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From the Editor

Patient Safety and Medical Error: A Constant Focus in Medical Ethics

The theme editor introduces a special issue that examines patient safety and medical errors.

It is not expected that medicine can cure everyone; it might be expected that it makes no one worse than he or she was before. Patient safety has always been an important principle in the practice of medicine. The Institute of Medicine reports, *To Err is Human* and *Crossing the Quality Chasm*, have increased awareness of patient safety issues both within the health care professions and in the mind of the public [1,2]. Even more well known is the principle "first, do no harm," which is an essential feature of the foundation of the practice of medicine since Hippocratic times. In fact the Hippocratic writings consider avoiding harm to be a moral imperative of physician behavior [3].

Nonmaleficence, the contemporary articulation of the obligation to avoid causing harm, is not restricted to deliberate harm. Harm committed with the intent of healing is no less prohibited by this principle than malicious harm, and every physician must assume the duty of preventing all harm [4]. Harm from errors, system flaws, accidents, complications, and known risks are all consequences that must be avoided wherever possible. This is an aspirational goal, meaning medicine should strive to eliminate all potential harm from health care, but reality dictates that we will never fully succeed. The fact that there will always be ways to improve patient safety is the main reason that it always has been and always should be such a prominent feature of medical practice and medical ethics.

The learning objectives for this month's issue of *Virtual Mentor* on patient safety and medical error are:

1. Understand the challenges to patient safety.
2. Understand that medical professionals are personally responsible for improving patient safety in their practices.
3. Identify individual opportunities for improving patient safety and reducing medical errors.
4. Identify institutional initiatives and strategies for improving patient safety and reducing medical error.

Since we can never eliminate all risk for all patients, it is exceedingly important that physicians are conscious of safety concerns and are actively involved in improving patient safety at every opportunity. The Institute of Medicine report, *To Err is Human*, estimates that 44 000 to 98 000 deaths occur annually as a result (at least in part) of medical error [1]. The increased attention given to safety concerns in health care because of this report is both a reminder that this issue is always with us and a wake-up call that we may not be doing all we can to prevent injury to patients.

Many of the articles in this issue refer to the IOM report, *To Err*, and, as with any landmark document, a critical look at the information it contains and the context of its conclusions is essential to using the report meaningfully. Because of the crucial role of the report, one article in this issue focuses on the report's contents and data and its impact.

Injury due to error is especially destructive to the patient-physician relationship because it lowers expectations of high quality care and dedication from physicians and other health care professionals. Errors seem to imply lack of concern and dereliction of duty, when in fact, many errors are the result of poor systems and inadequate infrastructure. Several articles in this issue address these concerns.

In addition to discussing the safety concerns related to errors, this issue covers practice parameters and physicians

duties regarding problem coworkers. In the current environment where attempting to control rising health care costs is a central societal concern, it is critical to be aware of the boundaries of safe care. Being familiar with the clinical literature promotes safety and cuts costs, and, therefore, is vital to patient safety. Systemic safety mechanisms and evidence-based medical practice, however, do not protect patients from impaired or incompetent physicians. Protecting patients from such dangerous physicians is the responsibility of other physicians, but it is a difficult task that no physician enjoys and some may avoid.

Patient safety is intertwined with legal and policy issues such as granting hospitals increasing legal protection for acting quickly to restrict potentially dangerous caregivers. Congress has also tried to improve patient safety through legislation, with mixed success. Physicians may feel a tension between a desire to be honest and genuinely apologetic for unexpected outcomes and the need to protect themselves from liability.

In this issue of *Virtual Mentor* we take a broad look at a variety of approaches to reducing medical errors and improving patient safety. In doing so we hope to create the foundation for physician activism in this arena as well as to promote attitudes of personal responsibility for preventing errors and minimizing the impact of errors that occurr. There are a number of ways physicians can be active in protecting patients and reducing error. Preventing harm is one of the most basic duties of a physician. Therefore physicians at all levels of training should devise multiple mechanisms to prevent error and improve outcomes.

Sincerely,

Erin Egan, MD, JD

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