HUNTINGDON VALLEY, Pa., SOLANA BEACH, Calif. & ATLANTA--(BUSINESS WIRE)--Dec. 9, 2002--On Dec. 9, 1997, "Beyond Blame" premiered in Atlanta. "The documentary drew national attention to the problem of medication errors," says Institute for Safe Medication Practices President Michael R. Cohen, RPh, MS, DSc, FASHP. "Two years later, the Institute of Medicine reported that thousands of hospital patients experience the often tragic results of medication errors similar to those the film details. An estimated 7,000 of these are fatal."

Today, Beyond Blame producer Bridge Medical officially donated exclusive Beyond Blame distribution rights, and all ensuing video revenues, to the Institute, notes Cohen. "Judging by its continued popularity, Beyond Blame's educational mission is far from complete," explains Bridge President and CEO John B. Grotting. "Giving Beyond Blame to ISMP ensures the broadest possible dissemination of its key messages, supports ISMP's mission of promoting medication safety and allows Bridge to focus its full attention on MedPoint." The bedside barcoding system prevents medication errors similar to those detailed in the documentary.

The ten-minute film premiered at Atlanta's historic Fox Theater during the 1997 Midyear Clinical Meeting of the American Society of Health-System Pharmacists. Since then, it has been distributed by the American Hospital Association to all its members and used by Department of Veterans Affairs hospitals in new employee training. An estimated 15,000 copies have been distributed in total.

Notes Cohen: "Bridge received the 1998 ISMP Cheers Award for Beyond Blame's role in raising awareness of the system flaws behind most medication errors. Today, ASHP members are back in Atlanta for the 2002 Midyear Meeting (the conference officially opened Sunday at the Georgia World Congress Center) and Beyond Blame is still a powerful force for changing behavior." Beyond Blame's case histories of a pharmacist, a nurse, and a physician -- each of whom has been involved in a fatal medication error -- demonstrate the impact of medication errors on clinicians and patients. Last New Year's Day, Dateline NBC focused on Ben who died because of a simple error -- pouring the right medication into the wrong container. Beyond Blame had told
the 7-year-old hospital patient's story many years earlier. "The badly designed system in their operating room," reported NBC Correspondent John Hockenberry, "had allowed good people to do something terribly wrong."

"Beyond Blame demonstrates the courage and wisdom exhibited by the Stuart, Fla., hospital where Ben had his ear surgery," says Cohen, a former hospital pharmacist. "Hospitals like Martin Memorial have decided to help families heal by admitting their mistakes and making a fair settlement that recognizes the family's loss. They analyze the error, correct its root cause(s) and move on. Beyond Blame's message is simple: Why waste energy blaming 'bad' individuals? Fixing the 'bad' systems that breed errors is so much more productive. "ISMP and Beyond Blame are essentially saying the same thing: sharing your experience will help others learn from past mistakes. Both strive to draw attention to a serious public safety issue, and focus on solutions not blame."

About ISMP
Headquartered in Huntingdon Valley, Pa., the Institute for Safe Medication Practices works closely with healthcare practitioners and institutions, regulatory agencies, professional organizations and the pharmaceutical industry to provide education about adverse drug events (ADEs) and their prevention. The nonprofit organization provides an independent review of medication errors voluntarily submitted by practitioners to a national Medication Errors Reporting Program (link to http://www.usp.org/frameset.htm?http://www.usp.org/reporting) operated by the U.S. Pharmacopeia. USP shares information derived from MERP reports with the FDA (link to http://www.fda.gov) and pertinent pharmaceutical manufacturers. An FDA MEDWATCH partner, ISMP regularly communicates with the FDA to help prevent medication errors and encourages error reporting to MEDWATCH. The biweekly ISMP Medication Safety Alert! provides vital information about medication and device errors, and ADEs, to more than 560,000 U.S. health professionals -- as well as regulatory agencies and others in 30 foreign countries. ISMP also sends urgent advisories about serious errors or information requiring immediate attention. A national advisory board assists the Institute in helping to promote the safe use of medications through its advocacy of improvements in drug distribution, naming, packaging, labeling and delivery system design. Order Beyond Blame on videocassette at http://www.ismp.org/Pages/videoorder3.asp or at ASHP Booth #755. All proceeds benefit ISMP medication safety activities.