

Identifying and Preventing Medical Errors

You can't listen to the news these days without hearing something about medical errors from the tragedy of incompatible organs being transplanted into a young girl to doctors' illegible handwriting leading to prescribing errors. Fortunately on this issue, the medical community is trying to be proactive rather than waiting for the legislators to inundate us with laws that may not even address the true problems.

Identifying potential sources of errors is the first and critical step to fixing the problem. During your subinternship it is our goal to give you more autonomy than at any other point in your training thus far. Consequently, you will be in a position to see how errors can occur in our particular system and whether you do things that either promote or prevent errors. The goal of this experience is to introduce you to some concepts of how errors may occur and to raise your awareness so you will be part of the solution as you develop your own practice style.

Dr. Eric Rosenberg has conducted research about medication errors and is a member of the Department of Medicine Quality Improvement Committee. He has agreed to give you the one hour presentation he gives to the faculty about errors. Following that, we ask to start paying closer attention to how errors are potentially occurring on your service. Choose one incident that could be a potential adverse event that was averted or an adverse event that might have been averted. This is not an indictment on anyone so please do not use names and make every effort to protect privacy. Briefly describe the incident. We will provide you with some suggested reading to choose from that will help you analyze the event. You will need to jot down some notes for a small group discussion, but a formal paper is *not* required and nothing will be turned in. However, participation is required in a one hour small group where you will share your experience and what you learned with each other.

It is anticipated that this entire curriculum will take a total of 3-4 hours (one hour for Dr. Rosenberg's presentation; one hour for the small group discussion, 10-15 minutes of which you will lead; and 1-2 hours to read an article and make some notes for your presentation). Failure to participate will result in a lowering of your "Systems-based practice" competency evaluation by one box. Exceptional work can raise your "Systems-based practice" competency evaluation by one box if it is not already at the top. The following is a *suggested* format for your presentation:

1. Brief description of the event
2. Identify the potential causes of the adverse event
3. Comment on key issue(s) you learned from the reading
4. Suggest possible solutions

For those of you who enjoy a good debate, you may want to choose something we currently do to "prevent errors" and provide some reasons *with evidence* of why you don't think it works. Or conversely, if there is something you think we should be doing and don't discuss that *with evidence*. A debate format would even be acceptable.

References

“To Err is Human”, report from the Institute of Medicine

www.iom.edu/includes/dbfile.asp?id=4117

This was the seminal report that drew the public’s attention to the issue of medical errors and consequently has driven the medical community to take more aggressive action to address this problem.

Wachter RM, Shojanaia KG, et al. Learning from our mistakes: quality grand rounds, a new case-based series on medical errors and patient safety. *Ann Int Med.* 2002;136:850-2

This editorial introduces the series “Quality Grand Rounds” in the Annals of Internal Medicine. The following is a list of the articles in that series along with the website for the abstract:

1. Advance Care Planning for Fatal Chronic Illness: Avoiding Commonplace Errors and Unwanted Suffering. Lynn J, Goldstein NE. *Ann Int Med* 2003;138:812-8.
www.annals.org/issues/v138n10/abs/200305200-00009.html
2. A hospitalization from Hell: A Patient’s Perspective on Quality. Cleary PD. *Ann Int Med* 2003; 138:33-9.
www.annals.org/issues/v138n1/abs/200301070-00009.html
3. Hospital-Onset Infections: A Patient Safety Issue. Gerberding JL. *Ann Int Med* 2002; 137:665-70.
www.annals.org/issues/v137n8/abs/200210150-00011.html
4. Unexpected Hypoglycemia in a Critically Ill Patient. Bates DW. *Ann Int Med* 2002; 137:110-6.
www.annals.org/issues/v137n2/abs/200207160-00009.html
5. Are Bad Outcomes from Questionable Clinical Decisions Preventable Medical Errors? A Case of Cascade Iatrogenesis. Hofer TP, Hayward RA. *Ann Int Med* 2002; 137:327-33.
www.annals.org/issues/v137n5/abs/200209030-00008.html
6. The Wrong Patient. Chassin MR, Becher EC. *Ann Int Med* 2002; 136:826-33.
www.annals.org/issues/v136n11/abs/200206040-00012.html

Volpp KGM, Grande D. Residents’ Suggestions for reducing errors in teaching hospitals. *N Engl J Med.* 2003; 348(9): 851-5.

Bates DW, Gawande AA. Improving safety with information technology. *N Engl J Med.* 2003; 348(25): 2526-4.

Gandhi TK, Weingart SN, et al. Adverse drug events in ambulatory care. N Engl J Med. 2003; 348(16): 1556-64.

Complications: A Surgeon's Notes on an Imperfect Science, Atul Gawande, M.D. 2003, Picador, 288 pages.

This is an excellent, highly readable book written by Dr. Gawande when he was a surgical resident. He addresses many types of errors through the use of compelling stories. This was a NY Times notable book.