Prevention Guidelines
Bad Process, Bad Outcome

Steven E. Nissen, MD

Thomas Jefferson, the third American President and author of the Declaration of Independence, famously opined, “Governments derive their just powers from the consent of the governed.” The principle underlying this simple statement is an essential component of any collection of rules that govern how individuals conform to behavioral standards. Clinical practice guidelines should explicitly or implicitly require for AHA to release untoward (false) required for One of the fully analyzed of JAMA Internal developed a calculator, designed Related article page 1964.
Summary: Minimizing The Effect of “Medical Errors”

- Admit that humans and their work product are inherently imperfect and subject to failure in judgment and action.
- Systematize all critical activities into best practices/evidence-based clinical pathways.
- Build fault tolerance into all clinical pathways.
Summary: Minimizing The Effect of “Medical Errors”

- Take systems approach to error management. Sentinel events. Root cause analysis.
- Employ automated decision support wherever possible.
- Avoid the term “medical error” for individual performance, and instead utilize the concept of clinical pathway compliance.
“...the definition of quality may be almost anything anyone wishes it to be, although it is, ordinarily, a reflection of values and goals current in the medical care system and in the larger society of which it is a part.”

Avedis Donabedian, 2005
"A fundamental principle of industrial quality control is the recognition, analysis, and elimination of variation."

In an effort to provide health care of optimal quality, providers traditionally assess or measure performance where performance improvement may not be inherent in the system. A broad enough fundamental approach to analyzing, analyzing, and eliminating variation in processes, including outcomes and techniques, may well make important advances in the health care profession through the application of these principles and techniques.

Glenn Laffel, MD, David Blumenthal, MD

(JAMA. 1989;262:2869-2873)
Walter Shewhart
(1891-1967)
Plan-Do-Check-Act
Walter Shewhart: Statistical Process Control