Editorial

Learning from Our Mistakes: Quality Grand Rounds, a New Case-Based Series on Medical Errors and Patient Safety

The case presentation has long been revered as an educational tool for physicians. Beginning early in medical school, many students eagerly devour the case presentations (often called "clinical–pathologic conferences," or CPCs) in major medical journals, admiring both the marvelous complexity of the clinical details and the virtuoso performances of the invited discussants (1).

Over the past 20 years, the case presentation and discussion method has become more varied and nuanced. In "clinical problem-solving" exercises, cases were presented to expert discussants in "aliquots," giving learners a chance to observe the experts' reasoning process (2). This format, as well as the incorporation of patients' and providers' perspectives into case protocols in two recent series (3, 4), has expanded the scope and utility of case presentations in medical education. These changes dovetailed nicely with a trend in many medical schools to replace lectures with case-based learning (5).

Case-based learning can be tremendously instructive and stimulating but can also carry a subtle educational threat. By emphasizing the "great case" (usually the more unusual and complex the case, the better) and the remarkable reasoning abilities of the master clinician, learners may assimilate the seductive but unrealistic message that a physician's individual knowledge and skill play the dominant role in determining patient outcomes. The patient safety corollary to this message is that poor outcomes primarily reflect deficiencies in the physician's knowledge base or cognitive and technical abilities. This unrealistic expectation of perfection undoubtedly contributes to physicians' traditional reluctance to discuss errors (6) and tends to distort these discussions when they do occur, such as in the morbidity and mortality (M&M) conferences held in many hospitals.

Although designed to provide a setting in which mistakes can be discussed openly and honestly, most M&M conferences follow one of two paths, neither of which optimally promotes the goal of learning from errors. The conference either gradually but inexorably mutates into a CPC-like great case conference, or an error is presented followed by the excoriation of an individual physician for his or her failings (more common in the surgical specialties and popularized by many television and movie productions). As our understanding of patient safety and error reduction has matured, we now realize that, although the M&M–cum–CPC conference simply sidesteps the consideration of errors, the "find-and-punish-the-bad-apple" approach may be equally unproductive in efforts to decrease errors that harm patients (7, 8).

Catalyzed by the 1999 Institute of Medicine report, *To Err Is Human: Building a Safer Health System,* the medical system recently began to respond to the tremendous public outrage over medical errors (9). Many of the responses focused on reporting systems and other methods of gathering data about the problem (10, 11). Several important articles, monographs, and books highlighted some of the key issues in patient safety and the conceptual underpinnings of quality improvement, often drawn from industries unrelated to health care, such as aviation and nuclear power (12, 13). However, for reasons that include liability issues and a medical culture that has discouraged open discussion of mistakes, the power of the individual case presentation, so important in the physician's clinical medicine education, has not been harnessed to educate providers about medical errors.

In this issue, *Annals* launches a new series, "Quality Grand Rounds." In it, we present articles and companion conferences in a format similar to that of clinical problem-solving cases. Each article describes an actual case involving a medical error or quality issue but does not identify the patient, providers, or institution. Although much of the case material is clinical (that is, drawn from the medical record), in a few cases, the involved institutions allowed us (the series editors) to observe their internal fact-finding and problem-solving process, known as "root-cause analysis." In addition, we often interviewed key participants (including the patient, doctor, nurse, or risk manager) to be sure we could convey a full understanding of the events. Parts of these interviews are included in several of the case presentations in *Annals*, and additional information can be found accompanying the on-line version of the articles (see www.annals.org). Each case was presented to the discussants in a conference format (Quality Grand

Rounds), and the manuscripts were revised to reflect the issues raised at the conferences—including those discussed during the question-and-answer sessions.

In contrast to traditional CPCs, in which the discussant focuses on diagnosing the disease based on the patient's presenting symptoms, the focus in Quality Grand Rounds is on *diagnosing the systems problems* that led to a serious error or adverse outcome for the patient. Our discussants, who are national experts in the relevant patient safety and quality issues, help the reader understand the cause of the errors, frame them in the context of what we know about patient safety, and suggest ways of decreasing the risk to future patients of similar errors. Throughout the series, discussants emphasize not only individual errors but also system failings that allowed the inevitable human fallibility to reach the patient and cause harm (13–15). For example, in this issue's "The Wrong Patient," Drs. Chassin and Becher describe the 17 errors that came together to allow one patient to receive an invasive procedure intended for another (16). Although neither the authors nor the other discussants in the series deny or sugarcoat the individual errors, they identify the failure or absence of systems to catch patient misidentifications and a cultural milieu that provides rich soil for system problems and individual mishaps to blossom into errors. Throughout the series, readers will be introduced to patient safety concepts, such as systems thinking, the "culture of safety," root-cause analysis, and human-factors engineering, as well as to controversies in the field, including the central question, "What is an error?".

This series, which will appear in every three to four issues of *Annals*, is supported by the California HealthCare Foundation as part of its Quality Initiative. We are also grateful to our consulting editor, Kathy Dracup, RN, DNSc; our discussants; and our conference audiences for their participation and interest. The *Annals* Editors—particularly Drs. Harold Sox, Cynthia Mulrow, David Goldmann, and Frank Davidoff—have been unstinting supporters of this effort, demonstrating their commitment to educating physicians and trainees about quality and patient safety.

Our largest debt, of course, is owed to the patients, family members, providers, and institutions that shared their stories with us. Almost to a person, participants told us that they did so in the hope that their tale would help prevent errors from harming other patients. Perhaps surprisingly, they reflected on their experiences with equanimity and even a sense of humor. For instance, the patient described in this issue, who underwent an unneeded invasive cardiac procedure because her name was similar to that of the intended patient, not only emphasized her desire to protect others but went on to say, "I was glad that my heart checked out OK." We hope that Quality Grand Rounds does justice to this extraordinary spirit of generosity and makes a difference in promoting the systems and cultural changes needed to make health care safer.

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