Patient Safety: Things **I** Wish **I** Had Known Sooner

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Mistakes happen.

Unfortunately, the large studies of medical error and preventable adverse events were not published until 3 years after I graduated from medical school. Adverse events are one of the most common diagnoses that a student will encounter during their medical training. The best estimate is that 13% of patients admitted to hospital will experience an adverse event. By contrast, the most common diagnoses on our inpatient medical teaching service are stroke and pneumonia-about 10% each.

It is excellent news that patient safety is becoming part of the medical undergraduate, postgraduate and continuing professional education curriculum. For example, The Royal College of Physicians and Surgeons of Canada (http://rcpsc.medical.org) is offering a one-day symposium on patient safety and medical error in September, 2001. The symposium features world leaders in patient safety from Canada, United States, Australia and the United Kingdom.

Mistakes happen to patients you are taking care of.

I was stunned and shocked the first time a patient experienced a preventable adverse event. I was unprepared. I did not know how to talk to the patient and the family and I did not know how to handle my own feelings. Students need a mechanism for dealing with catastrophic events. Some programs have developed 'critical incident' support services to help students (and other hospital staff) in these situations.

People are fallible.

No matter how dedicated, responsible, and well-trained you are, you will make a mistake. When a colleague (ie any health care professional) is involved in an error, a gentle word of encouragement is a wise investment. Encourage the person to discuss what happened so that future similar events can be prevented. Tell them that most medication errors are caused by system problems, not faulty individuals.

People are forgiving.

As an overworked resident, I would often keep a patient and family waiting a few hours for an emergency room consultation. The patient and family might express displeasure at the delay. I used to feel annoyed. I have learned to apologize and explain the cause of the delay, and I am amazed that people will forgive and smile.

Once you start apologizing for the small problems, it becomes easier to apologize when there is a serious error. Patients and families are remarkably forgiving as long as you give a frank and timely explanation of the events. Medical students are now trained on how to break bad news, including adverse events.

An incident report is a golden learning opportunity.

Incident reports used to ruin my day. Whenever a patient received an incorrect medication, I was given the sinister piece of paper to complete and sign. I viewed this with suspicion and annoyance. Now I understand that the incident report is not an admission of guilt, or an attribution of blame to someone else.
The incident report is a chance to learn from a mistake, so that future similar mistakes can be avoided, and future patients will be safer.

Institutional memory is a professional responsibility.

As a resident, I would work for 1-2 months on one service then move on. During those 1-2 months I would learn safety 'tricks' to prevent adverse events. These tricks would occasionally be passed on informally to subsequent residents, but there was no systematic way for sharing knowledge about the system of care and its potential flaws. This situation is changing, so that students and residents are routinely 'debriefed' and safety problems can be identified.

Today's students are learning more about patient safety. Tomorrow's patients will be safer.

This article reflects the personal opinions of the author.