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PROFESSION

Chicago doctors to spread system of reporting, reducing medical errors

A $3 million federal grant will test whether the University of Illinois Medical Center's "seven pillars" model can work at other hospitals.

By KEVIN B. O'REILLY, amednews staff. *Posted Oct. 6, 2010.*

Chicago -- Physician leaders at the University of Illinois Medical Center in Chicago are combining federally funded research and Hollywood-style communication to spread their approach to disclosing and reducing medical errors.

A three-year, $3 million Agency for Healthcare Research and Quality demonstration grant will help evaluate whether the center's "seven pillars" model of identifying, investigating and disclosing medical errors -- and compensating patients and families when appropriate -- can work at other hospitals, said David Mayer, MD, co-executive director of the University of Illinois at Chicago Institute for Patient Safety Excellence.

"In 56 cases of clear harm we've identified, 55 were settled out of court," Dr. Mayer told a gathering of the Assn. of Healthcare Journalists' Chicago chapter in September. "We think that's really great. Now we want to take what we've been doing for the last few years and try to roll it out to nine other hospitals in the Chicago area."

The project is one of 20 demonstration and planning grants totaling $25 million that AHRQ announced in June as part of the Dept. of Health and Human Services' Patient Safety and Medical Liability Initiative.

Dr. Mayer and his colleague, Timothy McDonald, MD, associate chief medical officer at the medical center, will examine how hospitals implementing the UIC approach fare on the number and severity of medical claims, overall compensation costs and medical-error reductions. The project will start at five hospitals, then expand to four others after 18 months. Initial results should be ready for publication within two years, Dr. Mayer said.

Going to the movies

In the meantime, Drs. Mayer and McDonald have dug into their own pockets to spread their patient safety message, spending $100,000 to fund an educational documentary on how medical errors happen and the toll they take on patients and families.

Dr. Mayer showed segments of the first of a planned multipart documentary series called "The Faces of Medical Error ... From Tears to Transparency." The 50-minute film tells the story of Lewis Blackman, 15, who died in 2000 at a South Carolina hospital after undergoing elective surgery.

Medical residents missed signs that a painkiller Blackman was given caused massive internal bleeding. The documentary features interviews with Blackman's mother, Helen Haskell, and examines the diagnostic errors and systemic factors that contributed to the teen's preventable death.

A second film, "The Story of Michael Skolnik," is set for DVD release on Nov. 1. Trailers for the movies are available on YouTube (**www.youtube.com/user/TransparentHealth**).

The documentaries are intended for "everyone from health science students all the way up to the C-suite," Dr. Mayer said.

"I've always been impressed with how Hollywood takes a scene and connects the gut, the heart and the mind," he said. "The best way to do this, we thought, is to take these patients' stories and put them into an educational narrative so you move away with emotion after seeing it."

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