Medication Errors.

Cohen M, editor. American Pharmaceutical Association, Washington, DC, 1999.
Hardcover, 356 pages. US$70.00.

This book, edited the president of the Institute for Safe Medication Practices, summarizes years of experience relating to the detection and prevention of medication errors. The book explains why such errors occur and outlines strategies for preventing or reducing their occurrence. The book also explores human factors involved in medication errors, describes a system approach to analyzing errors, and discusses the culture in health-care environments that deal with errors. Various suggestions are made throughout the book for implementing mechanisms to ensure that system precautions are put in place.

The book consists of 20 chapters in 5 parts. The chapters are written by experts on the subject. Part I outlines the causes of medication errors. Part II discusses the human perspective of the problem. Part III

highlights prevention strategies related to prescribing, dispensing, and labelling, as well as the patient's role in preventing or reducing medication errors. Part IV discusses medication errors related to specific disease conditions, such as chemotherapy, pediatric drug therapy, and immunological products. Part V reviews medication error reporting systems and the roles of risk management and risk analysis.

There is minimal information relating to medication errors in ambulatory care settings. However, many of the principles concerning how errors occur, the associated human error factors, and the strategies for implementing system improvements to prevent errors and thereby maximize patient safety, as raised in this book, are also applicable to ambulatory settings.

The availability of this book is both timely and significant for hospital pharmacy. At a time when many health-care professionals, including pharmacists, nurses, and physicians, are showing growing interest in patient safety issues, this book will not only be an excellent source of information, but will also provide a road map for improving safe medication practices in various health-care settings.

To summarize, I consider *Medication Errors* a "must" textbook reference for both health-care management and professional staff who are providing patient care. I would also strongly recommend this book as a reference for senior management and risk management personnel in hospitals and other institutional facilities. To effect culture change and to foster a commitment to embark on the mission of reducing medication errors, the impetus has to come from all levels.

David U, BScPhm, MScPhm
Pharmacy Manager
Centre for Addiction and Mental Health
Queen Street Site
Toronto, Ontario