Role of medical students in preventing patient harm and enhancing patient safety

S C Seiden, C Galvan, R Lamm

Background: Substantial efforts are focused on the high prevalence of patient harm due to medical errors and the mechanisms to prevent them. The potential role of the medical student as a valuable member of the team in preventing patient harm has, however, often been overlooked.

Methods: Four cases are presented from two US academic health centers in which medical students prevented or were in a position to prevent patient harm from occurring. The authors directly participated in each case.

Results: The types of harm prevented included averting non-sterile conditions, missing medications, mitigating exposure to highly contagious patients, and respecting patients’ “do not resuscitate” requests.

Conclusion: Medical students are often overlooked as valuable participants in ensuring patient safety. These cases show that medical students may be an untapped resource for medical error prevention. Medical students should be trained to recognize errors and to speak up when errors occur. Those supervising students should welcome and encourage students to actively communicate observed errors and near misses and should work to eliminate all intimidation by medical hierarchy that can prevent students from being safety advocates.

This paper illustrates the powerful role medical students can play in preventing patient harm and introduces students as an untapped resource for error prevention. We present four real case histories in which one of the authors (then medical students) prevented or could have prevented patient harm (table 1).

CASES

Case 1: Sterile technique in the operating room (OR)

Case history

A third year medical student on her surgery rotation was scrubbing on a wrist arthroscopy case. The student had seen two previous wrist arthroscopies performed by other surgeons. The resident and student positioned the patient’s arm for sterile preparation. After the arm was in position the attending, resident, and student left the OR to scrub. As the patient’s arm was being positioned into the traction apparatus the student noticed that skin on the arm of the Caucasian patient lacked the residual yellow hue of the iodine based prep and concluded that the arm must not have been prepped steriley. The student assumed that the attending was aware of this. On previous surgeries the student had noticed that the surgeon would often double glove while prepping and setting up and then remove their outer gloves. At one point in draping, the patient’s unprepped hand touched the attending’s arm above his outer gloves. The student mentioned this to the attending but the attending did not respond.

The student felt that the maxim in surgery was “medical students should be seen and not heard” and therefore did not repeat the warning. The student also still thought sterile prep was forthcoming. After the patient’s arm was positioned, the student inquired if they should take off their outer gloves (which had been holding the patient’s unprepped arm). The resident and attending, confused by the question, responded that the student could. As the attending prepared to make the first incision on the unclean skin, the student quietly told the resident that the patient’s arm had not been prepped. The resident replied that the arm had been prepped, but then noticed the patient’s arm was still white. The patient’s arm
was re-draped, prepped, a sterile traction apparatus located, and the operation proceeded without incident.

**Error analysis**
This near miss raises many important issues. As in many medical errors, the etiology was one of poor communication and follow through. The OR team failed to communicate who was going to be responsible for prepping. The student’s perception of surgical hierarchy and the OR culture made it difficult for the student to speak up when she first noticed the unprepped arm. The student also felt more comfortable disclosing the error to the resident instead of the attending (a behavior seen elsewhere).

In this case the student prevented the medical error. Some students might have spoken up sooner; some may not have said anything at all. In addition, some luck was involved in making this case a near miss (the hue of the iodine based prep on a light skinned patient).

**Lessons learned**
The Accreditation Council for Graduate Medical Education (ACGME) competencies for US resident education provide a useful framework for categorizing the lessons learned in the cases in this paper and illustrate how this construct can be applied to undergraduate medical education. Firstly, the competencies of patient centred care and professionalism suggest that students should prioritize the safety of the patient ahead of their own hesitancy to speak up. However, the student also needs sufficient medical knowledge to recognize that sterile preparation is always performed for invasive procedures. Increased use of interdisciplinary team training (with emphasis on talking to superiors) would enhance the practice-based learning and improvement opportunities, and aim to provide an increased comfort level for any team member to speak up when an error is recognized.

The cornerstone of earlier detection of the near miss in this case rests upon interpersonal and communication skills. Students, as well as the entire healthcare team, should be encouraged to speak up in times of uncertainty regarding procedures and patient safety. Unfortunately, the case above is not an isolated example of a failure to speak up. The pre-procedure “time out”, which is now mandated by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) immediately prior to beginning invasive procedures, creates a valuable opportunity for communication between members of the operative team. If the team leader uses this “time out” not only for verification of the patient’s name and anticipated procedure but also as a forum to remind all operative team members that they are expected to speak up if they see any safety concerns, even junior or novice team members such as medical students may be more likely to express concerns when they arise. Finally, systems based practice changes (such as standardization of the sterile prepping procedure) could provide another approach to prevent this kind of near miss from recurring.

### Case 2: Drugs prescribed versus drugs administered

**Case history**
A student on her first third year clinical rotation was assigned to follow a 21 year old man with steroid treated ulcerative colitis admitted for a planned total abdominal colectomy. The patient was doing well for the first three postoperative days, but on day 4 the student found while pre-rounding that the patient had not received the ordered postoperative famotidine (Pepcid) during the first four postoperative days. This near miss raised many important issues. As in many medical errors, the etiology was one of poor communication and follow through. The OR team failed to communicate who was going to be responsible for prepping. The student’s perception of surgical hierarchy and the OR culture made it difficult for the student to speak up when she first noticed the unprepped arm. The student also felt more comfortable disclosing the error to the resident instead of the attending (a behavior seen elsewhere).

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#### Table 1 Case examples of student involvement in prevention of medical error

<table>
<thead>
<tr>
<th>No</th>
<th>Description of event</th>
<th>Contributing factors or problems</th>
<th>Role of medical student</th>
<th>Lessons learned</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Non-sterile prep on limb noticed before incision</td>
<td>Poor team communication, Assumptions of OR staff responsibilities, OR culture and hierarchy limiting communication, Daily variation of OR team members</td>
<td>Observations of procedures and deviations from the norm prompted the student to question the omission of sterile technique</td>
<td>Don’t assume anything, keep a suspect eye when things do not look correct. Err on the side of caution. Err in favor of the patient. Don’t be afraid to speak up, even if you are wrong. Learn proper sterile techniques</td>
</tr>
<tr>
<td>2</td>
<td>Drugs ordered but not administered</td>
<td>Drug order system requires transcription from handwritten order to computer based MAR, No formal practice of confirming that ordered drugs are administered</td>
<td>Drug administration was not confirmed</td>
<td>Students are in a position to follow the practice of checking orders are carried out and medications administered</td>
</tr>
<tr>
<td>3</td>
<td>DNR order not followed</td>
<td>No system for alerting DNR orders to team, Student hesitant to communicate knowledge of DNR order</td>
<td>Communicated DNR order to team</td>
<td>Students encouraged to communicate with team members when there are questions about proper procedures</td>
</tr>
<tr>
<td>4</td>
<td>Infection exposure</td>
<td>Language barrier, Emergency setting, Complete history not taken</td>
<td>Student initiated translator consult</td>
<td>Effective communication is vital in patient safety. When language barriers arise, translators must be used to ensure safe patient care</td>
</tr>
</tbody>
</table>

**OR**, operating room; **DNR**, do not resuscitate; **MAR**, medication administration record.
Lesson learned

Like case 1, this case illustrates the troubling pattern of medical students being afraid to speak up, suggesting greater need for increased communication based competency training of all parties from student to faculty member. When medical students possess vital information it is essential that it is promptly communicated to the team. In addition, students’ medical knowledge competency should include information on appropriate initiation and termination of resuscitation efforts. Finally, in terms of patient centred care, emphasis should be placed on appropriate display and communication of patients’ individual resuscitation preferences.

Case 4: Infection precautions complicated by language barrier

A third year student on his medicine rotation was called to the Emergency Department (ED) to evaluate a Spanish speaking patient with a presumed pneumonia. As the student had only moderate Spanish skills, he decided to request a translator. The student found the patient’s symptoms included hemoptysis, night sweats, and weight loss, and the patient had recently immigrated from Mexico where her mother had died of tuberculosis (TB). The student immediately obtained protective masks for the providers, the patient, and the patient’s husband. The student asked the ED attending whether TB was on her differential diagnosis for this patient, to which the attending responded: “Yeah, I thought about it”. The attending did not comment about the possible danger the patient posed to the other patients, the student, or the translator. Examination of the chest radiograph revealed markings consistent with TB. Several days later the patient’s sputum tested positive for acid-fast bacilli (diagnostic for TB). The patient was placed on appropriate treatment and exposed staff were screened for PPD conversion.

Error analysis

The error in this case is one of delaying treatment and exposing other patients and staff to a potentially infectious disease. This error probably occurred because of insufficient triage evaluation of a patient with a cough and was complicated by the language barrier.

Lesson learned

Medical students are repeatedly told in their training that the patient’s history is their most powerful diagnostic tool. An inability to communicate effectively, due to language barrier or otherwise, significantly diminishes the effectiveness of patient histories. Students, with their additional time, may more readily seek the help of translators. In this case we can see that this student’s perseverance led to the correct diagnosis and correct treatment for the patient and also avoided further unnecessary exposure of hospital personnel. However, this case also illustrates the difficulty that students and other trainees may encounter when trying to convey information or management suggestions to an un receptive superior, and the need for competency in communication and patient centred care. In this case the student pursued a diagnosis of TB that the attending had dismissed. In such

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Table 1 Example of work round checklist to reduce medication errors.

<table>
<thead>
<tr>
<th>Name: Mr. Patient MR: 1234567</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DOSE ADJUST FOR RENAL INSUFFICIENCY</strong></td>
</tr>
<tr>
<td>Med</td>
</tr>
<tr>
<td>Famotidine</td>
</tr>
<tr>
<td><strong>DAILY MAR CHECK</strong></td>
</tr>
</tbody>
</table>
situations, appropriate but sensitive confrontation with the goal of providing safe patient care is imperative. In addition, students should note that systems changes could also improve patient-centred care and communication—for instance, by automatically paging a translator when a non-English speaking patient arrives in triage.

DISCUSSION AND RECOMMENDATIONS

In this paper, we present several cases in which medical students appropriately characterized a problematic situation and, in some cases, prevented a medical error and patient harm. Medical students are members of the healthcare team with sufficient knowledge and awareness to recognize medical errors and add another layer to system defenses. Moreover, because students follow fewer patients and can spend more time with each patient than residents, they can afford greater attention to detail. While students can and should participate in their fullest ability to enhance patient safety, it should be noted that students should never be seen as being the principal team member responsible for patient safety, as they may often be required to leave patient care activities for lectures, examinations, or to study. And there is always the possibility that a student’s knowledge base will be deficient to prevent a particularly complex error from occurring.

This paper does not present examples in which students themselves may cause errors (procedural or otherwise), another important subject that has received only limited attention.31 Some recommendations—such as a patient safety curriculum for undergraduate medical education,16 17 32–34 the use of interdisciplinary team training,32–40 and the use of simulation34 41 42—show promise as useful interventions to improve safety, but have been significantly discussed elsewhere. We offer below new recommendations categorized by the ACGME resident based competencies35 to increase student awareness of medical errors and to empower them as team members who can contribute to patient safety. These recommendations are derived from the experiences seen in the cases presented above. However, the small number of cases examined may mean that the cases are not generalizable to all medical student experiences.

- **Recommendation 1:** Improve students’ interpersonal, communication, and professionalism skills
  - Providing health care always involves accessing pertinent information and data. The number of sources and the large volume of information that must be synthesized stack the odds that a clinician may at some point miss an important piece of data. Students should be trained and have practical experience in speaking up without hesitation when they possess information that is critical to safe patient care. The wrist arthroscopy and the DNR order cases illustrate the need for students to be vocal when they possess overlooked information and how hierarchy and unfamiliarity with roles and responsibilities can hamper disclosure. Prefacing phrases such as “I’m probably mistaken, but...” or “this might be a ridiculous question, however...” can deflect the confrontational interaction that might otherwise discourage a student from questioning the action of his/her superior.

- **Recommendation 2:** Train students to practise patient centred care and to be familiar with patient information that is essential to safety
  - Providing health care involves accessing pertinent information and data. The number of sources and the large volume of information that must be synthesized stack the odds that a clinician may at some point miss an important piece of data. Students should be trained and have practical experience in speaking up without hesitation when they possess information that is critical to safe patient care. The wrist arthroscopy and the DNR order cases illustrate the need for students to be vocal when they possess overlooked information and how hierarchy and unfamiliarity with roles and responsibilities can hamper disclosure. Prefacing phrases such as “I’m probably mistaken, but...” or “this might be a ridiculous question, however...” can deflect the confrontational interaction that might otherwise discourage a student from questioning the action of his/her superior.

Similarly, the medical staff hierarchy must become receptive to students raising patient safety-related questions. Students rarely spend a period longer than a month in any one clinical setting, and thus may always have a tendency to feel like an outsider.16 Our experience and that of others shows that students may feel hesitant and delay communicating a known error because of their junior or outsider status and the intimidation they feel from the medical hierarchy.34 35 In aviation, a hesitancy to question the captain led to 583 fatalities in the 1977 collision at Tenerife, Canary Islands—the worst aviation accident in history. As a result of this accident, however, the training technique of crew resource management (CRM) was pioneered in an attempt to teach that concerns regarding safety can and must be conveyed by any team member.34 Moreover, high-reliability organizations (such as aviation and nuclear power) teach us the importance of having respect for an individual’s expertise, regardless of their rank.34 43 In addition, because patient safety is such a new topic in the realm of medical knowledge, all learners from medical student to attending faculty can be considered novices and should be equally receptive to questions and comments regarding safety.43

Making the medical staff more receptive to students raising safety questions requires challenging cultural changes that will not occur without consistent high-level leadership, ongoing training in communication and teamwork, and accountability for patient safety outcomes.44 45 In this way, the medical staff might see students as assets in trying to help the team reach patient safety goals. Finally, students should recognize that appropriate competency in professionalism means the patient’s needs for safe patient care supersede any self-interest that might cause hesitancy in bringing attention to a potential error.

**Recommendation 2:** Train students to practise patient centred care and to be familiar with patient information that is essential to safety

Students should be familiar with common and essential data about their patients such as medications (that they are ordered and administered), allergies, code status, and other information that might easily be overlooked. The second case above illustrates how an ordered drug may not actually be administered. Also, when patients have a procedure or surgery planned, students should assist the team in completing verification of site, side, correct patient, and correct procedure.

**Recommendation 3:** Train students in elements of practice-based learning and improvement as well as systems-based practice

Students should report errors and near miss events to available reporting systems to enhance understanding of errors.37 46 47 While students sometimes report errors to residents and faculty, event reporting tools are used much less frequently.29 Moreover, by reporting both errors and near miss events, students contribute to the knowledge base that can help prevent future errors and increase their own awareness of error prevention.

In addition, a demonstrated understanding and attention to quality and patient safety should be part of medical student competencies and corresponding evaluation. For medical students especially, assessment drives behavior.14 If students are expected to achieve competency in improving quality and safety and are given methods to achieve this competency, they will do so. For example, routine evaluations on clinical clerkships could include a question as to whether the student noticed, discussed, or otherwise contributed to areas of quality improvement or safety concerns.29

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In the case series presented here, medical knowledge was necessary in sterile technique (case 1); postoperative perforations after gastrointestinal surgery and medication prophylaxis (case 2); ethical termination of resuscitation efforts (case 3); and recognition of contagious diseases such as TB (case 4). This is merely an anecdotal list of ways in which medical knowledge should be matched to related content in medical school curricula so that specific safety related content should also be provided. Comprehensive literature on the epidemiology and etiology of medical error should be matched to related content in medical school curricula so that specific safety related medical knowledge is developed.

Incorporation of these recommendations can bolster the safety in academic medical centers by using medical students as a previously untapped advocate for patient safety.

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