Patient safety culture should start in medical school

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At the Brody School of Medicine at East Carolina University, students and residents bring to life what a new medical textbook describes: a culture of patient safety.

As part of their training, students at the Greenville, North Carolina, medical school participate in a monthly patient safety conference on their pediatrics clerkship where they identify errors and near misses. On their surgery clerkship they conduct a root cause analysis to gain firsthand experience in learning from mistakes and, in so doing, make necessary systemic changes that enhance patient safety.

“Often, it is a system problem that leads to an error, rather than an individual making a mistake,” said Danielle S. Walsh, MD, an associate professor of pediatric surgery at Brody. “These efforts help teach students and residents how to identify the system errors that lead to problems and help change the culture of patient safety,” added Dr. Walsh, a co-author of the patient safety chapter in the new textbook, *Health Systems Science*.

Dr. Walsh and her co-authors authors—Luan E. Lawson, MD, MAEd, Brody’s assistant dean of curriculum, assessment and clinical academic affairs, and Jesse M. Ehrenfeld, MD, MPH, an associate professor of anesthesiology, surgery, biomedical informatics and health policy at Vanderbilt University School of Medicine—note that “most errors occur largely due to system errors, though human error is commonly the focus of blame.” The book teaches students that efforts must be made at the individual, local and even international levels to create and implement tools for evaluating and preventing patient harm.

The patient safety chapter also discusses the history of patient safety, the basic principles of patient safety and specific types of medical errors, including those related to medication, surgery, diagnosis, care transitions, teamwork and communication.

“Through the use of standardization in communication, error assessment and awareness of human infallibility, a culture of vigilance for errors can supplement current prevention efforts and improve the safety of our health care systems,” the authors wrote. “Providing the right care for every patient at the right time requires that all members of the health care team understand errors and error prevention while being committed to creating solutions to improve patient care.”

“By teaching these skills at the onset of medical education as integral to patient care, the culture of safety and blame can be changed for the better,” they added. “Through these efforts, it is hoped that all health care professionals enter practice understanding their essential role in creating a patient-centered and team-based approach to patient safety.”

Health Systems Science was co-written by experts from the AMA and faculty from 11 of the 32 member schools in the AMA’s Accelerating Change in Medical Education Consortium. The textbook retails for $59.99 and can be ordered from the AMA Store and the publisher, Elsevier, as well as from Amazon and other online booksellers. AMA members may order it from the AMA Store for $54.99. Individual chapters are available from Elsevier’s Student Consult platform for $6.99 each.