The 2000 Institute of Medicine report "To Err is Human" raised awareness of medical errors as an important cause of adverse patient outcomes and challenged the medical community to improve patient safety. Medicine traditionally has taken a "blame and shame" approach to errors, identifying and admonishing the individual involved, but failing to focus on the interaction between system factors and human factors which perpetuate these errors. Not surprisingly, then, these errors continue to recur. Leaders in patient safety call for a new approach to errors, one which understands systems and human factors in medicine and strives to build safer, more fail-proof processes to redress errors. Physicians must take a leadership role in making health care safer, but need the tools and he knowledge to do so.

This unique educational project is designed to train physicians in the scientific underpinnings of patient safety and to familiarize them with a rigorous method of analyzing errors in medical care. Residents will have the opportunity to use their knowledge to analyze an error in their own practice and to design, implement and evaluate an intervention to address the causal factors identified in their analysis.

In PGY1 the trainees participate in two interactive seminars on medical error during their ambulatory curriculum. They learn the basics about human factors, cognition, systems thinking and error prevention.

In PGY2 trainees participate in a seminar on error analysis, learning in a case-based format and practicing error analysis using practice cases. They are then assigned an actual case(reported through the voluntary error reporting program of the UMA patient safety project) or, if they prefer, can analyze an error of their own. The trainees are then responsible for investigating the details of the case, drawing up an event flow diagram and constructing a causal tree. They then present their case analysis to the interdisciplinary UMA patient safety committee for discussion and design of interventions to address the root causes of the case.

In PGY3 trainees will re-visit their cases to determine the effectiveness of their interventions.

Types and numbers of errors reported by residents, types of interventions and their effectiveness in reducing errors and improving care will be some of the outcome measures evaluated at the end of this project. Residents completing PGY2 will be interviewed to assess the effects that the curriculum had on attitudes toward errors, attitudes toward reporting and how they felt about discussing their own errors.

This curriculum in patient safety offers residents the opportunity to learn the fundamentals of patient safety and to apply that knowledge in a meaningful "living framework" within their own ambulatory practice.

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