Open School

Video Activity: Learning from Medical Errors (Part 1)
(http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Activities/PerspectivesTheMistakesPart1.aspx)

Lucian Leape, MD, Adjunct Professor of Health Policy at the Harvard School of Public Health; Kathy Duncan, RN, IHI faculty; Michael Leonard, MD, Physician Leader for Patient Safety, Kaiser Permanente

Facilitator Instructions

- Review the learning objectives and description with your group.
- Watch the video together (8 min 35 sec).
- Lead your group in a discussion using the questions below as a guide.
- Note: You can expand this activity by combining it with “Learning from Errors (Part 2), at http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Activities/PerspectivesTheMistakePart2.aspx.

Learning Objectives
At the end of this activity, you will be able to:

- Give examples of errors that clinicians have made in their patients’ care.
- Discuss the range of feelings providers can have in the aftermath of a medical error.
- List factors that contribute to errors in the medical setting.

Description
A patient suffers horrible burns. An operation takes twice as long as it should. A child dies from internal bleeding. Errors like these, unfortunately, still happen in health care.

What is one error that you’ve made? What did you learn from it? What can others learn from it? In this video, prominent clinicians describe the errors that still haunt them today — and point out ways those errors could have been prevented.

Related IHI Open School Online Courses
Key Topics
Adverse event, adverse drug event (ade), redesign processes and systems, transparency, culture of safety.

**Facilitator**, show the video on this page then lead your group in a discussion, using the questions below as a guide. Feel free to adjust these questions and/or add your own.

**Discussion Questions**

1. What is an error you (or someone you know) made in a health care setting? What did you learn from it? How might it have been prevented? (If you can’t think of a medical error you’ve experienced, talk about any significant error you’ve made in your life.)

2. Lucian Leape’s story centers around a decision that was based on unambiguous findings in the medical literature. Was his error truly an error, then? Why or why not? To help in your discussion, you can refer to **PS 100: Introduction to Patient Safety, Lesson 2: Understanding Unsafe Acts**, which defines different types of errors.

3. Kathy Duncan says competent care providers often get flustered during emergencies and don’t take basic safety measures. Imagine you’re the CEO of the hospital where Duncan’s error (burning a patient with an unpadded defibrillator) occurred. What might you do to ensure no one in your hospital would ever make this mistake again?

4. In his story, Michael Leonard talked openly with his patient’s wife about the error in her husband’s care. If you were a member of that patient’s family, how would you have reacted to the information? Would you want your loved one to continue to receive care at that facility? What would be your primary concerns in the aftermath of the error?