] summarize their experience in their organization with a particular form of technology, and Bagian et al[3] describe a method to keep track of an organization's experience with incidents. What are we to make of these three articles as a collection? Although we might examine each individually, their juxtaposition invites us to compare them, to contrast them, to look for their common themes, and to test their conclusions against the others'.

Yet rather than having a common theme, the articles and the views they contain stand some distance apart from each other. The authors use different methods, address different issues, make different assumptions, and draw different conclusions. One remarkable feature of the collection is that, with a single exception, these three patient safety articles have no references in common. If we are to discover common features, we may have to look both deeper and further than we are usually inclined to do. What prompts these articles—rather than some other set—to appear? What factors lead them to appear now rather than last year? What do these collected articles tell us about *patient safety* itself? What do they tell us about progress on patient safety? Even if we cannot answer these questions completely or definitively, seeking the answers may give us a sense of the possible futures for patient safety.[4]

One feature that the three articles have in common is *complexity.* Each article reflects the complexity that comes whenever people try to grapple with some aspect of patient safety. Whether it is the complexity of trying to mesh a safety program into the machinery of a large bureaucratic health care system, to match the characteristics of a large information technology application to technical work routines in hospitals, or to trace all the threads of cause and cost that follow an accident through the organization in which it occurred, complexity is the dominant feature of real work on safety. In each case, the authors have *accommodated rather than mastered the complexity that confronts them.* The work they report reflects their assessments of what it is possible to do, what matters for safety, and, most of all, what can be made to work.

In the early days of the patient safety movement (what David Woods calls the "era of good intentions"),

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there was much talk about the way that technology or training or organizational change could revolutionize patient safety. There was an intense—almost unbounded—optimism about the possibility of making progress by pursuing the "low-hanging fruit" that would produce quick but significant increments in patient safety. There is little of such talk to be found in these articles. The authors are more circumspect, make more modest claims, and offer many provisos and caveats about their work and the efforts required to make technology, organizational change, or economic analysis work in the furtherance of patient safety. There is no low-hanging fruit here; the authors have had to build ladders and climb trees and even plant new trees in anticipation of future harvests. As a collection, the articles reflect a lot of hard work and, one senses, a great many frustrations and obstacles. There is a great deal of learning how to learn about patient safety[5] reflected in the articles. It is clear that the authors are themselves learning about safety as they experiment and explore.

Another feature of the three articles is the authors' preference for *crafting* solutions and approaches rather than importing them. The Institute of Medicine report *To Err Is Human*[6] suggests that health care adopt the safety approaches of other domains (especially aviation) to allow it to catch up quickly. This turns out to be much more difficult to do than to say. Although the articles nod toward other domains as sources of inspiration, in each case the approach used is tailor-made to the needs and opportunities of the individual organization. The authors have not simply adopted some method that worked in some other domain. Instead, they have crafted the technology (or management or analytical approach) to make it useful for safety work. The articles give us a sense of how carefully this craftsmanship matches the precise situations the authors find in their organizations. Whether it concerns an information system or a reporting system or the assembly of a story describing how accidents propagate through a system, each article depends critically on the authors being *insiders* within their systems. They use their detailed knowledge of what is going on and how it can be influenced together with sophisticated capability and substantial resources to do work on safety. When we look at the articles together, we do not see the authors as disembodied experts offering advice to organizations from the outside, nor does it appear that mimicry of work in other domains is useful.

The era of good intentions that surrounded the first years of the patient safety movement is ending. These three articles in this issue of the *Journal* indicate that the next era is one of sustained work on safety. Crafting approaches in the face of complexity is the substance of this work. The results of this craftsmanship will draw on the deep knowledge of safety and accidents and on the intimate knowledge of how health care works at the sharp end. As Churchill said in 1940, this is not the end or even the beginning of the end, but it is, perhaps, the end of the beginning. J

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