The purpose of patient safety work is to reduce avoidable patient harm. This requires us to slay dragons—to eliminate or at least mitigate risks to patients. Instead, current practice focuses almost exclusively on investigating dragons—tracking reports on the number and type of dragons that appear, how many villagers they eat and where, whether they live in caves or forests, and so on. Information about risks is useful to the extent that it informs effective action—but only to that extent. By itself, it does nothing to make patients safer. We cannot investigate a dragon to death. No more can we risk assess our way to safer care.

Recent research by Bates et al.1 adds new evidence to a long-simmering realization: the patient safety movement has stagnated. After a brief convulsion of innovation, the practice of patient safety has settled into a long period of bureaucratization, bolstered by confidence in its (very real) good intentions and constrained by a hastily developed standard of practice that has not kept pace with advances in safety science.3–6

This stagnation has stymied safety improvement in a number of ways, but the field’s continuing failure to focus on solutions all but guarantees that patient harm will continue unabated.

Healthcare has adopted tools from other safety-critical or high-reliability industries to address the causes of patient harm. Patient safety practitioners and frontline healthcare workers invest untold time and effort in incident reporting,1 incident investigation (eg, root cause analysis and its various subcomponents8,11), and the occasional prospective risk assessment12,13 (eg, once every 18 months to meet Joint Commission requirements). More rarely, organizations might use electronic health record trigger tools to help uncover adverse events.1,14–16 These techniques provide important support for risk assessment (problem exploration)17 but provide no direct support for risk control (designing and managing interventions to solve those problems).18–21

This approach might work in the industries where these tools originated, where they are used by safety and reliability engineers, experts in human factors, and others. These professionals receive extensive training in how to design robust safety solutions after a risk assessment. The clinicians who generally use these tools in organizations should engage with experts in sociotechnical intervention design, such as safety scientists, human factors and design experts, engineers, architects, sociologists, and public health practitioners, among others,41–49 to help improve the patient safety risk control process. In the early days of the modern patient safety movement, this kind of interdisciplinary engagement was more common and gave rise to important advances. Since then, the healthcare industry has gradually retrofitted and resiloed itself.2 This time, it will be crucial to ensure a more intentional and sustained approach.

The time to begin these changes is now. We cannot tabulate dragons into toothlessness. We have a moral obligation to take

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up arms and start slaying dragons. It is only by moving beyond analysis and grappling with the messy work of systems change that we will ever reduce the intolerable burden of patient harm.

REFERENCES