Massachusetts Medical Society

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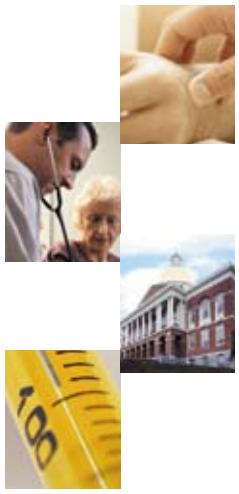

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System-Level Changes Are Key to Improving Patient Safety

BY TOM WALSH

With National Patient Safety Awareness Week (March 2 through 8) upon us, Massachusetts health care leaders acknowledge that we've made great strides in patient safety but that much remains to be done. Lucian Leape, M.D. — the Massachusetts pediatric surgeon who is often described as the father of the patient safety movement — reflected on our progress and remaining hurdles in this crucial area of health care during a recent interview with *Vital Signs*.

In 2000, Dr. Leape spoke before a U.S. Senate subcommittee, saying:

"[Medical] errors are seldom due to carelessness or lack of trying hard enough. More commonly, errors are caused by faulty systems, processes, and conditions that lead people to make mistakes. They can be prevented by designing systems that make it hard for people to do something wrong and easy to do it right."

More than eight years later, Dr. Leape said he would tell the subcommittee the same thing. "I stand by every word of that," he said. "We've learned that what we're trying to do sounds simple, but is not easy at all."

Dr. Leape cited an example of a hospital patient acquiring a preventable infection. "The answer isn't that a patient's doctor should be fined or fired," he said. "It's that we ought to ask about the system. The doctor is not the only one who made that infection happen. The issue is how do we get the system to respond?"

Interviews with patient safety experts in Massachusetts suggest that the state is populated with health care professionals and executives determined to place the Commonwealth at the forefront of efforts to reduce, if not eliminate, medical errors.

Much Work Still to Do

But at the same time, there is also agreement that much work remains to be done to fully achieve that end, here and in the rest of the nation.

"We're still a long way from where we need to be," said B. Dale Magee, M.D., MMS president. "We're not yet doing as well as we can."

Nevertheless, the raw material for systemic patient safety breakthroughs exists today in Massachusetts. Dr. Leape, an author of the landmark 1999 Institute of Medicine report *To Err is Human*, said, "A lot of [patient safety] research is done here. Everyone who is in health care in Massachusetts gets a lot of information and support. There can't be many places where patient safety is more on the minds and agendas of people than in Massachusetts."

James Conway, senior vice president of the Institute for Healthcare Improvement (IHI), another important patient safety organization, said, "I can't get over the level of engagement on this issue." In a separate capacity, Conway also chairs the board of directors of the Partnership for Healthcare Excellence, which sponsors a multiyear patient safety initiative aimed at motivating consumers to improve the safety of their own health care (see *Vital Signs*, February 2008, page 4). The MMS sits on the organization's Leadership Council.

Need for Better Systems and a New Mindset

Those at the forefront of the patient safety movement in the Commonwealth agree with Dr. Leape that the key to eradicating medical errors and advancing

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Special CME Courses for Patient Safety Week

In recognition of National Patient Safety Awareness Week (March 2 through 8), the MMS will offer its members FREE online CME opportunities addressing various patient safety issues. Go to **www.massmed.org/cme** for log-in information. Complimentary courses include:

- Unmasking Depression in Primary Care Practice
- Cultural Competence in Women's Health: Implications for Cardiac Risk Factors and Disease
- Cost Performance Ratings: What You Need to Know about Episode Treatment Groups (ETGs)
- How to Improve Medication Safety and Reduce Drug Costs through e-Prescribing
- Recognizing and Preventing Youth Violence

The MMS is also collaborating with three other organizations to present a March 4 CME course focused on patient safety in obstetrics (see page 8 for details).

MMS Helps Drive Patient Safety Gains

BY TOM WALSH

From sponsoring major conferences and legislative advocacy to highly relevant continuing medical education (CME) programs and the contributions of individual members, the MMS has long been a leader in patient safety.

"We continually offer courses on patient safety issues, and our committees are always looking at policies related to patient safety," said B. Dale Magee, M.D., MMS president.

The Society plays an active role in Massachusetts organizations dedicated to patient safety. These include the Massachusetts Coalition for the Prevention of Medical Errors and the Betsy Lehman Center for Patient Safety and Medical Error Reduction.

Earlier this year, the MMS led a coalition of provider organizations that worked with the state's Public Health Council to ensure enhanced patient safety in the operation of limited service clinics (see *Vital Signs*, February, page 1).

As concern over patient safety has increased, accrediting organizations overseeing CME are requiring that CME programs address patient safety.

"Now CME programs must identify physician practice or performance gaps and try to improve or change a physician's way of practicing," said Caroline B. Carregal, MMS director of continuing education and certification. VS