

Virtual Mentor

American Medical Association Journal of Ethics
September 2011, Volume 13, Number 9: 663-675.

Suggested Readings and Resources

Accreditation Council for Graduate Medical Education. Common program requirements. http://www.acgme.org/acwebsite/home/Common_Program_Requirements_07012011.pdf. Accessed June 1, 2011.

Agency for Healthcare Research and Quality. The Patient Safety and Quality Improvement Act of 2005. <http://www.ahrq.gov/qual/psoact.htm>. Accessed August 17, 2011.

Alper E, Rosenberg EI, O'Brien KE, Fischer M, Durning SJ. Patient safety education at U.S. and Canadian medical schools: results from the 2006 Clerkship Directors in Internal Medicine survey. *Acad Med*. 2009;84(12):1672-1676.

American Academic of Pediatrics Retail-Based Clinic Policy Work Group. AAP principles concerning retail-based clinics. *Pediatrics*. 2006;118(6):2561-2562.

American Medical Association. Health courts; June 2007. http://www.ama-assn.org/ama1/pub/upload/mm/378/healthcrt_principles.pdf. Accessed July 15, 2011.

Association of American Medical Colleges. MedEdPORTAL. <http://www.mededportal.org>. Accessed August 19, 2011.

Balkrishnan R, Foss CE, Pawaskar M, Uhas AA, Feldman SR. Monitoring for medication errors in outpatient settings. *J Dermatolog Treat*. 2009;20(4):229-232.

Bell SK, Moorman DW, Delbanco T. Improving the patient, family, and clinician experience after harmful events: the “when things go wrong” curriculum. *Acad Med*. 2010;85(6):1010-1017.

Berlinger N, Wu AW. Subtracting insult from injury: addressing cultural expectations in the disclosure of medical error. *J Med Ethics*. 2005;31(2):106-108.

Berwick DM, Finkelstein JA. Preparing medical students for the continual improvement of health and health care: Abraham Flexner and the new “public interest.” *Acad Med*. 2010;85(9 Suppl):S56-S65.

Best hospitals. *US News and World Report*. <http://health.usnews.com/best-hospitals>. Accessed August 17, 2011.

Blustein J. On taking responsibility for one's past. *J Applied Philosophy*. 2000;17(1):1-19.

Boothman RC. Apologies and a strong defense at the University of Michigan Health System. *Physician Exec*. 2006;32(2):7-10.

Bosk CL. *Forgive and Remember: Managing Medical Failure*. 2nd ed. Chicago: University of Chicago Press; 2003.

Brennan TA, Sox CM, Burstin HR. Relation between negligent adverse events and the outcomes of medical-malpractice litigation. *N Engl J Med*. 1996;335(26):1963-1967.

Charles S, Warnecke R, Wilbert JR, Lichtenberg R, DeJesus C. Sued and non-sued physicians. Satisfaction, dissatisfactions, and sources of stress. *Psychosomatics*. 1987;28(9):462-468.

Chassin M. Achieving and sustaining improved quality: lessons from New York State and cardiac surgery. *Health Aff (Millwood)*. 2002;21(4):40-51.

Christensen JF, Levinson W, Dunn PM. The heart of darkness: the impact of perceived mistakes on physicians. *J Gen Intern Med*. 1992;7(4):424-431.

Coker TR, Chung PJ, Cowgill BO, Chen L, Rodriguez MA. Low-income parents' views on the redesign of well-child care. *Pediatrics*. 2009;124(1):194-204.

Cook RI. How complex systems fail. Chicago: University of Chicago Cognitive Technologies Laboratory; 2000.
<http://www.ctlab.org/documents/How%20Complex%20Systems%20Fail.pdf>. Accessed August 7, 2011.

Cooke M, Irby DM, O'Brien BC. *Educating Physicians: A Call for Reform of Medical School and Residency*. San Francisco, CA: Jossey-Bass; 2010.

Cost of medical malpractice top \$55 billion a year in US. *US News & World Report*. September 7, 2010. <http://health.usnews.com/health-news/managing-your-healthcare/healthcare/articles/2010/09/07/cost-of-medical-malpractice-tops-55-billion-a-year-in-us>. Accessed July 15, 2011.

Croskerry P. The importance of cognitive errors in diagnosis and strategies to minimize them. *Acad Med*. 2003;78(8):775-780.

Cullen DJ, Bates DW, Small SD, Cooper JB, Nemeskal AR, Leape LL. The incident reporting system does not detect adverse drug events: a problem for quality improvement. *Jt Comm J Qual Improv*. 1995;21(10):541-548.

Davis R. "Wrong site" surgeries on the rise. *USA Today*. April 17, 2006
http://www.usatoday.com/news/health/2006-04-17-wrong-surgery_x.htm. Accessed August 11, 2011.

Devine J, Chutkan N, Norvell DC, Dettori JR. Avoiding wrong site surgery: a systematic review. *Spine*. 2010;35(9 Suppl):S28-S36.

Engel KG, Rosenthal M, Sutcliffe KM. Residents' responses to medical error: coping, learning, and change. *Acad Med*. 2006;81(1):86-93.

Enright RD. *Forgiveness Is a Choice: A Step-by-Step Process for Resolving Anger and Restoring Hope*. Washington, DC: American Psychological Association; 2001.

Fahrenkopf AM, Sectish TC, Barger LK, et al. Rates of medication errors among depressed and burnt out residents: prospective cohort study. *BMJ*. 2008;336(7642):488-491.

Farrow FL. The anti-patient psychology of health courts: prescriptions from a lawyer-physician. *Am J Law Med*. 2010;36(1):188-219.

Ferris AH, McAndrew TM, Shearer D, Donnelly GF, Miller HA. Embracing the convenient care concept. *Postgrad Med*. 2010;122(1):7-9.

Finkelstein D, Wu AW, Holtzman NA, Smith MK. When a physician harms a patient by a medical error: ethical, legal, and risk-management considerations. *J Clin Ethics*. 1997;8(4):330-335.

Fischer MA, Mazor KM, Baril J, Alper E, DeMarco D, Pugnaire M. Learning from mistakes. Factors that influence how students and residents learn from medical errors. *J Gen Intern Med*. 2006;21(5):419-423.

Frankel AS. *The Essential Guide for Patient Safety Officers*. Oakbrook Terrace, IL: Joint Commission Resources; 2009.

Frankel AS. Revealing and resolving patient safety defects: the impact of leadership walk rounds on frontline caregiver assessments of patient safety. *Health Serv Res*. 2008;43(6):2050-2066.

Gallagher TH, Studdert D, Levinson W. Disclosing harmful medical errors to patients. *New Engl J Med*. 2007;356(26):2713-2719.

Gallagher TH, Waterman AD, Ebers AG, Fraser VJ, Levinson W. Patients' and physicians' attitudes regarding the disclosure of medical errors. *JAMA*. 2003;289(8):1001-1007.

Gandhi TK, Weingart SN, Borus J, et al. Adverse drug events in ambulatory care. *New Engl J Med*. 2003;348(16):1156-1164.

Gawande A. Cowboys and pit crews. *The New Yorker News Desk*. May 26, 2011. <http://www.newyorker.com/online/blogs/newsdesk/2011/05/atul-gawande-harvard-medical-school-commencement-address.html>. Accessed August 17, 2011.

Graber M, Gordon R, Franklin N. Reducing diagnostic errors in medicine: what's the goal? *Acad Med*. 2002;77(10):981-992.

Graber M. Diagnostic errors in medicine: a case of neglect. *Jt Comm J Qual Patient Saf*. 2005;31(2):106-113.

Griswold C. *Forgiveness: A Philosophical Exploration*. Cambridge: Cambridge University Press; 2007.

Gurwitz JH, Field TS, Harrold LR, et al. Incidence and preventability of adverse drug events among older persons in the ambulatory setting. *JAMA*. 2003;289(9):1107-1116.

Harris S. Contract language: take care when firing a patient. *American Medical News*. February 4, 2008. <http://www.ama-assn.org/amednews/2008/02/04/bica0204.htm>. Accessed January 10, 2011.

HealthGrades America's 50 best hospitals: new study finds more than a half million preventable deaths in last decade. *HealthGrades*. February 23, 2011. <http://www.healthgrades.com/cms/ratings-and-awards/2011-Americas-50-Best-Hospitals-Award-Announcement.aspx>. Accessed August 17, 2011.

Helmchen LA, Richards MR, McDonald TB. How does routine disclosure of medical error affect patients' propensity to sue and their assessment of provider quality: evidence from survey data. *Med Care*. 2010;48(11):955-961.

Hirsh DA, Ogur B, Thibault GE, Cox M. "Continuity" as an organizing principle for clinical education reform. *N Engl J Med*. 2007;356(8):858-865.

Hobgood C, Hevia A, Tamayo-Sarver JH, Weiner B, Riviello R. The influence of the causes and contexts of medical errors on emergency medicine residents' responses to their errors: an exploration. *Acad Med*. 2005;80(8):758-764.

Homer CJ, Klatka K, Romm D, et al. A review of the evidence for the medical home for children with special health care needs. *Pediatrics*. 2008;122(4):e922-e937.

Hospital administrator takes plea deal in whistle-blower retaliation case. *Outpatient Surgery Magazine*. March 24, 2011.

<http://www.outpatientsurgery.net/news/2011/03/27-hospital-administrator-takes-plea-deal-in-whistle-blower-retaliation-case>. Accessed August 17, 2011.

Hospital admits surgeon removed wrong kidney. *Fox News*. March 19, 2008. <http://www.foxnews.com/story/0,2933,339170,00.html>. Accessed August 11, 2011.

Hoyt RE, Hall EB. Evidence shows changing roles of health care risk managers. *J Healthc Risk Manag*. 2003;23(2):7-11.

Improvement Science Research Network (ISRN). What is improvement science? http://www.improvementscienceresearch.net/about/improvement_science.asp. Accessed August 19, 2011.

In place of safety nets: don't assume disasters won't happen at the frontiers of technology—presume they will. *Economist*. <http://www.economist.com/node/18586658>. April 20, 2011.

Institute for Healthcare Improvement Open School for Health Professions. <http://www.ihl.org/IHIOpenSchool>. Accessed August 19, 2011.

Institute for Healthcare Improvement. Eight knowledge domains for health professional students. <http://www.ihl.org/offerings/ihioschool/resources/Pages/Publications/EightKnowledgeDomainsForHealthProfessionStudents.aspx>. Accessed August 22, 2011.

Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academies Press; 2001.

Johnson and Johnson Health Care Systems. The Safe Surgery Initiative. <http://www.safesurgeryinitiative.com>. Accessed August 11, 2011.

Johnson J, Kochar R, Young RA. Comparing costs and quality of care at retail clinics with those of other medical settings. *Ann Intern Med*. 2010;152(4):266.

Kachalia A, Kaufman SR, Boothman R, et al. Liability claims and costs before and after implementation of a medical error disclosure program. *Ann Intern Med*. 2010;153(4):213-221.

Kahn MW. What would Osler do? Learning from “difficult” patients. *N Engl J Med*. 2009;361(5):442-443.

Kaldjian LC, Forman-Hoffman VL, Jones EW, Wu BJ, Levi BH, Rosenthal GE. Do faculty and resident physicians discuss their medical errors? *J Med Ethics*. 2008;34(10):717-722.

Kaldjian LC, Jones EW, Wu BJ, Forman-Hoffman VL, Levi BH, Rosenthal GE. Disclosing medical errors to patients: attitudes and practices of physicians and trainees. *J Gen Intern Med.* 2007;22(7):988-986.

Kaldjian LC, Jones EW, Wu BJ, Forman-Hoffman VL, Levi BH, Rosenthal GE. Reporting medical errors to improve patient safety: a survey of physicians in teaching hospitals. *Arch Intern Med.* 2008;168(1):40-46.

Karliner LS, Jacobs EA, Chen AH, Mutha S. Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health Serv Res.* 2007;42(2):727-754.

Katz L, Paul MB. When a physician may refuse to treat a patient. *Physician's News Digest.* February 2002. <http://www.physiciansnews.com/law/202.html>. Accessed January 10, 2011.

Keckley P. Retail clinics: updates and implications: 2009 report. Deloitte Center for Health Solutions; 2009. http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us_chs_RetailClinics_111209.pdf. Accessed December 10, 2010.

Kohn LT, Corrigan JM, Donaldson MS. *To Err Is Human: Building a Safer Health System.* Washington, DC: National Academies Press; 1999.

Kolb DA, Boyatzis RE, Mainemelis C. Experiential learning theory: previous research and new directions. In: Sternberg RJ, Zhang L-F, eds. *Perspectives on Thinking, Learning, and Cognitive Styles.* Mahwah, NJ: Lawrence Erlbaum Associates; 2001. Educational Psychology Series.

Kraman SS. A risk management program based on full disclosure and trust: does everyone win? *Compr Ther.* 2001;27(3):253-257.

Kuo AA, Inkelas M, Lotstein DS, Samson KM, Shor EL, Halfon N. Rethinking well-child care in the United States: an international comparison. *Pediatrics.* 2006;118(4):1692-1702.

Kwaan MR, Studdert DM, Zinner MJ, Gawande AA. Incidence, patterns, and prevention of wrong-site surgeries. *Arch Surg.* 2006; 141(4):353-358.

Lamb S, Murphy JG, eds. *Before Forgiving: Cautionary Views of Forgiveness in Psychotherapy.* Oxford: Oxford University Press; 2002.

Landon BE, Gill JM, Antonelli RC, Rich EC. Prospects for rebuilding primary care using the patient-centered medical home. *Health Aff (Millwood).* 2010;29(5):827-834.

Landrigan CP, Parry GJ, Bones CB, Hackbarth AD, Goldmann DA, Sharek PJ. Temporal trends in the rates of patient harm resulting from medical care. *New Engl J Med*. 2010;363(22):2124-2134.

Laws M, Scott MK. The emergence of retail-based clinics in the United States: early observations. *Health Aff (Millwood)*. 2008;27(5):1293-1298.

Lee v Dewbre, 362 SW2d 900, 902 (1962).

Lee TH. The future of primary care: the need for reinvention. *New Engl J Med*. 2008;359(20):2085-2086.

Levine C. Life but no limb: the aftermath of medical error. *Health Aff (Millwood)*. 2002;21(4):237-241.

Levy PF. More kudos to Ben and the team. *Not Running a Hospital*. <http://runningahospital.blogspot.com/2007/09/more-kudos-to-ben-and-team.html>. Accessed August 11, 2011.

Levy PF. The message you hope never to send. *Not Running a Hospital*. <http://runningahospital.blogspot.com/2008/07/message-you-hope-never-to-send.html>. Accessed August 11, 2011.

Levy PF. Transparency works! Better than you can imagine. *Not Running a Hospital*. <http://runningahospital.blogspot.com/2008/11/transparency-works-better-that-you-can.html>. Accessed August 11, 2011.

Lewis M. *Moneyball: The Art of Winning an Unfair Game*. New York: W.W. Norton; 2003.

Liang BA. Law, health care, and ethics: detoxifying the lethal mix. *Virtual Mentor*. 2004;6(3). <http://virtualmentor.ama-assn.org/2004/03/oped1-0403.html>. Accessed August 17, 2011.

Lucian Leape Institute Roundtable On Reforming Medical Education. *Unmet Needs: Teaching Physicians to Provide Safe Patient Care*. National Patient Safety Foundation; 2010. <http://www.npsf.org/download/LLI-Unmet-Needs-Report.pdf>. Accessed August 19, 2011.

Mariner WK. Medical error reporting: professional tensions between confidentiality & liability. *Issue Brief (Mass Health Policy Forum)*. 2001;(13):1-35.

Mayer D, Klamen D, Gunderson A, Barach P. Designing a patient safety undergraduate medical curriculum: the Telluride Interdisciplinary Roundtable experience. *Teach Learn Med*. 2009;21(1):52-58.

Mazor KM, Fischer MA, Haley HL, Hatem D, Rogers HJ, Quirk ME. Factors influencing preceptors' responses to medical errors: a factorial survey. *Acad Med*. 2005;80(10 Suppl):S88-S92.

McDonald T, Smith HM, Mayer D. "Full disclosure" and residency education: resident learning opportunities within the context of a comprehensive program for responding to adverse patient events. *ACGME Bulletin*. 2008;May:5-9. http://www.acgme.org/acWebsite/bulletin/bulletin5_08.pdf. Accessed August 19, 2011.

McDonnell WM, Guenther E. Narrative review: do state laws make it easier to say "I'm sorry?" *Ann Intern Med*. 2008;149(11):811-816.

McManus v Donlin, 23 Wis 2d 289, 300; 127 NW2d 22, 27-28 (1964).

Medically Induced Trauma Support Services (MITSS), Carr S. *Disclosure and Apology: What's Missing?* [2009]. http://www.mitss.org/MITSS_WhatsMissing.pdf. Accessed August 5, 2011.

Mehrotra A, Liu H, Adams JL, et al. Comparing costs and quality of care at retail clinics with that of other medical settings for 3 common illnesses. *Ann Intern Med*. 2009;151(5):321-328.

Mehrotra A, Wang MC, Lave JR, Adams JL, McGlynn EA. Retail clinics, primary care physicians, and emergency departments: a comparison of patients' visits. *Health Aff (Millwood)*. 2008;27(5):1272-1282.

Mello MM, Gallagher TH. Malpractice reform--opportunities for leadership by health care institutions and liability insurers. *New Engl J Med*. 2010;362(15):1353-1356. <http://healthpolicyandreform.nejm.org/?p=3215>. Accessed July 15, 2011.

Mello MM, Studdert DM, Kachalia AB, Brennan TA. "Health courts" and accountability for patient safety. *Milbank Q*. 2006;84(3):459-492. <http://www.milbank.org/quarterly/8403feat.html>. Accessed July 15, 2011.

Mello MM, Studdert DM, Moran P, Dauer EA. Policy experimentation with administrative compensation for medical injury issues under state constitutional law. *Harvard J Legislation*. 2008;45(1):60-105. http://www.hsph.harvard.edu/faculty/michelle-mello/files/45_Harv_J_on_Legis_59-106.pdf. Accessed August 15, 2011.

Minow M. *Between Vengeance and Forgiveness: Facing History After Genocide and Mass Violence*. Boston: Beacon Press; 1999.

Mishori R. Is "quick" enough? Store clinics tap a public need, but many doctors call the care inferior. *Washington Post*. January 16, 2007. <http://www.washingtonpost.com>.

com/wp-dyn/content/article/2007/01/12/AR2007011201858.html. Accessed August 22, 2011.

Mizrahi T. Managing medical mistakes: ideology, insularity and accountability among internists-in-training. *Soc Sci Med*. 1984;19(2):135-146.

NASA Aviation Safety Reporting System. *Callback*. 1996;204.
http://asrs.arc.nasa.gov/docs/cb/cb_204.pdf. June 2011

Nash D. Today's new physicians are unable to improve patient safety. *KevinMD*.
<http://www.kevinmd.com/blog/2010/08/todays-physicians-unable-improve-patient-safety.html>. Accessed June 1, 2011.

National Coordinating Council for Medication Error Reporting and Prevention. What is a medication error? <http://www.nccmerp.org/aboutMedErrors.html>. Accessed August 23, 2011.

New WSJ.com/Harris interactive study finds satisfaction with retail-based health clinics remains high. Harris Interactive. June 6, 2008.
<http://www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=1308>. Accessed December 15, 2010.

Newman MC. The emotional impact of mistakes on family physicians. *Arch Fam Med*. 1996;5(2):71-75.

Newman-Toker DE, Pronovost PJ. Diagnostic errors--the next frontier for patient safety. *JAMA*. 2009;301(10):1060-1062.

Obama B. Letter concerning meeting on health reform. March 2 2010.
<http://www.whitehouse.gov/blog/2010/03/02/president-obama-follows-thursdays-bipartisan-meeting-health-reform-0>. Accessed July 15, 2011.

Office of Management and Budget, Executive Office of the President of the United States. Fiscal year 2012 budget of the U.S. government.
<http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/budget.pdf>. Accessed July 15, 2011.

Pear R. Medicare says it won't cover hospital errors. *New York Times*. August 19, 2007. <http://www.nytimes.com/2007/08/19/washington/19hospital.html>. Accessed August 11, 2011.

Peron EP, Marcum ZA, Boyce R, Hanlon JT, Handler SM. Year in review: medication mishaps in the elderly. *Am J Geriatr Pharmacother*. 2011;9(1):1-10.

Peters PG. Health courts? *Boston University Law Rev.* 2008;88(1):227-289.
<http://www.bu.edu/law/central/jd/organizations/journals/bulr/documents/PETERS.pdf>. Accessed August 15, 2011.

Pickens S, Boumbulian P, Anderson RJ, Ross S, Phillips S. Community-oriented primary care in action: a Dallas story. *Am J Public Health.* 2002;92(11):1728-1732.

Porter S. AAFP board revises retail health clinic policy. *AAFP News.* February 24, 2010. <http://www.aafp.org/online/en/home/publications/news/news-now/inside-aafp/20100224retail-policy.html>. Accessed February 10, 2011.

Powell S. When Things Go Wrong: Responding to Adverse Events: A Consensus Statement of the Harvard Hospitals. Massachusetts Coalition for the Prevention of Medical Errors; March 2006.
<http://www.macoalition.org/documents/respondingToAdverseEvents.pdf>. Accessed August 17, 2011.

Pratt SD, Mann S, Salisbury M. The John M. Eisenberg Patient Safety and Quality Awards: Impact of CRM-based team training on obstetric outcomes and clinicians' patient safety attitudes. *Jt Comm J Qual Patient Saf.* 2007; 33(12).
http://www.npic.org/contracts/Impact_of_CRM-Based_Team_Training.pdf. Accessed August 11, 2011.

Radecki L, Olson LM, Frintner MP, Tanner JL, Stein MT. What do families want from well-child care? Including parents in the rethinking discussion. *Pediatrics.* 2009;124(3):858-865.

Ranking web of world hospitals: January 2011: hospitals of United States of America. Cybermetrics Lab of the Consejo Superior de Investigaciones Cientificas (CSIC). http://hospitals.webometrics.info/rank_by_country.asp?country=us. Accessed August 17, 2011.

Redelmeier DA. Improving patient care. the cognitive psychology of missed diagnoses. *Ann Intern Med.* 2005;142(2):115-120.

Ricks v Budge, 91 Utah 307, 314; 64 P 2d 208, 211 (1937).

Ring DC, Herndon JH, Meyer GS. Case 34-2010—a 65-year-old woman with an incorrect operation on the left hand. *N Engl J Med.* 2010; 363:1950-1957.

Robert Wood Johnson Foundation. Resolving medical malpractice cases in health courts—an alternative to the current tort system; 2010.
<http://www.rwjf.org/files/research/58662.pdf>. Accessed July 15, 2011.

Robinson PM, Muir LT. Wrong-site surgery in orthopaedics. *J Bone Joint Surg Br.* 2009;91-B(10):1274-1280.

Rohrer JE, Angstman KB, Furst JW. Impact of retail walk-in care on early return visits by adult primary care patients: evaluation via triangulation. *Qual Manag Health Care*. 2009;18(1):19-24.

Rohrer JE, Yapuncich KM, Adamson SC, Angstman KB. Do retail clinics increase early return visits for pediatric patients? *J Am Board Fam Med*. 2008;21(5):475-476.

Schenker Y, Lo B, Ettinger KM, Fernandez A. Navigating language barriers under difficult circumstances. *Ann Intern Med*. 2008;149(4):264-269.

Scott SD, Hirschinger LE, Cox KR, et al. Caring for our own: deploying a systemwide second victim rapid response team. *Jt Comm J Qual Patient Saf*. 2010;36(5):233-240.

Scott SD, Hirschinger LE, Cox KR, McCoig M, Brandt J, Hall LW. The natural history of recovery for the healthcare provider “second victim” after adverse patient events. *Qual Saf Health Care*. 2009;18(5):325-330.

Seid M, Stevens GD. Access to care and children’s primary care experiences: results from a prospective cohort study. *Health Serv Res*. 2005;40(6 Pt 1):1758-1780.

Sharpe VA. Behind closed doors: accountability and responsibility in patient care. *J Med Philos*. 2000;25(1):28-47.

Smith AK, Buss MK, Giansiracusa DF, Block SD. On being fired: experiences of patient-initiated termination of the patient-physician relationship in palliative medicine. *J Palliat Med*. 2007;10(4):937-947.

Stahel PF, Sabel AL, Victoroff MS, et al. Wrong-site and wrong-patient procedures in the universal protocol era. *Arch Surg*. 2010; 145(10):978-984.

Starfield B, Shi L. The medical home, access to care, and insurance: a review of evidence. *Pediatrics*. 2004;113(5 Suppl):1493-1498.

Sullenberger C. Presentation at: Patient Safety Leadership Roundtable; April 28, 2011; MIT Sloan School of Management; Cambridge, MA.

Teinila T, Kaunisvesi K, Airaksinen M. Primary care physicians’ perceptions of medication errors and error prevention in cooperation with community pharmacists. *Res Social Admin Pharm*. 2011;7(2):162-179.

The Just Culture Community. <http://justculture.org>. Accessed August 11, 2011.

The Plan-Do-Study-Act (PDSA) cycle was originally developed by Walter A. Shewhart as the Plan-Do-Check-Act (PDCA) cycle. W. Edwards Deming modified

Shewhart's cycle to PDSA, replacing “Check” with “Study.” See: Deming WE. *The New Economics for Industry, Government, and Education*. 2nd ed. Cambridge, MA: The MIT Press; 2000.

Thomsen LA, Winterstein AG, Sondergaard B, Haugbelle LS, Melander A. Systematic review of the incidence and characteristics of preventable adverse drug events in ambulatory care. *Ann Pharmacother*. 2007;41(9):1411-1426.

Tierney WM. Adverse outpatient drug events--a problem and an opportunity. *New Engl J Med*. 2003;348(16):1587-1589.

Tobias CW. Health courts: panacea or palliative? *University of Richmond L Rev*. 2005;40(1):49-52.

Truog RD, Browning DM, Johnson JA, Gallagher TH. *Talking with Patients and Families About Medical Error: A Guide for Education and Practice*. Baltimore, MD: Johns Hopkins University Press; 2010.

Wachter B. Atul Gawande's *The Checklist Manifesto* reviewed. *KevinMD*. <http://www.kevinmd.com/blog/2010/02/atul-gawande-checklist-manifesto-reviewed.html>. Accessed August 11, 2011.

Wachter RM. Why diagnostic errors don't get any respect—and what can be done about them. *Health Aff (Millwood)*. 2010;29(9):1605-1610.

Wachter RM, Pronovost PJ. Balancing “no blame” with accountability in patient safety. *N Engl J Med*. 2009;361(14):1402-1403.

Wahlberg D. Her pain's still raw, nurse says suspension over, but she can't work in a U.S. hospital for five years. *Madison.com*. July 20, 2008. http://host.madison.com/news/article_67e9a9ae-0357-5446-b10e-158125f23283.html. Accessed August 17, 2011.

Waterman AD, Garbutt J, Hazel E, et al. The emotional impact of medical errors on practicing physicians in the United States and Canada. *Jt Comm J Qual Patient Saf*. 2007;33(8):467-476.

Webster JS, King HB, Toomey LM, et al. Understanding quality and safety problems in the ambulatory environment: seeking improvement with promising teamwork tools and strategies. In: Henriksen K, Battles JB, Keyes MA, et al, eds. *Advances in Patient Safety: New Directions and Alternative Approaches*. Rockville, MD: Agency for Healthcare Research and Quality; 2008. Performance and Tools; vol 9.

West CP, Huschka MM, Novotny PJ, et al. Association of perceived medical errors with resident distress and empathy: a prospective longitudinal study. *JAMA*. 2006;296(9):1071.

West CP, Tan AD, Habermann TM, Sloan JA, Shanafelt TD. Association of resident fatigue and distress with perceived medical errors. *JAMA*. 2009;302(12):1294.

White AA, Bell SK, Krauss MJ, et al. How trainees would disclose medical errors: educational implications for training programmes. *Med Educ*. 2011;45(4):372-380.

White AA, Gallagher TH, Krauss MJ, et al. The attitudes and experiences of trainees regarding disclosing medical errors to patients. *Acad Med*. 2008;83(3):250-256.

Widman A. Why health courts are unconstitutional. *Pace Law Rev*. 2006;27(1):55-88. <http://digitalcommons.pace.edu/cgi/viewcontent.cgi?article=1118&context=plr>. Accessed August 16, 2011.

Wolfstadt JI, Gurwitz JH, Field TS, et al. The effect of computerized physician order entry with clinical decision support on the rates of adverse drug events: a systematic review. *J Gen Intern Med*. 2008;23(4):451-458.

Woodburn JD, Smith KL, Nelson GD. Quality of care in the retail health care setting using national clinical guidelines for acute pharyngitis. *Am J Med Qual*. 2007;22(6):457-462.

Wu AW. Medical error: the second victim. *West J Med*. 2000;172(6):358-359.

Wu AW, Folkman S, McPhee SJ, Lo B. Do house officers learn from their mistakes? *Qual Saf Health Care*. 2003;12(3):221-226.

Wu A, Folkman S, McPhee S, Lo B. How house officers cope with their mistakes. *West J Med*. 1993;159(5):565.

Zahiri HR, Stromberg J, Skupsky H, et al. Prevention of 3 “never events” in the operating room: fires, gossypiboma, and wrong-site surgery. *Surg Innov*. 2011;18(1):55-60.

Zimmerman R. Doctors’ new tool to fight lawsuits: saying “I’m sorry.” Malpractice insurers find owning up to errors soothes patient anger. *J Okla State Med Assoc*. 2004;97(6):245-247.

Copyright 2011 American Medical Association. All rights reserved.