dear residents

Patient Safety and Resident Safety are Complementary Concepts **January 12, 2025**

Dear Residents,

In 1988, Dr. Arnold Relman, the then-editor-in-chief of the NEJM, penned an article about the third revolution in medical care. He recounts the first revolution, the Era of Expansion, which spanned the period from the end of World War II until the late 1960s, characterized by a surge in research, the establishment of Medicare, and substantial funding for medical education. However, as medical costs escalated, the Era of Cost-Containment, sparked by the "revolt of payers," emerged. This period led to the development of a strategy centered around high throughput, a perspective payment system, encompassing shorter hospital stays, discharge planning, and other measures aimed at managing costs. Concerns arose that this shift might compromise patient safety and the quality of care, prompting the third Era of Assessment and Accountability.

In 1984, the death of Libby Zion, who passed away while under the care of unsupervised and exhausted residents, sparked concerns about supervision and work hours. A New York State Committee investigating the incident recommended that residents should not exceed 80 hours of work per week. In 1999, the Institute of Medicine (now known as the National Academy of Medicine) highlighted preventable deaths in the United States caused by medical errors. This led to the birth of the patient safety movement, which emerged as an extension of the accountability era that began in the 1980s as a countermeasure to the high-throughput era. As many others have written, health systems and hospitals constantly struggle to balance the cost-benefit of funding residency training programs, considering costs, throughput, and the quality of care. The current equation favors trainees as frontline providers.

The patient safety movement has now been firmly integrated into the medical care landscape. The barrier to reporting patient safety incidents was significantly reduced by eliminating the notion of personal blame and recognizing patient care errors as systemic issues. The ACGME now mandates that all trainees possess the knowledge and skills to report patient safety events and actively participate in patient safety analysis whenever feasible. As a program, we strongly encourage you to report patient safety incidents (which are incorporated as a "procedure" in MedHub) and actively participate in Patient Safety Conferences to gain insights into the principles of patient safety event analysis.

There are inherent patient safety mechanisms within the electronic health record and in the deliberate design of care pathways incorporating counterchecks and redundancies. Patient throughput in resident services has increased as the length of stays has shortened, even as the number of admissions has remained steady. IV antibiotic therapy can now be completed as outpatients, and procedures and

complex imaging can be performed post-discharge. This high throughput has positive effects, such as providing more learning encounters compared to a few decades ago and allowing patients to be more comfortable at home. However, these benefits are offset by the rise in patient complexity, the pressure of efficiency, and the complexity of communication systems. These factors, coupled with medical uncertainty, create ample opportunities for patient care errors. Shortened lengths of stay can also create gaps in learning. It can be challenging to fully understand the outcomes of the patients you took care of briefly. The prevention of errors is an ongoing and iterative process that has consistently improved outcomes, particularly in areas that we actively monitor, such as the wrong-patient wrong-procedure error, catheter-associated infections, and dosing errors. Maximizing your learning in a high throughput system is a constant challenge.

In the context of resident-led teams, patient safety is only achievable when resident safety is also prioritized. A safe learning environment ensures proper work hours, work intensity monitoring, and fatigue supervision. It also recognizes the significance of psychological safety, fostering an environment where residents feel comfortable seeking help, acknowledging their mistakes, and speaking up about potential safety issues. Healthcare systems follow the Just Culture framework which is a philosophy and organizational approach that promotes accountability and learning in the workplace while fostering a culture of safety and trust. It recognizes the need to balance accountability with the understanding that humans are fallible, and errors are often the result of flawed systems rather than individual negligence.

Healthcare systems and hospitals have consistently prioritized patient safety, but they have lagged behind in ensuring the safety of their workers. The responsibility for resident well-being has largely fallen on residency programs, and these initiatives often clash with the priorities of health systems and hospitals. Health systems and hospitals may focus more on operational efficiency, cost containment, and patient metrics, sometimes neglecting or undervaluing resident well-being. This competition for resources can create a disconnect between the goals of residency programs and the policies or resources provided by health systems. Residency training is best accomplished in a clinical learning environment that can be at odds with a clinical earning environment.

Managing this tension involves creating a safe space for you to express yourself, buttressed by the program’s ability to listen attentively, and a commitment to the implementation of necessary changes to enhance the learning environment. Over the years, we have made significant strides in ensuring your safety while promoting patient safety. I sincerely appreciate your unwavering commitment and active participation in the safety movement.

Best wishes for a safe and enjoyable week.
Dino Kazi