Throughout history, inquiry has proven itself a prerequisite to innovation and improvement. While the saying goes something like “curiosity killed the cat”, these curious investigations sparked monumental progress, from the civil rights movement to the discovery of insulin. Similarly, the coronavirus (COVID-19) pandemic has prompted reflection into the significant systemic gaps within our healthcare systems, both domestically and internationally. The tremendous strain on resources, the significant pressure on healthcare providers, and the immense stress on members of the general public across the world due to the sudden pandemic have unveiled the shortcomings of our medical systems and have shed light on the fundamental structures that lend to medical error. The topic of patient safety, however, is still not viewed as a priority in members of the general public, largely due to the lack of exposure and experience in the healthcare system. Even among those who acknowledge the prevalence of medical error, the fragmentation in definition, coupled with the variation in postulated root causes and proposed solutions, illustrate the very problem with our healthcare system at present: How do we start solving the problem when the population we are trying to serve doesn’t realize the severity and the systemic nature of the problem in the first place? Where do we start and where do we go from there? To begin to answer these questions, initial inquiry into the current state of the world and the perceptions within are necessary to build a thorough foundation for subsequent improvement.

The Patient Safety Movement Foundation (PSMF), a non-profit focused on eliminating preventable patient deaths in healthcare by 2030, took the first steps in exploring the current perceptions of patient safety during the COVID-19 pandemic. The following report illustrates results from both the PSMF community and from the general public on healthcare topics in order to assess perceptions and establish a platform for patient safety movements forthcoming. This report aims to demonstrate current state as a baseline for comparison for future patient safety efforts. This global shock has proven that our healthcare problems are systemic and were not caused solely by COVID-19. We have the opportunity to show that it was the pandemic that exposed them and we can apply the lessons learned from this pandemic to improve health worker safety, and in turn patient safety. We can’t just hope for zero deaths from medical anymore. We have to plan for it.

Methodology

This survey was conducted between April 20th and May 4th of 2020 by Clearpath Strategies. Those surveyed were separated into two groups. Group 1, “US General Population”, was a nationally representative sample (n = 1000) of those who were not involved in the PSMF community in any way. Group 2, “PSMF Community”, consisted of US and international members of the PSMF
network (n=195). All members in group 2 were recruited via PSMF mailing lists and PSMF social media. 71%, 13%, 7%, 4%, 3%, 2%, and 1% of PSMF community survey respondents were within the US, Europe, Mexico, Latin America, Japan, AMER, and India, respectively. PSMF community respondents were nurses (28%), followed by hospital administrators (9%), anesthesiologists (8%), suppliers or vendors (6%), advocates (5%), quality control leaders or infection preventionists (6%), other medical professionals (21%), or fell into the other category (17%), consisting of retirees, educators, or business people.

**Themes**

As it has been speculated based in previous research that members of the general public are unaware of the significant patient safety hazards in the hospital, PSMF investigators were focused on examining the group-distinguished perceptions of patient safety, interactions with the healthcare system, encounters with medical error, propositions for solutions, and speculations on what it means to have a culture of safety.

**Current Concerns**

To capture the baseline political and social priorities, participants were asked to rank their top three most pressing concerns. The “coronavirus pandemic” was the most highly rated topic for both the PSMF community and general public respondents. Concerns about the coronavirus specifically dominated in both groups by a significant magnitude. In the PSMF community, for example, this topic was more pressing than economic and financial well-being by over a 3:1 ratio. The second and third most highly-ranked areas of concern among the general public were “The economy, including jobs and prices” and “Access and availability of healthcare” in respondents of both groups. In the PSMF community “Access and availability of healthcare” was ranked second at 66%, 2.5 times that of the general public. As distinguished as the prioritized responses became further down the list, it is evident that the public is keeping a watchful eye on both the epidemiology of the disease and the availability of healthcare in response. An assessment of the general public audience created a baseline for understanding perspectives in the subsequent data [see image 1].

![Image 1](image1.png)
Awareness of medical error

To delineate the perspectives further, both groups were asked to select their top three issues of concern specific to the healthcare system. While general public respondents selected “out of pocket costs” (49%) with the most frequency, PSMF community members opted for “safety of patients when receiving care” (59%) and “out of pocket costs” was ranked 7th. Interestingly, “safety of patients when receiving care” was ranked in 5th place by members of the general public (30%), illustrating that members of the general public may not recognize the significant potential for error upon hospitalization [see images 2 & 3].

The general public’s worry around medical error, or lack thereof, is again confirmed when most general public respondents reported only occasional worry about medical error in their care. A comparison with the PSMF community respondents, a majority of whom reported worry about medical error every time they use the healthcare system, demonstrated again that there is a significant discrepancy between the groups [see image 2].

<table>
<thead>
<tr>
<th>Issue</th>
<th>The Public</th>
<th>Our Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of pocket costs</td>
<td>49</td>
<td>34</td>
</tr>
<tr>
<td>The health of healthcare workers</td>
<td>39</td>
<td>32</td>
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<tr>
<td>Access to quality hospitals and treatment</td>
<td>34</td>
<td>34</td>
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<tr>
<td>Unexpected or surprise bills</td>
<td>4</td>
<td>4</td>
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<tr>
<td>Safety of patients when receiving care</td>
<td>30</td>
<td>59</td>
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<tr>
<td>Limited options for healthcare insurance</td>
<td>23</td>
<td>9</td>
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<tr>
<td>Health and wellness in nursing homes</td>
<td>21</td>
<td>9</td>
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<tr>
<td>Medication safety</td>
<td>26</td>
<td>21</td>
</tr>
<tr>
<td>Access to care for mental health</td>
<td>22</td>
<td>20</td>
</tr>
<tr>
<td>Mistakes made by healthcare workers</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>Continued education of healthcare workers</td>
<td>28</td>
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</tbody>
</table>

*Image 2*
This lack of awareness shouldn't come as a surprise, as most members of the US general public (70%) reported that they hadn't heard or read any reports on medical error in their state of community in the last year, including during the early COVID period [see image 4]. The results in image 4 are very similar to research conducted by other patient safety organizations. The PSMF survey question displayed in image four was replicated exactly from the 2014 “Public’s View on Medical Error in Massachusetts” Harvard School of Public Health Report, commissioned by the Betsy Lehman Center for Patient Safety and Medical Error Reduction. This report yielded similar results and reported that nearly 77% of respondents hadn't heard or read any news reports about the number of medical errors in MA hospitals in the last year. When we surveyed the Massachusetts-specific oversample for this current study, nearly 6 years after the Betsy Lehman awareness efforts in the MA area, only 52% of MA residents report that they haven't heard or read any reports on medical error, thereby lending credibility to the effectiveness of patient safety campaign efforts in raising awareness.
64% of general public respondents reported that they had never experienced some form of medical error and only 34% of respondents said they knew the term and after hearing the description, reported that it was exactly as they thought [see images 5 & 6]. For the purposes of this survey, participants were asked the following to assess their understanding of medical error:

“Sometimes when people receive medical care, mistakes are made. These mistakes sometimes result in no harm and, sometimes, they may result in additional or prolonged treatment, disability, or death. These types of mistakes are called medical errors.”

The results as shown in images five and six are well-aligned with the data conducted by other leading patient safety-focused organizations. In fact, the PSMF asked both questions exactly as they had been asked in the respective surveys as tracking questions. The 2019 Betsy Lehman How to Talk about Patient Safety report shows that 32% of respondents had never heard of the term “medical error” [see image 6] versus 16% of respondents in our survey. We believe this shows that publishing the Betsy Lehman study may have increased awareness in the Massachusetts area. In 2017 the Institute for Healthcare Improvement (IHI) and National Patient Safety Foundation (NPSF) published a report called Americans’ Experiences with Medical Errors and Views on Patient Safety. We see that 64% of our respondents have not personally been involved in a medical error and did not have a loved one involved in a situation where a medical error was made. Compare that to the IHI’s report nearly three years later where 79% of respondents had never had an experience of medical error. We believe this is significant and may mean that more people are beginning to understand and connect what Americans may have thought was just a complication of treatment as a medical error, with increased exposure to the term.

The term ‘medical error’ is nuanced and vague for both members of the public and for professionals. Without a standardized, well-known definition, these serious safety events will remain underreported, thereby compromising the opportunities for acknowledgment and improvement.
These results further highlight the need for a universal definition of medical error by highlighting the potential that the term ‘medical error’ may or may not convey the avoidability of harm. An analysis of the data showed that members of the public did not believe that preventability was inherent in the definition of medical error, as displayed by the majority of responses indicating that medical errors can be prevented “three-quarters of the time” or “half of the time” (see image 7). This seemingly small nuance significantly shifts organizational priorities in documentation, treatment, improvement, and culture.

The combination of a lack of definition, exposure, or media coverage of medical errors in the healthcare system may attenuate the recognition of error while in the hospital, thereby leaving significant room for medical errors that are never acknowledged.
Image 6

Image 7
Individual versus systemic blame

Even among those who understood the definition and implications of ‘medical error’, further analysis revealed that many members of the general public believed that medical errors occurred due to a fault of the individual [see image 8]. Participants reported most frequently that they believed medical error occurred due to “healthcare workers who are overworked, stressed, or tired” (73%) and “healthcare workers and other staff not working together or communicating well as a team” (62%). These top two results reveal that, even in hospitals that acknowledge medical error occurrences, the blame is often placed on the individual instead of on the larger system.
While the data from image eight indicated a link to individual competence and quality of care, it also foreshadowed the data from the more explicit question: How do we reduce patient harm in the healthcare system?

**Punitive approach in a culture of fear**

Because the general public speculated individual responsibility for medical error, it should come as no surprise that the general public resorted to punitive action as a way to improve safety. Upon probing for solutions to reduce patient harm in the healthcare system, the general public and PSMF community members indicated almost equally a strong belief that holding organizations and people accountable for unsafe healthcare was the most effective way to reduce harm. The PSMF community respondents as a whole, however, were more partial to the idea of providing incentives to organizations and people who practice good safety in our pursuit of safer care [see image 9].

Similar to image nine, image ten lends further evidence to the differences in perceptions by audience. The understanding of the systemic gaps that compromise clinicians’ abilities to provide safe care serves as the key distinguishing factor between the general public and the PSMF community. These results fortify, then, that this understanding of the organizational gaps is the key to create a foundation for a culture of safety instead of a culture of fear.

**Key Takeaways**

A culture of safety inherently seeks to understand the environment of the individual at the time of the medical error and often looks to flaws in the system and processes rather than the faults of the individual themselves. When people, of the general public or of the healthcare system, believe that the majority of errors occur based on a sole mistake, there is no opportunity for learning and improvement as a whole.

Acknowledging and responding proactively to a medical error requires a thorough understanding of the term and its implications. A universal understanding, from both patients and clinicians, can allow healthcare systems with a deep-rooted culture of safety to embrace the opportunity for open and honest dialogue, can transform a situation from guilt and blame to one of conversation, and can offer valuable lessons for the individual and the system as a whole.

With the new results indicating that there was a gap in public understanding of the systemic flaws that compromise clinicians’ abilities to provide safe care, our next step was to determine how to best bolster the general public awareness.
It was determined that a message with information, urgency, and personal connection would be most convincing for attitude change toward patient safety and medical error [see image 11]. A powerful message would incorporate all three elements and these findings should be articulated in patient safety campaigns and messages moving forward.

The top three priorities for both the general public and the PSMF community mirrored one another and included creating a patient safety curriculum for universities, sharing tools with patients to allow for hospital and doctor visit preparation, and partnering with hospitals and universities to require communications training for all medical staff [see image 12]. Inherent in all three of these top responses is a support for universal growth and shared development across the healthcare system. Based on these results, members of the general public and PSMF community members are unanimously seeking shared knowledge and united change. It can be argued that these respondents are recognizing the current culture of competition and fear as detrimental to progress in patient safety and in healthcare as a whole.

The understanding that the lack of knowledge of the systemic gaps increased the general public’s tendencies for individual blame can be leveraged to craft patient safety improvement programs that reflect the needs of both the general public and the community.
Now that the current state, gaps, and potential solutions have been evaluated, pursuing the next steps to create actionable solutions, mobilize change and organize efforts may lend to the same issue we often see in potential healthcare improvement projects: Who’s going to do it? It’s no secret, especially in times of crisis like the COVID-19 pandemic, that clinical time, money, and resources are limited. To discern who would ultimately be in charge of leading these efforts, both our general public and PSMF community respondents were asked to indicate which governing bodies they personally relied on most for safer care. While “healthcare workers” took first place in both groups, presumably due to the aforementioned focus on individual responsibility for safe care, it is worth noting that informed targets relied more on patient advocacy organizations and nonprofits to advocate for them than the general public members did [see image 13]. Because a significant gap was identified earlier in the lack of knowledge of medical error and the systematic factors contributing to a culture of blame, it is not surprising that those without this knowledge, the general public, were less likely to rely on groups that can change the system behind error. This finding fortifies our strategy at PSMF to first educate for systemic change instead of individual reprimand and second leverage the public’s newfound knowledge to position ourselves as leaders in systemic change.

The discrepancy between general public and PSMF community awareness is clearly indicative of a lack of knowledge of the current gaps in the healthcare system, presumably due to a systematic tendency to cover up mistakes instead of seeking opportunities for growth. These systems without a culture of safety often position individual clinicians poorly in a catch-22 situation where they are not equipped to nor supported in their efforts toward transparency, continuous improvement, and united development. The culture currently in healthcare systems is a result of hundreds of years of hierarchy, lack of transparency, and competition. These poor systemic values have infused their way into the perceptions of behaviors of clinicians, thereby making visible the individual errors that occur on the frontline and disregarding the organizational implications that craft the perfect storm. Without this understanding of the fundamental organizational gaps, a culture of individual blame will continue to perpetuate.

An analysis of the current state of public perceptions of patient safety helped create a baseline for moving forward in 2020. While the world is meticulously looking into the healthcare system amid the COVID-19 pandemic, patient safety should be top of mind for everyone. However, it has been demonstrated that,
Currently, even a pandemic can’t prompt the awareness in all members of the public necessary to create and sustain change. These findings fortify the need for PSMF’s general awareness building infused in all efforts for the upcoming year.

About the Patient Safety Movement Foundation

Each year, more than 200,000 people die unnecessarily in U.S. hospitals. Worldwide, 4.8 million lives are similarly lost. The Patient Safety Movement Foundation (PSMF) is a global non-profit on a mission to eliminate preventable patient deaths from medical errors. PSMF uniquely brings patients and patient advocates, healthcare providers, medical technology companies, government, employers, and private payers together under the same cause. From our Actionable Patient Safety Solutions and industry Open Data Pledge to our World Patient Safety, Science & Technology Summit and more, PSMF won’t stop fighting until we achieve zero. For more information, please visit www.patientsafetymovement.org.