

## AMSA Patient Safety and Quality Symposium

On September 7-8, 2012, the American Medical Student Association (AMSA) hosted a Patient Safety and Quality Symposium (PSQS) at the Jefferson School of Population Health (JSPH). Organized in partnership with the National Patient Safety Foundation (NPSF) and JSPH, and funded through a grant from the Agency for Healthcare Research and Quality (AHRQ), the nearly two-day event brought together students, residents, and some of the most prominent leaders in patient safety and health quality.

In 1999, the Institute of Medicine report *To Err is Human* estimated that there were between 44,000 and 98,000 preventable deaths in the U.S. each year.<sup>1</sup> The World Health Organization has also estimated that in developed countries, serious preventable adverse events occur in one out of every ten patient hospitalizations.<sup>2</sup> These alarming statistics have spurred efforts over the past several years to improve patient safety. In 2010, the Lucian Leape Institute at the National Patient Safety Foundation published *UNMET NEEDS: Teaching Physicians to Provide Safe Patient Care*. This white paper identifies a series of high-level recommendations needed to reform medical education and educate clinicians-in-training about providing safe, effective care.

This is the third year that JSPH has partnered with AMSA to respond to the call of *UNMET NEEDS*, having hosted two of the past three AMSA Patient Safety and Quality Leadership Institutes. Besides increasing awareness of the white paper report, the key objectives of the conference were to improve the knowledge, skills, and attitudes among physicians-in-training, medical schools, and teaching hospitals about patient safety; to bring the participants together in order to discuss safe patient care, and to develop actionable steps for how to improve it.



*Lucian Leape, MD, renowned expert on safety and quality speaks to attendees at the American Student Medical Association Patient Safety Symposium.*

Over 50 students and practitioners from a variety of disciplines, including medicine, public health, and pharmacy, gathered for the two-day event. On the first day, they heard from the leaders in the field of patient safety. Carolyn Clancy, MD, the Director of AHRQ, discussed the strategic goals of the government agency, particularly to improve the quality, safety, efficiency, and effectiveness of the health care system. Dr. Clancy highlighted some of the AHRQ projects related to patient safety, such as the AHRQ Patient Safety Network, the Patient Safety Culture

Surveys, Team STEPPS, Project RED, MATCH for medication reconciliation, and reducing Healthcare Associated Infections (HAIs), among others. Resources for each of these initiatives can be found on the AHRQ website at [www.ahrq.gov](http://www.ahrq.gov).

Diane Pinakiewicz, MBA, CPPS, the President of the NSPF, shared some of the work the foundation has done in the patient safety movement, particularly with the Lucian Leape Institute. Lucian Leape, MD, Adjunct Professor of Health Policy at the Harvard School of Public

Health, noted challenges when facing disruptive behavior from a health care provider, and how an individual's attitude can also be a threat to patient safety.

Other speakers included Tim McDonald, MD, JD, the Chief Safety and Risk Officer at the University of Illinois at Chicago, who discussed the work he is pioneering at UIC. The Seven Pillars Project, which is supported by AHRQ, is a comprehensive response to examining patient incidents when they do occur. David Mayer, MD, the Vice President of Quality and Safety at MedStar Health, Jennifer Myers, MD, the Director of Quality and Safety Education at University of Pennsylvania, and JSPH's Dr. James Pelegano and Dr. David Nash discussed a wide range of topics, from creating a culture of safety to practicing safe transitions of care.

The second portion of the event allowed attendees to work in small groups and discuss challenging issues in patient safety and health quality, such as the culture of medicine, curriculum, institutional capacity, and leveraging change. They then identified concrete, actionable steps to overcome some of these obstacles. After sharing these ideas with the rest of the group, students were equipped with strategies to promote patient safety at their home institutions. Sonia Lazreg, an MD/MPH student at Mt. Sinai University and event organizer, stated "The symposium was successful in ways I did not expect. We were interested in getting trainees involved in the safety movement and their own education, and I've been overwhelmed by the work attendees are already putting into improving systems nationally and at their own institutions since the conclusion of the program."

The PSQS advanced the discussions around patient safety among students, health care providers, and national leaders. For the third year, it has built upon the *UNMET NEEDS* report to train the next generation health care providers to embark upon safe patient care practices. The PSQS will likely continue next year, and will again seek to empower students to strive for patient safety in all components of their educational and professional experiences. ■

---

**Preyanka Makadia**

*D.O. Candidate, Class of 2013  
Philadelphia College of Osteopathic  
Medicine  
Council of Student Members,  
American College of Physicians  
National DO Advisory Board Chair,  
American Medical Student Association  
preyankama@pcom.edu*

## REFERENCES

1. Kohn LT, Corrigan J, Donaldson M, (eds). *To Err Is Human: Building a Safer Health System*. Washington, D.C.: National Academy Press; 1999
2. Donaldson LJ, Fletcher MG. The WHO World Alliance for Patient Safety: towards the years of living less dangerously. *Med J Aust*. May 15 2006;184(10 Suppl):S69-72.