# The Educational Mission to Reduce Medical Errors and Improve Patient Care Outcomes

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#### **Session Objectives**

By the end of this session we will have discussed, debated and hopefully educated each other on:

- Why patient safety is an important issue today
- What has happened in health care
- How these changes have effected patient care
- How these changes will impact your careers

# Beyond Blame Video

# As to diseases, make a habit of two things - to help or at least to do no harm.

Hippocrates, Epidemics

## Institute of Medicine 1999 Report:

"To Err is Human: Building a Safer Health System"

#### Institute of Medicine Report 1999

98,000 patients die each year from preventable medical errors

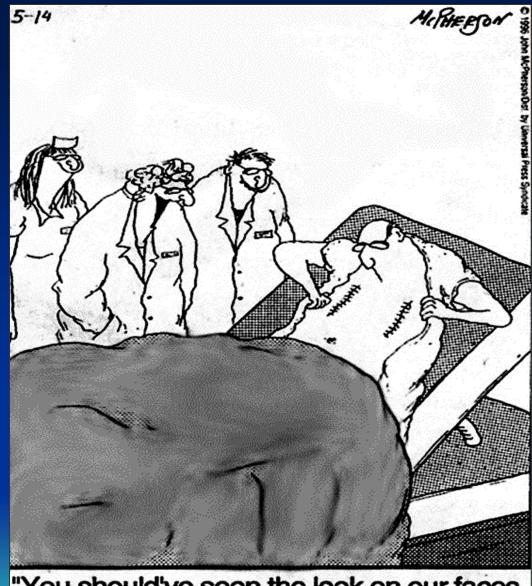
\$17 - \$29 billion in costs

Fifth leading cause of death in U.S.

"Medicine used to be simple, ineffective and relatively safe. Now it is complex, effective, and potentially dangerous."

> Sir Cyril Chantler, Dean of London's Guy's Hospital

# Patient safety has become an important public and private concern



"You should've seen the look on our faces when we realized that we'd been looking at the x-rays backward for the first hour of surgery."

#### **Definition of Professionalism**

- AAMC & NBME:
- Altruism
- Honor and Integrity
- Caring and Compassion
- Respect
- Responsibility
- Accountability
- Excellence and Scholarship
- Leadership

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Definition of Insanity: Doing the same thing over and over but expecting a different result.

Albert Einstein

#### **Error in Medicine**

Lucian Leape, MD

"How can there be an error without negligence?"

#### **Error in Medicine**

Lucian Leape, MD

"Far better to conceal a mistake or, if that is impossible, to try to shift blame to another, even the patient."

In a survey given to over 1000 doctors, nurses, and residents in both urban teaching and non-teaching hospitals, one-third of staff members stated that they have never made an error

Most denied any deleterious effects of stress on their judgment and affirmed that their decision making skills are just as good in emergencies as in normal situations

Less than a third of staff reported that errors are handled appropriately and over half reported that they find it difficult to discuss mistakes

Why are we afraid to admit we do not know?

Why are we afraid to admit we do not know? Why are we afraid to ask for help?

What is the number one cause of medical error today?

#### **Poor Communication Skills**

Clinical Case Discussion

# Medical malpractice reform and patient safety

#### Newer Health Care Skills

- Teamwork and collaboration
- Leadership
- Interpersonal communication
- Risk management
- Stress management
- Error science
- Systems and process management
- Resource management

- Simulation Training
  - Aviation industry CRM
  - Musicians require many years of practice
  - Takes 10 years to achieve "expertise" level

- Types of Simulation Training
  - Computer programs
  - Task trainers
  - Mannequins (team and procedure)
  - Standardized patients; role plays
  - Virtual reality

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