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[illegible] My role presently is as the president and CEO of University Health Network in Toronto. In that capacity, I am also, in my view, the chief patient safety officer of the organization. I'm a surgeon and I trained many years ago now as a cancer surgeon and worked, most recently prior to my UHN role, in the United States at the University of Texas, MD Anderson Cancer Center.

[illegible] I'm here to share a story that impacted me personally, a story of patient harm. My own interest in patient safety really began with a personal event at the time when I was working at the University of Texas, MD. Anderson Cancer Center as a professor of surgery. And on one day there, we were doing a very, very complicated operation for a patient who had disease in his esophagus in the swallowing tube. And we were doing a [illegible] When I looked at the two x-rays that had been done, I couldn't, for the life of me, figure out what that was. And I realized at that moment that during my surgical training, during my fellowship training, in textbooks, in exams, I had never seen x-rays of foreign

Much of what we have to do today is to acknowledge and recognize that in health care, we have had, historically, a culture of shame and blame and a practice, oftentimes, of covering up our mistakes and moving on to the next patient. We need to move past that, embrace principles and concepts of adjust culture, and employ systems thinking to better understand the complexity of the work environment that we have in health care.

One big opportunity that we have is to adopt principles, practices, and approaches that are used by other industries. If we look at the gains that have been made in commercial aviation or in nuclear power or chemical manufacturing, those industries are often grouped together as high-reliability organizations by academics. And by adopting many of the principles and approaches that have been taken in this group of industries and taking them to health care, we can really introduce dramatic change.

One of the biggest changes that we're bringing about at University Health Network is an approach and a program that we call Caring Safely. It's a program that we have designed and built and rolled out together with the Hospital for Sick Children in Toronto. It really brings about a structured approach to patient safety that begins with an effort to bring about adjust culture, to bring about an approach that encourages a process of speaking up on safety, an approach that extends not only to patients but also to employees and to workplace safety.

I think patients and families do understand the complexity of medical care, the way it's delivered today. They do understand that at times things don't go the way that we plan. And the candor and honesty that we demonstrate, even the uncertainty that we convey in times when we don't know, that, in a paradoxical way, builds trust with those patients and families.

Being involved in an episode like mine invokes tremendous emotions and all types of responses. Perhaps the best thing that can happen to many providers in this situation is to become safety champions, to realize that this event can spark an interest. Sometimes a change in your career trajectory can cause you to volunteer to be on a hospital committee, to read different literature, to understand that the science of human error is in fact a science, and that there's much that we have to learn, to think about the culture around safety in your organization or in your practice, and to really operate in the future as a champion for patient safety.

Those champions, especially when they are physicians, have tremendous influence in the health care environment in which they work. This, in turn, can lead to saving thousands of lives.

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