

## 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 the 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 the 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 an interest in this topic and sits on the Pharmacy and Therapeutics Committee, which deals with medication-related errors. 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 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 the 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.