

Opinion

BY RICHARD P. MILLS, MD, MPH

Patient Safety: Can It Be Improved?

Since the 1999 Institute of Medicine report *To Err Is Human* there has been a crescendo of expectation that our medical establishment will begin to reduce the frequency of medical errors. The public is aghast that the most expensive medical system in the world either can't or won't fix itself.

We have been fortunate in ophthalmology that serious medical error is unusual. It is not that ophthalmologists and their ancillary personnel are better—instead, it is the nature of our specialty that the opportunity for life- or vision-threatening misadventure is simply less frequent than it is for other specialties. It is therefore tempting for us to pay little personal attention to the public demand to reduce medical errors; it is somebody else's problem. Yet sooner than any of us wish, ourselves or those we love will be patients in this broken system, potential victims rather than perpetrators.

Over the years, medicine developed according to a military model, where the physician was "captain of the ship" who accepted responsibility for everything that went on. When things went well, as they did more often than not, the physician accepted adulation, and when they didn't, there was no question as to who should get the blame. When perfectionists encounter such a situation, they soon learn to blame themselves more harshly than others do, surviving with the knowledge that they have helped far more people than they have harmed. Our legal system exacerbates this culture

of blame by attempting to find a guilty party on whom financial damages can be hung. Evidence that might potentially incriminate a physician is suppressed by the medical system, seldom openly, but often covertly.

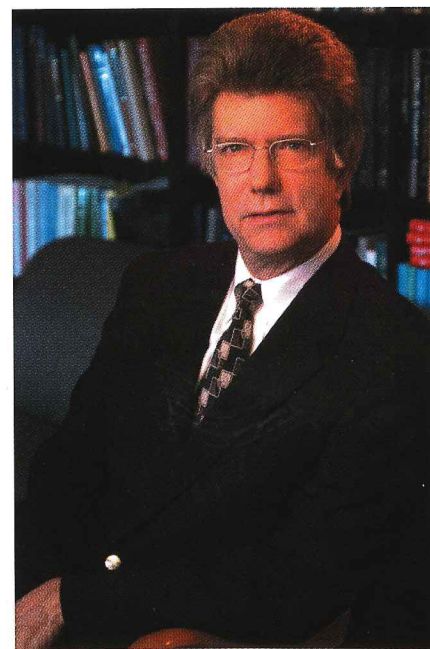
This culture of blame stands in stark contrast to the culture of improvement that exists in the commercial airline industry. Each incident represents an opportunity for improvement. Reporting of near-misses is mandatory, and their subsequent analysis helps suggest improvements in the system that will reduce their frequency and eliminate the occasional tragedy. This analysis always reveals human failings. But the industry understands that to be safe, the system must be resistant to human failings, which are bound to occur.

As *EyeNet* went to press, the U.S. Senate Committee on Health approved by unanimous vote a bill to allow voluntary and confidential error reporting to protected Patient Safety Organizations. Little heralded in medical circles, the law (if passed by the Senate, and reconciled with a similar bill that has already passed the House) could go a long way toward reversing the culture of blame that stymies real progress on

medical mistakes.

While I fully support this legislation as critically important, I am not convinced the problem will be so easy to fix. Unfortunately, those of us who were trained in a culture of blame ("Who forgot to call the lab to find the culture results?"), who have learned to fear long shadows cast by lurking malpractice attorneys and who blame themselves far more than is reasonable, we may not be able to learn a new culture. For that, we may need to wait for the next generation of physicians who learned in school how to behave in a true quality improvement model.

As their future patients, we can hardly wait.



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