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LETTER FROM THE EDITOR
Systemic Problems and Personal Accountability

"First, do no harm." It was the most recognizable line of the oath we dutifully recited as graduating medical students on that sweltering afternoon in June, and it was an obvious moral imperative: in a profession dedicated to healing people, we should not make them worse.

Yet preventable medical errors—like hospital-acquired infections and injuries, wrong-site surgeries, and incorrectly dosed medication—are at least as frequent and pernicious as they were when the now-famous 1999 Institute of Medicine report on errors first shocked the health care community [1, 2]. By recent estimates, medical errors occur in one out of three hospital admissions [3] at an annual cost of $17.1 billion [4]. Anyone who has spent time in the hospital wards or the clinic knows just how easily a detail in a patient's history can be dropped or a drug list left unconfirmed and how quickly a workaround can become the norm. So how do we as clinicians stay true to our oath? In this month's issue of *Virtual Mentor* we ask how we, as clinicians, stay true to our oath.

Now, for some definitions. When we refer to medical errors, we are talking about preventable harms or injuries to patients that are the direct result of our medical interventions. Patient safety is the emerging discipline that seeks to analyze and minimize these errors, otherwise known as preventable adverse events. In the past few decades, we have seen a distinct shift in ways of thinking about patient safety and medical errors. We have moved away from blaming individuals for mistakes and from simply asking them to work harder. Instead, there has been a strong push to address the systemic flaws that contribute to a given error and to redesign these processes to prevent future mistakes [5].

As David B. Nash, MD, MBA, writes in his clinical case commentary, effective communication among members of the health care team is key to such efforts. Paul F. Levy, former CEO of Boston's Beth Israel Deaconess Medical Center, argues in his op-ed that financial deterrents, and even the now-popular checklists [6], will not eliminate the most serious medical errors until institutional culture promotes a shared sense of responsibility for patients. Citing the example of a wrong-site surgery at his own hospital, he makes the case for transparency as an agent for change. Adrian Gropper, MD, highlights the role of health software in shaping these systems; he argues that open-source electronic medical records would help to standardize care across sites and would promote innovative responses to the needs of health care teams.

Some are concerned, however, that the pendulum of blame might have swung too far in the systems direction. Kavitha V. Neerukonda, JD, MHA, reviews an article in which health policy experts Robert Wachter and Peter Pronovost consider if "no-blame" policies diminish individual clinicians' accountability and therefore might explain lack of improvement in rates of hand washing and other safety measures [7].

So what is the extent of a physician's responsibility to her patients when she has limited time and competing work demands? Dan Blumenthal, MD, MBA, tackles this difficult question in the context of outpatient medicine, in which the patient's participation in his or her care is particularly meaningful. As we are learning, asking patients to take an active role in their care can make it safer.

The medical community has learned the importance of disclosing what mistakes do occur despite our best efforts and apologizing for them [8]. But should we ask or expect harmed patients to forgive their care givers? In exploring this question, Nancy Berlinger, PhD, writes about the cultural underpinnings of our society's views on forgiveness and argues that self-forgiveness may be just as important and difficult to achieve.

For many, medical error is synonymous with lawsuit, and, in fact, a recent study estimates that by the time they turn 65, 75 percent of physicians in low-risk specialties and 99 percent in high-risk specialties will have been sued [9]. Valarie Blake, JD, examines health courts, a new approach to mitigating the disruption and cost of our current medical malpractice system that is now being tested.

Inherent in the study of patient safety is the imperative to measure our errors to better learn from them. Allan S. Frankel, MD, considers the history and the ethical implications of patient safety organizations, created by Congress in 2005 to confidentially collect adverse event data on a grand scale.

Patient safety is a particularly challenging concept for medical trainees, who are more likely than not to be involved in errors and are extremely sensitive to their consequences [10, 11]. In a clinical commentary, Andrew A. White, MD, and Thomas H. Gallagher, MD, reflect on the impact of committing an error on the trainee's well-being and ability to care effectively for other patients, and on the responsibilities of the trainee and his or her institution to address the error.

For then medical student Elaine Besancon, MD, classroom lessons in patient safety meant little until she watched her mother suffer as a result of multiple medical errors. In a moving personal narrative, she writes about how her experience playing the dual roles of patient advocate and trainee fueled her passion for patient safety and her conviction that safety training should be emphasized early and often.

And finally, in her medical education piece, Samara Ginzburg, MD, shares strategies for doing just that. She writes about ways to teach both patient safety and quality

improvement to medical students, based on her experience helping to create such a curriculum for a New York medical school that opened its doors last month.

Of course, there is much more to say about patient safety than we could fit in these (web)pages. Still, I hope that this issue will provoke discussion and help you to reexamine your own practice and that of your institution through the lens of safety.

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