Book surveys patient safety from AP, CP standpoint

June 2017—*CAP Press released in May* Patient Safety in Anatomic & Clinical Pathology Laboratories. *Editor Deborah Sesok-Pizzini, MD, MBA, and 11 additional contributors cover handoff communications, technology, tools and methods, human factors, a patient safety curriculum, and more. For an excerpt on pathologist cognition, from the chapter "Diagnostic Errors and Cognitive Bias,"* click here*.*

Dr. Pizzini is chief of blood bank and transfusion medicine in, and vice-chief of, the Department of Pathology and Laboratory Medicine, Children's Hospital of Philadelphia. She is the department safety officer for CHOP Pathology and Laboratory Medicine, and she is a professor of clinical pathology and laboratory medicine, Perelman School of Medicine, University of Pennsylvania. We asked her about the new book. Here is what she told us.

This book is a first for CAP Press on patient safety. Why do you think there is a need for this book today?

We are fortunate that there is so much now in the lay press, medical literature, institutional reports, and regulations that really brings into focus the importance of patient safety and reducing medical and diagnostic errors. As pathologists, we are integral to patient care and as a discipline we can contribute significantly to preventing and reducing medical error. In my opinion, this book brings together some of the main concepts that are important for pathologists and other laboratory medical professionals to know in order to contribute to a high-reliability organization in their own laboratories at their own institutions. It also provides a framework for creating a culture of safety with the emphasis on minimizing patient harm while promoting effective teamwork, communication, systems thinking, and tools and methods for event analysis.

How did you decide what its 10 chapters should focus on?

The chapters focus on main concepts in patient safety literature that often relate across other medical disciplines as well. What is unique about this book is that we frame the concepts around pathology perspectives. For example, handoffs are important in any medical specialty. The chapter in this book ["Communication, Handoffs, and Transitions"] provides information on the importance of effective handoffs and the unique handoff chain in the pathology laboratory. Other examples are how cognitive bias especially relates to pathology diagnosis. The reader will learn about slow and fast thinking and how this may contribute to pathology diagnostic errors.

Other chapters focus on the culture and education of patient safety, tools for analysis, human factors that contribute to medical errors, technological strategies to reduce errors, and communication as it relates to teamwork and effective patient navigation.

For whom is the book most appropriate?

This book will be useful for pathologists in practice and in training and other laboratory medical professional personnel, including laboratory administrators, who want a basic understanding and more in-depth knowledge about patient safety as it relates to anatomic and clinical laboratories.

Would you like to say a few words about your 11 contributors?

This book is authored by many key thought leaders in pathology who have contributed to previous work in patient safety and quality. We were also able to work with pathology resident authors who contributed significantly to the chapter on communication, handoffs, and transitions as it relates to pathologists in training.

What two or three main messages do you hope your readers take away from the book?

I hope the readers of this book take away the message that patient safety is important and achievable in their practice. As we aspire to practice in a high-reliability organization, you can be the change that is needed to prevent diagnostic errors, facilitate improved teamwork for caring for patients across disciplines, and educate the next generation of pathologists and laboratory medical professionals to have a high acuity for reducing medical errors in anatomic and clinical pathology.

Can you tell us a little about your own chapter in the book on developing a patient safety curriculum for resident and fellow education?

The Accreditation Council for Graduate Medical Education requirements include patient safety milestones as part of the expectation for trainees prior to residency completion. There are many ways these milestones can be achieved including traditional classroom teaching, simulation training, and experiential opportunities during training. The importance of this chapter is to provide examples of a structured approach to meeting, reaching, and exceeding these milestones, emphasizing how important it is for the practicing pathologist and laboratory professional to be a role model for the behaviors and culture that support patient safety. This would include a culture that aspires to be transparent in reporting medical errors, in a nonpunitive environment, where the focus is on systems thinking and opportunities for learning.

What does the job of the department safety officer at Children's Hospital of Philadelphia entail? Is there a safety officer for each clinical department at CHOP?

Yes, there is currently a patient safety officer for each clinical department at CHOP. I am in the role of patient safety officer for my pathology department, and my responsibilities in that job are to provide leadership in this area in addition to supporting the larger hospital strategy to reduce medical errors with a zero tolerance for serious safety events. This involves leading initiatives to improve patient safety. As an example, we most recently completed a major institutional change to have the death packet for autopsy available online with electronic ordering of autopsies and body release. This project involved systems thinking throughout the hospital and early identification of potential failure modes that we addressed prior to implementation. Even in this example, patient error happens, because if the body is released before the autopsy or proper genetic tests are performed, the parents will be uninformed of results that may have an impact on future children. My own philosophy is to consistently think of ways to make a positive difference for patients and families, reduce the probability of medical errors occurring, and work with the health care team with mutual collaboration and trust to make it happen.
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