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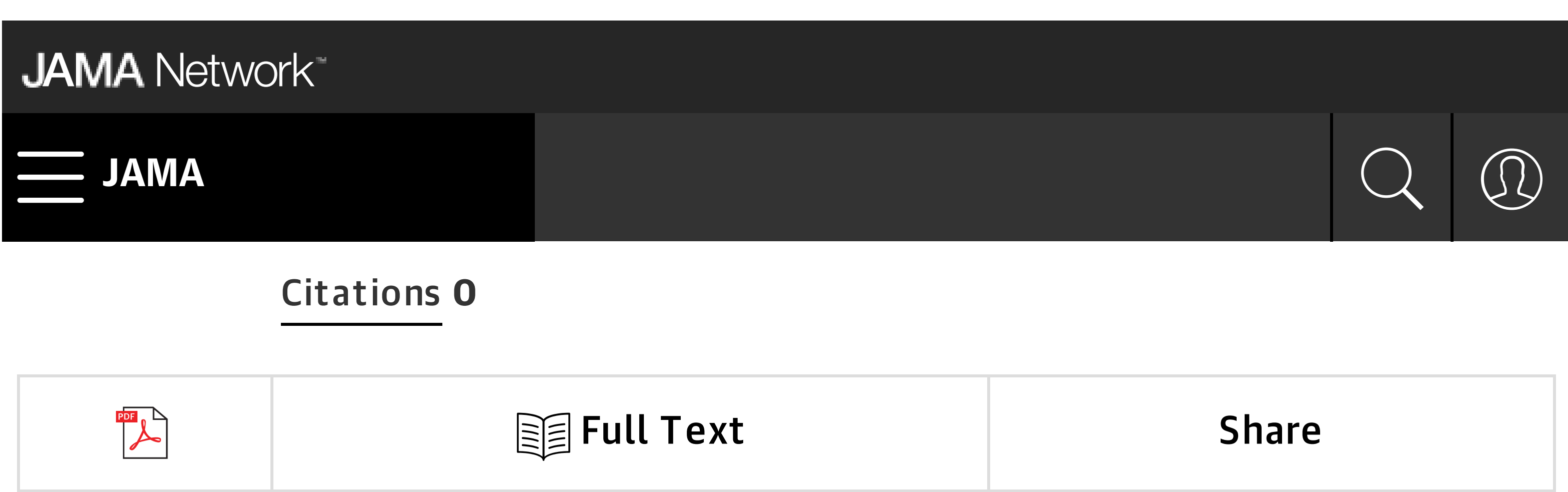

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April 14, 2004

Surgical Training, Error

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JAMA. 2004;291(14):1775-1776. doi:10.1001/jama.291.14.1775

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The publishing of the second edition of *Forgive and Remember*, Charles L. Bosk's study of the consequences of errors made by surgical residents, is timely. The Institute of Medicine (IOM) report *To Err Is Human* and a more recent article published in JAMA[1] indicate that 32 000 to 98 000 patients die in the United States each year owing to preventable medical errors. These injuries require 2.4 million extra hospital days at a potential cost of $4.6 billion annually. Despite calls for action by the IOM report, the Leap Frog Group, and the US Department of Health and Human Services Agency for Healthcare Research and Quality, preventable medical errors remain a significant problem. Bosk's study sheds light on the difficulties in reducing errors in the health care system.

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Surgical Training, Error

Forgive and Remember: Managing Medical Failure, by Charles L. Bosk, 2nd ed, 276 pp, paper, $14, ISBN 0-226-06678-9, Chicago, Ill, University of Chicago Press, 2003.

THE PUBLISHING OF THE SECOND EDItion of *Forgive and Remember,* Charles L. Bosk's study of the consequences of errors made by surgical residents, is timely. The Institute of Medicine (IOM) report *To Err Is Human* and a more recent article published in *JAMA*[1] indicate that 32 000 to 98 000 patients die in the United States each year owing to preventable medical errors. These injuries require 2.4 million extra hospital days at a potential cost of $4.6 billion annually. Despite calls for action by the IOM report, the Leap Frog Group, and the US Department of Health and Human Services Agency for Healthcare Research and Quality, preventable medical errors remain a significant problem. Bosk's study sheds light on the difficulties in reducing errors in the health care system.

The second edition still presents the findings of the first, 1979, edition. Bosk, a sociologist, studied a surgical service in a US teaching hospital for 18 months. His goal was to try to understand the norms and values that are invoked to categorize clinical errors as blameless or blameworthy, how residents learn these norms and performance standards, the responses that each type of violation provokes, and the effects of violations on the resident's career. Bosk's work is one of the classic studies of medical education. In another work he argues that the socialization that physicians experience during their residency training has replaced medical education as the most important experience shaping the physician's professional identity. His study highlights many of the experiences and occupational rituals that teach residents and reinforce for attending physicians what it means to be a surgeon.

Based on his observations, Bosk classified medical errors in four categories: technical, judgmental, normative, and quasinormative. Technical and judgmental errors were considered largely the result of the uncertainty inherent in medical decision making and inevitable in the training of surgical residents. Normative and quasinormative errors were considered inexcusable and blameworthy. Normative errors entailed breaches in the role relations between residents and attending physicians involving dishonesty, carelessness, or insubordination; these errors could be cause for the dismissal of a surgical resident before the successful completion of residency training. While normative errors were breaches of standards shared by all attending physicians, quasinormative errors were specific to each attending. In areas in which scientific evidence is inconclusive and there is not a consensus among physicians, the attending responsible for the patient is the one who decides which approach is appropriate.

In contrast to the stringent social control of residents' behavior, Bosk observed that there was little or no social control over attending physicians' behavior, even when they committed normative breaches resulting in errors and serious harm to patients or death. The difference in treatment of house staff and attending failures was quite marked. Questioning of residents during attending rounds provided an accounting and test of their competency; mistakes and failures resulted in sharp rebukes and public humiliation. In contrast, the forums in which attending physicians were expected to account for their successes and failures, grand rounds and mortality and morbidity conferences, were quite different. During grand rounds attending physicians celebrated their successes. By admitting failures during mortality and morbidity conferences, a process that Bosk terms "putting on the hair shirt," they transformed negative evidence of failure into a positive display of the surgeon's skills and elicited support from colleagues.

In general, physicians were expected to internalize the norms during their residency training and subsequently to self-regulate. In practice, errors and failures after training were met with tolerance and silence. Physicians were loath to question another physician's judgment. Bosk points out that this reliance on individual responsibility once a physician completes residency training weakens ties to the professional community and fails to instill in physicians a sense of what constitutes good and bad practice.

A new preface and epilogue discuss the changes that have occurred in medical practice since the first edition appeared and how the training of surgical residents has been affected. The development of ethics consultation services and managed care have weakened the power once wielded by attending physicians over residents. In *Strangers at the Bedside* (Basic Books, 1992; second edition, Aldine de Gruyter, 2003), David J. Rothman documents how the rise of bioethics has altered almost every aspect of the doctor-patient relationship by bringing a number of new parties and procedures into medical decision making. Bosk observes that while the clarity of the old norms has broken down, they have not been replaced by a new set of shared norms. According to Bosk, this breakdown of norms has occurred because the authority of the single decision maker, the attending physician, has been diminished by managed care and bioethics committees. Moreover, in the quest for cost containment, the fiduciary relationship and norm of "do everything possible" for the patient have broken down. Today, administrators, patients, and their families may challenge the attending physician's judgment, resulting in a loss of authority and uncer-

Books, Journals, New Media Section Editor: Harriet S. Meyer, MD, Contributing Editor, *JAMA*; David H. Morse, MS, University of Southern California, Norris Medical Library, Journal Review Editor.

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