With medical errors caused more often by systems failures rather than individual lapses, it’s up to everyone in the system—medical students included—to identify problems, say something and work toward reducing the risk of patient harm.

An education module offered via the AMA Ed Hub™ helps medical students, residents and physicians who may not have received this type of training during their medical school years, better understand the basic principles of patient safety and learn about what actions they can take to reduce the risk of medical errors and create a trustworthy health care delivery system.

The AMA Ed Hub is an online platform that brings together high-quality CME, maintenance of certification, and educational content in one place—with relevant learning activities, automated credit tracking and reporting for some states and specialty boards.

The free online module, “Patient Safety,” is one of six modules part of the Health Systems Science Learning Series. Another seven modules will be released as part of the series in early 2020.

A medical safety glossary

Medical errors are the third leading cause of death in the United States and it’s estimated that half the errors are preventable. Here are a few key terms to understand when discussing patient safety:

**Mistake**—An action thought to be correct, but is not.

**Slip**—An action that does not occur as planned.

**Lapse**—An action a person misses or forgets to do.
Violation—A deliberate, illegal or otherwise unsanctioned action is undertaken.

Error—The failure of a planned action to be completed as intended or the use of the wrong plan to achieve an aim.

Malpractice—Improper, illegal or negligent activity.

Near miss—Unplanned event or close call that does not reach the patient or cause an injury or damage to the patient.

What to do if there is an adverse event

It’s best for an organization to be transparent when a patient safety event happens, providing honest communication to patients and their families, the module tells learners. The module outlines a four-step process.

Explain—Provide an explanation of why the error occurred.

Apologize—When appropriate, provide an apology.

Communicate—Share how the health impact will be minimized and explain how the event will impact the patient’s future care.

Prevent—Discuss the actions that will be taken to minimize the chances of a similar event occurring in the future.

How you can make a difference

Individuals and systems need to be held accountable to make the system safer. But before individuals are accused of wrongdoing, the system needs to be examined for flaws. In a “just culture,” each member of the heath care team advocates for an environment where safety concerns can be addressed in a nonpunitive manner, with a willingness to address underlying causes that led to the problem.

As a member of the team, you can operate under a mindset where you look for potential system issues that can cause harm and try to address them. When caring for patients, you can look for gaps where patients are susceptible to a patient safety event. And you can be aware of the framework,
working with a team to report an error or safety concern through the hospital-based reporting system.

More help to study health systems science

The AMA also recently released the *Health Systems Science Review* book, published by Elsevier. The AMA is working with the National Board of Medical Examiners to develop a standardized exam, which is expected to be available later in 2020.

The review book complements the AMA’s 2016 *Health Systems Science* textbook, which outlines a formal method to teach students how to deliver care that meets patients’ needs in modern health systems. More than 4,000 copies have been sold worldwide, and it is being used in over 30 medical and health professions schools. Both books are available for purchase at the AMA Store.