

Enhancing Clinical Education and Training, Improving Care

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More than a decade ago the Institute of Medicine published its landmark study, *To Err is Human* (2000), documenting an unacceptably high rate of medical errors, many of them resulting from poor clinical decision-making. In fact, surgeons in the United States make medical errors more than 4,000 times a year, which can result in permanent injury or death. These types of preventable errors include wrong-site surgery, retained surgical items, wrong-patient surgery, and wrong-procedure surgery, causing nearly half of the affected patients to suffer temporary injury (Landro, 2012). In primary care, diagnostic errors account for 34% of negligent adverse events in the United States (Phillips et al., 2004) and 63% of claims against practitioners in the United Kingdom (Silk, 2000). Several factors have been found to be associated with errors in primary care, among them are co-morbidities, low prevalence, and atypical presentations (Kostopoulou, Delaney, & Munro, 2008). Despite diligent efforts on the part of both healthcare institutions and accrediting bodies to reduce errors, there is little evidence that the situation has significantly improved (Landrigan et al., 2010; Levinson, 2010; Liang & Mackey 2011; Schreve et al., 2010).