

CONTENTS

Foreword	xiii
William F. Rayburn	

Preface	xv
Paul A. Gluck	

Scope of Problem and History of Patient Safety	1
Lucian L. Leape	

Creating a safe environment in our incredibly complex health care system requires a major culture change. While it may be frustratingly slow and halting, that change is occurring and beginning to show results. This article addresses the issue of patient safety, discussing its history, and organizations and practices that are helping to make it more of a reality in today's health care environment.

Medical Error Theory	11
Paul A. Gluck	

Some errors in health care are inevitable because of human fallibility and system complexity. To improve patient safety we must develop *three strategies*. *First, prevent errors with forcing functions*, reducing complexity and providing reminders at the point of care. *Second, everyone working in health care should be alert to identify and eliminate latent (potential) errors before patients are harmed*. *Finally, we must establish defensive barriers that will intercept those errors that still occur and prevent them from causing patient injury*. Only in this way can health care fulfill its potential and significantly reduce iatrogenic harm.

**Practical Solutions to Improve Safety in the Obstetrics/
Gynecology Office Setting and in the Operating Room**

19

Paul G. Stumpf

There are great opportunities to enhance patient safety in office practice, but the pattern of medical errors and techniques to reduce their frequency appears to differ from the hospital environment. A focus on decreasing the risks of prescribing errors and tracking errors may be particularly fruitful in the office setting, such as electronic prescribing, electronic medical records, the use of detailed patient instructions, unambiguous prescribing, and meticulous follow-up of test results. The surgical environment presents its own unique set of risks to patient safety, particularly because of the catastrophic consequences that may result from even infrequent events. Vigilance against stress and fatigue is particularly important. Patient safety in surgery is promoted by routine use of the "universal protocol," antibiotic prophylaxis, thromboprophylaxis, open communication among all members of the surgical team, and clear guidelines for introducing new procedures and technology.

Medication Safety

37

Carol A. Keohane and David W. Bates

Patient safety is a state of mind, not a technology. The technologies used in the medical setting represent tools that must be properly designed, used well, and assessed on an on-going basis. Moreover, in all settings, building a culture of safety is pivotal for improving safety, and many nontechnologic approaches, such as medication reconciliation and teaching patients about their medications, are also essential. This article addresses the topic of medication safety and examines specific strategies being used to decrease the incidence of medication errors across various clinical settings.

Transparency, Apology and Disclosure of Adverse Outcomes

53

Patrice M. Weiss and Francine Miranda

Medical errors became a common topic of conversation with the release of the Institute of Medicine's "To Err Is Human" in November of 1999. This release reported that as many as 98,000 people die each year from inpatient medical errors. Putting this into perspective, deaths from medical errors surpassed deaths from breast cancer, motor vehicle accidents, and AIDS. Furthermore, medication errors account for more deaths annually than workplace injuries. This article addresses communication of adverse outcomes to patients (disclosure) through transparency and apology.

**Electronic Health Records and Electronic Prescribing:
Promise and Pitfalls**

63

Caitlin M. Cusack

Health information technology (health IT), especially technology related to electronic health records (EHRs) and electronic prescription (e-prescribing) systems, is believed to be the cornerstone for improvements in quality of care, patient safety, and efficiencies, all leading to cost benefits. With increasing requirements for quality reporting and with new pay-for-performance programs being initiated by insurers, many physicians are asking if it is time to invest in health IT. However, as those who have already made this decision have found, adopting EHRs and e-prescribing systems is not an easy task: Our colleagues resist their use, they are costly, the case for a return on investment for an ambulatory practice has not been well established, incentives to use are misaligned, implementations may be difficult, and often such systems disrupt or inhibit workflow.

Team Function in Obstetrics to Reduce Errors and Improve Outcomes

81

Peter Nielsen and Susan Mann

Crew resource management (CRM), adapted from aviation for the practice of medicine, offers the potential of reducing medical errors, increasing employee retention, and improving patient satisfaction. CRM, however, requires a culture that promotes teamwork and acceptance of new concepts. Leadership is needed to transform the culture, as well as to train, coach, and sustain the behavior CRM demands. Culture change can be fostered through teamwork activities that, when made part of a daily routine, provides the basis for modeling teamwork skills and sets the stage for sustained culture change. New tools are available to measure processes as well as patient and staff satisfaction.

Simulation in Obstetrics and Gynecology

97

Roxane Gardner and Daniel B. Raemer

Simulation is a practical and safe approach to the acquisition and maintenance of task-oriented and behavioral skills across the spectrum of medical specialties, including obstetrics and gynecology. Since the 1990s, the profession of obstetrics and gynecology has come to appreciate the value of simulation and major steps are being taken toward incorporating this technique into specialty-specific training, evaluation, and credentialing programs. This article provides an overview of simulators and simulation in health care and describes the scope of their current use and anticipated applications in the field of obstetrics and gynecology.

Elements of a Successful Quality Improvement and Patient Safety Program in Obstetrics and Gynecology	129
Joseph C. Gambone and Robert C. Reiter	

In this article we present the elements of one approach to quality improvement and patient safety that we believe can be successful and sustainable in the field of obstetrics and gynecology, along with several strategies (and caveats) that have worked and are working in academic and nonacademic institutions in the United States. Also included are several noteworthy definitions of quality to provide some additional perspectives on what is meant by quality in health care.

Quality Assessment Tools: ACOG Voluntary Review of Quality of Care Program, Peer Review Reporting System	147
Abraham Lichtmacher	

The Voluntary Review of Quality of Care Program is the American College of Obstetricians and Gynecologists' program of peer review. It is dedicated to quality improvement, patient safety, and peer review, which is conducted by a national professional specialty organization. Since the program's inception, 236 hospitals providing obstetric and gynecologic services in this country have been reviewed. This article presents the results of these reviews. Common problems are identified and possible corrective action is recommended. This program represents a useful model of national peer review activity that can impact patient care.

Index	163
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