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Not Yet Safe Enough: Patient Safety and Quality Improvement Curriculum

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To the Editor:

We read with interest the article titled “Effect of Patient Safety Curriculum for Internal Medicine Residents on a Health Care System” by Wahlberg and colleagues (1). We would like to congratulate the authors on their successful implementation and sustained case-based, longitudinal curriculum for internal medicine residents and their goal of developing a curriculum that results in real-world system change (2, 3). We would like to share our thoughts, given our experience with a similar curriculum designed to build quality and safety leadership capacity through a hands-on, one-year mentorship, now in its 10th year, for internal medicine residents.

As health care practitioners and educators, the challenge of improving the healthcare system often feels intractable given the decades-long efforts that seem to have minimal to no impact. This is confounded by the high reliance on volume-driven healthcare revenue that often seems in direct competition with quality and safety initiatives. Articles such as the one by

Wahlberg and colleagues offer the opportunity to acknowledge progress achieved, share best practices, and create road maps toward future goals.

The article emphasizes that health care education and efforts in quality and safety are not isolated from each other, even if that is how they are taught. A long-discussed “hidden curriculum” exists in medical education. Earlier descriptors of this hidden curriculum focused on patient-centered clinical skills and professionalism. Trainees were taught best practices, but what they witnessed in the clinical environment often deviated from these practices. More recently, the focus has been on resident well-being and, we would posit, quality and safety (4, 5).

As described by Wahlberg and colleagues, trainees receive foundational education on patient safety (PS) and quality improvement (QI). Some of these individuals continue their work, receive further training, and attain credentials and professional titles related to PS and QI, but the overarching healthcare culture

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remains far from what we would describe as a culture of safety or improvement. Critical educational efforts remain isolated and disconnected from their relevant clinical environments. Trainees learn fundamentals of PS and QI and then subsequently are given demands that are in direct opposition to these tenets. As with prior iterations of the hidden curriculum, we continue to do a disservice to our trainees, our patients, and ourselves with this approach. Until this hidden curriculum is acknowledged and rectified, true culture change will continue to elude us (6).

To further the disconnect, high degrees of provider fatigue, burnout, and guilt occur in a society that increasingly prosecutes individuals for medical errors (2, 7). Although a punitive response may be appropriate in some situations (e.g., malfeasance), it is not an effective way to prevent recurrence or increase reporting (3). Although we ask our trainees to report quality and safety issues, day after day they see examples of blame culture and outcome-based discipline in healthcare institutions; in the news, they observe the criminalization of medical errors and blame being placed on a single person, without shared culpability of the healthcare system that enabled and propagated at-risk or reckless behaviors among the staff.

At our institution, the QI curriculum includes an elective, one-year QI track in which residents receive one-on-one mentoring and develop advanced skills through managing their own projects from identifying gaps in care to presenting their work in an academic forum. The intent is for them to experience the successes and

struggles of leading change and the realistic pace of healthcare QI. Although the successes have been many, we are aware that barriers can easily suppress the spirit of our trainees in the track. We want trainees to learn how to implement change, but we often exclude them from the opportunities to effect that change and witness the results of these improvements. Although we emphasize universal PS and QI education to trainees, the ubiquitous nature of the work is inconsistently applied once they enter the workforce, either during clinical rotations or upon completion of their residencies. In the most extreme cases, the same healthcare systems teaching PS and QI impose demands that are in direct conflict with these teachings. How can this lead to anything but demoralization, cynicism, and burnout?

With increasing focus on provider well-being, high-value care, and PS, how can we ignore a disconnect between healthcare delivery, education, and improvement? To fully embody highly reliable safety attitudes, our trainees need both a thoughtful QI and PS curriculum and a seat at the improvement table within their healthcare institutions. The time is now to integrate our education efforts with our improvement efforts and use the synergy to create a just healthcare culture in which safety and quality predominate. The future of the healthcare system, and the very patients who seek care within the system, depends on this successful indoctrination of our current trainees.

Author disclosures are available with the text of this article at www.atsjournals.org.

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