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- 1. Association of an Educational Program in Mindful Communication with Burnout, Empathy, and Attitudes among Primary Care Physicians.**  
Krasner MS, Epstein RM, Beckman H, et al.  
JAMA. 2009(Sep 23/30); 302(12):1284–1293.  
*This study investigated whether mindfulness training could improve physicians' well-being and help to instill attitudes conducive to the provision of patient-centered care. The authors conducted before-and-after surveys of 70 primary care practitioners who participated in a continuing medical education course that focused on mindfulness, interpersonal awareness, and related techniques. They found that participation in the program was associated with improved well-being and reduced burnout, as well as heightened empathy and other personal qualities associated with a patient-centered approach to care. Implications and possibilities for further research are discussed. Four tables are included.*
- 2. Attending Physician Work Hours: Ethical Considerations and the Last Doctor Standing.**  
Mercurio MR, Peterec SM.  
Pediatrics. 2009(Aug); 124(2):758–762.  
*This article questions whether allowing attending physicians to work unlimited hours — in contrast to the restrictions that have been placed on the duty hours of medical residents — is ethically valid. The authors consider various possible arguments in favor of allowing unlimited hours and conclude that little justification exists for continuing such a practice given its potential detriment to patient safety.*
- 3. Balancing “No Blame” with Accountability in Patient Safety.**  
Wachter RM, Pronovost PJ.  
N Engl J Med. 2009(Oct 1); 361(14):1401–1406.  
*This commentary discusses the complexity of reconciling the ideal of a “no blame” culture with the need for individual accountability for safe practice in healthcare, and sets forth principles for the just application of discipline in response to unsafe behavior, using hand hygiene compliance as an example. Two tables are included.*
- 4. Bringing Patients' Own Medications into an Emergency Department by Ambulance: Effect on Prescribing Accuracy when These Patients Are Admitted to Hospital.**  
Chan EW, Taylor SE, Marriott JL, Barger B.  
Med J Aust. 2009(Oct 5); 191(7):374–377.  
*This study investigated whether patients admitted via the emergency department experienced fewer prescribing errors when they brought their current medications with them to the hospital. In an analysis of medication lists recorded on admission for 100 patients admitted through the ED at a teaching hospital in Melbourne, Australia, the authors found that prescribing errors occurred significantly less frequently for patients who arrived with their medications than for those who did not. The authors conclude that having emergency medical personnel bring patients' medications to the hospital with them whenever possible could help improve patient safety. Three tables and one figure are included.*

5. **Communication Failure in the Intensive Care Unit — Learning from a Near Miss.**  
Hendel SA, Flanagan BT.  
Anaesth Intensive Care. 2009(Sep); 37(5):847–850.  
*This article presents a case study of a “near miss” event involving an accidental intravenous medication overdose in an ICU patient. The authors describe how multiple communication failures contributed to the error and discuss how these problems could be remedied to avoid future such occurrences. One table is included.*
  
6. **Computerized Decision Support to Reduce Potentially Inappropriate Prescribing to Older Emergency Department Patients: A Randomized, Controlled Trial.**  
Terrell KM, Perkins AJ, Dexter PR, Hui SL, Callahan CM, Miller DK.  
J Am Geriatr Soc. 2009(Aug); 57(8):1388–1394.  
*This study investigated whether the use of computerized decision support could improve prescribing safety among physicians in the emergency department of an academic hospital. The authors compared prescriptions written for patients aged 65 and older from 63 ED physicians randomly assigned either to receive or not receive decision support as part of the hospital’s computerized prescribing system. They found that physicians who received computerized decision support were significantly less likely than those who did not to prescribe potentially inappropriate medications. Three tables and two figures are included.*
  
7. **Diagnostic Error in Medical Education: Where Wrongs Can Make Rights.**  
Eva KW.  
Adv Health Sci Educ Theor Pract. 2009(Sep); 14(Suppl 1):71–81.  
*In this paper, the author applies educational and cognitive theory to the question of how best to teach physicians skills to avoid diagnostic error. Drawing upon an extensive literature review, he argues that mistakes made during the learning process are essential to learners’ successful acquisition of new knowledge and ability, and that teaching methods that encourage error may therefore be more beneficial than those that focus strictly on error avoidance. Thus, while preventing errors in clinical practice remains of paramount importance, the medical education process should recognize the potential pedagogical value of errors and should embrace strategies, such as simulation-based training, that allow students to experience and learn from such errors without the risk of harming actual patients.*
  
8. **Educational Strategies to Reduce Diagnostic Error: Can You Teach This Stuff?**  
Graber ML.  
Adv Health Sci Educ Theor Pract. 2009(Sep); 14(Suppl 1):63–69.  
*This article argues that educational methods — training clinicians to act and think in certain ways — may be an effective approach to managing and preventing diagnostic error. The author looks at the systems-related and cognitive components of the diagnostic process and discusses potential educational strategies for reducing the risk of each type of error. One figure and an appendix are included.*

- 9. Engaging the Patient as Observer to Promote Hand Hygiene Compliance in Ambulatory Care.**  
Bittle MJ, LaMarche S.  
Jt Comm J Qual Patient Saf. 2009(Oct); 35(10):519–525.  
*This article describes the development and pilot implementation of an initiative that used patients to monitor providers' hand hygiene performance in the ambulatory care clinic of Johns Hopkins Hospital, Baltimore, Md. Patients participating in the program were asked to observe and report their providers' hand hygiene compliance using a simple comment card (neither the patient nor the provider could be identified from the information on the card). Results indicated that the system was well received by patients and providers and suggested that such an approach could provide a useful and cost-effective method of hand hygiene surveillance in the ambulatory care setting. Three tables and three figures are included.*
- 10. Health Literacy: A Barrier to Pharmacist–Patient Communication and Medication Adherence.**  
Ngoh LN.  
J Am Pharm Assoc. 2009(Sep/Oct); 49(5):e132–e149.  
*Patients' health literacy significantly affects their ability to understand and participate in their treatment, including the ability to comprehend and adhere to medication regimens. This article summarizes the published literature concerning health literacy and medication adherence, discusses the relationship between poor health literacy and medication non-compliance, and reviews strategies for improving communication between providers and patients, with a particular focus on the role of pharmacists. Multiple tables are included.*
- 11. Indiana Medical Error Reporting System: Final Report for 2008.**  
Whitson T, Garten B, Lewis J.  
Indianapolis, IN: Indiana State Department of Health; August 2009.  
Available at: [http://www.in.gov/isdh/files/2008\\_MERS\\_Report.pdf](http://www.in.gov/isdh/files/2008_MERS_Report.pdf)  
*This report presents data on patient safety events reported by Indiana healthcare facilities during 2008, including statewide data along with discussion of key findings and trends. Hospital-specific data tables and additional appendices are available at <http://www.in.gov/isdh/23433.htm>.*
- 12. Litigation Related to Inadequate Anaesthesia: An Analysis of Claims against the NHS in England 1995–2007.**  
Mihai R, Scott S, Cook TM.  
Anaesthesia. 2009(Aug); 64(8):829–835.  
*This study sought insight into the nature and costs of safety incidents involving insufficient anesthesia, using data from closed malpractice claims filed in the UK over a 12-year period. In their analysis of 1,067 anesthesia-related claims, the authors found that nearly 20% were related to inadequate anesthesia; of these, one-half involved intraoperative awareness during general anesthesia. The total cost of closed claims related to inadequate anesthesia was almost £3.2 million. Further details of the findings and implications are discussed. Four tables are included.*

- 13. Multihospital Collaborations for Surgical Quality Improvement.**  
Campbell DA Jr., Dellinger EP.  
JAMA. 2009(Oct 14); 302(14):1584–1585.  
*This commentary discusses the role of collaborative groups of hospitals as catalysts for healthcare quality improvement and highlights two recently established such initiatives: the Surgical Care Outcomes Assessment Program, made up of 50 Washington-state hospitals, and the Michigan Surgical Quality Collaborative, consisting of 34 hospitals in Michigan.*
- 14. Nursing Student Medication Errors Involving Tubing and Catheters: A Descriptive Study.**  
Wolf ZR, Hicks RW, Altmiller G, Bicknell P.  
Nurse Educ Today. 2009(Aug); 29(6):681–688.  
*This study sought to characterize nursing students' medication errors related to tubing misconnections or other mistakes in the use of tubes and catheters. Using data from the US Pharmacopeia's MEDMARX database, the authors examined 27 such cases of medication error. Details of the descriptive analysis are presented in the article. While the none of the errors examined in this study resulted in patient harm, the authors caution that this type of errors should be considered a serious patient safety threat and as such should be given more attention in nurse training and curricular materials. Three tables are included.*
- 15. One System's Journey in Creating a Disclosure and Apology Program.**  
Peto RR, Tenerowicz LM, Benjamin EM, Morsi DS, Burger PK.  
Jt Comm J Qual Patient Saf. 2009(Oct); 35(10):487–496.  
*This article reports on how Baystate Health, a three-hospital system in Western Massachusetts, developed and implemented an approach to organizational response to adverse events emphasizing prompt and thorough disclosure of the event to the patient involved. The authors describe experiences with the system thus far and discuss lessons learned and challenges remaining to be addressed. Two tables and one figure are included.*
- 16. Pharmacy Compounding of High-Risk Level Products and Patient Safety.**  
Mullarkey T.  
Am J Health-Syst Pharm. 2009(Sep 1); 66(17 Suppl 5):S4–S13.  
*This article gives an overview of pharmacy compounding in the US, focusing on regulatory and patient safety issues. In recent years, concerns about drug quality and safety have led to increased scrutiny of compounding practices and have generated legal and political controversy concerning the FDA's role in oversight of pharmacy compounding. The authors comment on this debate and highlight its implications for pharmacy practice and for patient safety. Three tables are included.*

**17. Risks of Complications by Attending Physicians after Performing Nighttime Procedures.**

Rothschild JM, Keohane CA, Rogers S, et al.

JAMA. 2009(Oct 14); 302(14):1565–1572.

*While much attention has been given to the relationship between medical residents' work hours and patient safety, few studies have examined the effects of extended work hours and sleep deprivation on attending physicians. This study assessed how having worked the previous night affected performance the following day among attending surgeons and obstetricians/gynecologists at an urban academic hospital. Using data from a 9.5-year period, the authors compared daytime procedures performed by an attending physician who had performed an emergency procedure during the previous night with similar procedures by the same physician not preceded by a nighttime procedure. They found that overall rates of complications did not differ significantly between cases where the physician had worked the previous night and control cases. However, complications were significantly more frequent when physicians had had less than 6 hours between the nighttime and daytime procedures than when a longer rest period was available. Multiple tables are included.*

**18. The Ethics of Anaesthesia Learning Curves.**

White SM.

Anaesth Intensive Care. 2009(Sep); 37(5):824–829.

*This article discusses ethical and safety considerations related to the involvement of patients in anesthetic procedures performed by trainees, i.e., those who may not yet have reached optimal proficiency according to the learning curve. In order for such practice to be ethical, the authors advise, careful supervision of the trainee by an experienced provider is imperative, and, above all, patients must be informed of the nature of the procedure and give their consent to participate in the training process. Three figures are included.*

**19. The Nature and Causes of Unintended Events Reported at Ten Emergency Departments.**

Smits M, Groenewegen PP, Timmermans DRM, Van der Wal G, Wagner C.

BMC Emerg Med. 2009(Sep 18); 9(16).

Available at: <http://www.biomedcentral.com/1471-227X/9/16>

*This study sought to describe the types and causes of actual and potential patient safety events in the emergency departments of ten hospitals in the Netherlands. Study data were obtained through self-report by staff at participating hospitals, who were asked to report over an 8- to 14-week period any inadvertent event that threatened patient safety, whether or not harm actually occurred. The authors present descriptive findings from their analysis of 522 reported events and discuss implications for practice and for further research. Four tables and two figures are included.*

**20. Variation in Hospital Mortality Associated with Inpatient Surgery.**

Ghaferi AA, Birkmeyer JD, Dimick JB.

N Engl J Med. 2009(Oct 1); 361(14):1368–1375.

*This study examined the incidence and correlates of hospital mortality in a large sample of US hospital patients. Using data from the American College of Surgeons National Surgical Quality Improvement Program on 84,730 patients who underwent inpatient surgery between 2005 and 2007, the authors analyzed the relationships between risk-adjusted hospital mortality and rates of overall complications, major complications, and mortality in patients with major complications. They found that hospital mortality varied considerably, but that this variation was not attributable to differences in rates of overall or major surgical complications, which were similar across the hospitals examined. However, mortality among patients with major complications was notably higher at hospitals with high overall mortality than at those with low overall mortality, suggesting that hospitals' management of complications, rather than the occurrence of complications as such, might be the determining factor in post-surgical mortality. Three tables and one figure are included.*

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