Concerns about our current health care system have not changed. As nurses we know that medical errors and “near misses”, in particular, often go unreported. Recently one of my nurse colleagues who had been a patient in a major medical center recalled her near misses as a recipient of care. She was reluctant to file a report as she did not want repeated contacts by the institution. More importantly she thought she might be labeled as a problem patient, a label that might lead to substandard care in the future. Our silence as patients and nurses is jeopardizing care. We must take a more active role in patient safety.

In a new program proposed at the federal level, patients would be asked to provide information about medical errors. As reported by Dr. Caroline Clancy, Director of the Agency for Health Care Research and Quality, the government will be seeking details of each incident, including areas such as what happened; details of the event; when, where, whether there was harm; the type of harm; contributing factors; and whether the patient reported the event and to whom.

As described in the September 22, 2012 *New York Times* article, the questionnaire asks why the mistake happened and lists possible reasons:

- A doctor, nurse or other health care provider did not communicate well with the patient or the patient’s family.
- A health care provider did not respect the patient’s race, language or culture.
- A health care provider did not seem to care about the patient.
- A health care provider was too busy.
- A health care provider did not spend enough time with the patient.
- Health care providers failed to work together.

Health care providers were not aware of care received someplace else (Pear, 2012).

Hopefully this plan will be implemented and a routine part of the process of care. Patient empowerment is critical to patient safety. If we can encourage patients to speak up, for themselves and for future recipients of care, we will have made progress in the patient safety movement. But nurse empowerment is as critical as patient empowerment. We also must help nurses find their voices as agents of change. Nurses must understand that their voices will be heard. Nurses cannot be bystanders in the patient safety movement; we must be active agents of change, as professionals and as scientists.

We will soon announce a call for papers for a special issue on research on patient safety. We know of current pockets of interest and expertise and encourage you to consider your work in progress for potential publication. The nurse’s role as patient advocate is extremely important in the practice setting. The nurse researcher’s role in patient safety research is also critical to fully understanding not just the ‘culture of silence’ but also the positive components of system functioning that are currently in place.

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Reference