

**STATE COMMISSION ON PATIENT SAFETY
ROUND ONE RECOMMENDATIONS
May 12, 2005**

Category B: Identifying and Learning from Errors

Code 26 (PeerProtect) - Peer Protection: The submitted testimony recommends: The development of an environment that provides legal protection for health care organizations and clinical practitioners when using data for improvement of patient safety practices.

Recommendation #B1¹

The State of Michigan should provide statutory protection for patient safety activities to encourage healthcare organizations and professionals to report information and to facilitate the development of a state-wide medico-legal environment that supports a learning versus a punitive approach to healthcare errors, adverse events, and near misses.^{2 3 4 5 6 7 8 9 10 11}

In particular, the Michigan state legislature should:

Recommendation # B1.a¹² Establish that all records, data, and knowledge collected for or by individuals or committees for patient safety improvement purposes in all healthcare settings are confidential and privileged information.^{13 14}
^{15 16 17 18 19 20}

Michigan health professional societies should:

Recommendation # B1.b²¹ Provide advocacy and lobbying efforts to achieve the necessary tort reform and liability protection within the healthcare industry to support patient safety improvement efforts.²²

Purchasers of health care should:

Recommendation # B1.c²³ Proactively help healthcare providers protect the confidentiality of any information disclosed to them for the purpose of improving patient safety through learning from sharing process of care information.²⁴

The Michigan Department of Community Health should:

Recommendation # B1.d^{25 26} Ensure that all healthcare employees are advised that MCL 333.20180(1) – (7) provides additional protection against retaliation by employers (beyond the Michigan Whistleblowers' Protection act) for hospital employees who report an unsafe practice or condition.²⁷

Rationale:

To improve patient safety, a clear picture of what is happening needs to be developed so that appropriate steps can be taken to prevent healthcare errors. In order to have an accurate picture of what is happening, data that are as complete as possible about errors, adverse events, and near misses need to be collected and analyzed. To collect complete data, everyone associated with the delivery of health care must be willing to

**STATE COMMISSION ON PATIENT SAFETY
ROUND ONE RECOMMENDATIONS
May 12, 2005**

report errors, adverse events, and near misses. People will do this only if they feel safe from legal and professional repercussions either within their own work setting or in the greater community.²⁸ This means that patient safety data must be protected from unintended uses and that healthcare practitioners and others working in the health care arena who, in good faith, report conditions, or events that jeopardize patient safety must be protected from blame and disciplinary actions. To guarantee the protections necessary to achieve the culture change where “the first response is not to assign blame, censure, or sue but to look at how and why an error occurred and take steps to avoid the error in the future”²⁹, it is critical that statutory protection for patient safety activities be secured.³⁰

Evidence and/or information on comparable initiatives being carried out in other states:

National level efforts related to protection of data:

IOM: Recommendation 6.1 of The IOM’s “To Err is Human” report in 2000, stated: Congress should pass legislation to extend peer review protections to data related to patient safety and quality improvement that are collected and analyzed by health care organizations for internal use or shared with others solely for purposes of improving safety and quality.³¹

Federal legislation: A Senate bill is under consideration to specifically protect patient safety data. If S.544 is enacted as it stands today, it would amend the Public Health Service Act to designate patient safety data as privileged and confidential while permitting certain disclosures of such data by a provider or PSO, including: 1) voluntary disclosures of non-identifiable data; 2) disclosures of data containing evidence of a wanton and criminal act to directly harm the patient; 3) disclosures necessary to carry out PSO or research activities; and 4) voluntary disclosures for public health surveillance. It would prohibit an accrediting body from 1) taking any accrediting action against a provider based on the provider’s good faith participation in collecting, developing, reporting, or maintaining patient safety data; or 2) requiring a provider to reveal its communications with any PSO. It prevents a provider from taking an adverse employment action against an individual based upon the good faith reporting of information. If passed as it stands, this would preempt state laws that govern disclosure of information provided to patient safety organizations. The bill has been read twice, referred to the Committee on Health, Education, Labor and Pensions which ordered it to be reported without amendment favorably on March 9, 2005.³²

Veteran’s Administration: End note 5 presents evidence offered during Michigan’s patient safety public hearing process regarding the experience of the Veteran’s Administration since implementing its nationwide internal and external reporting systems based on confidentiality protections. The VA and the National Aeronautics and Space Administration (NASA) together developed an independent and external reporting system (PSRS – Patient Safety Reporting System) to be complimentary to the

**STATE COMMISSION ON PATIENT SAFETY
ROUND ONE RECOMMENDATIONS
May 12, 2005**

VA's internal reporting system. The guiding principles of PSRS are voluntary participation, confidentiality of information submitted, and non-punitive reporting. "When individuals feel uncomfortable reporting to the internal systems, they have a safety valve they can use – PSRS," Dr. James Bagian, Director of the VA National Center for Patient Safety. Reports submitted to PSRS are confidential and privileged quality assurance documents protected under provisions of 38 USC 5705.³³

NASA Aviation Safety Reporting System: Linda Connell, Director NASA Aviation Safety Reporting System, summarized *why confidential reporting works* in five points:³⁴

- When organizations want to learn more about the occurrence of events, the best approach is simply to ask those involved.
- People are generally willing to share their knowledge if they are assured:
 - Their identities will remain protected
 - There is [sic] no disciplinary or legal consequences
- A properly constructed confidential, voluntary, non-punitive reporting system can be used by any person to safely share information.
- Confidential reporting systems have the means to answer the question why – why a system failed, why a human erred.
- Incident/event data is complementary to the data gathered by other monitoring systems.

State level efforts related to protection of data:

National Academy for State Health Policy: The National Academy for State Health Policy published a number of reports in the early 2000s which address protection and disclosure of data related to medical errors and related issues. On the state-level, the issue of patient safety data protection has to be considered in the context of medical malpractice concerns.

A report on NASHP's 2000 survey of states regarding activities related to the reporting of medical error and adverse events noted that 15 states required mandatory reporting from general and acute care hospitals of adverse events (as defined by the IOM or by the state in a way that encompassed part of all of the IOM definition). Most of these states indicated that they protect at least some reports from legal discovery. However, states varied in the types of information and reports that were protected. Five states protect the data from Freedom of Information Act requests. Seven states protected access to person-level reports; this was the most frequent method of protecting reports. Five states provided a promise of confidentiality, the second most frequent response. Various other methods of protecting data included removing certain identifying information, anonymous reporting, and destroying reports once data is extracted. State cited under-reporting and inadequate resources as the two greatest concerns with their reporting systems.³⁵

In a 2003 report, 21 states were noted as having mandatory reporting systems. Release of adverse event and medical error data to the public was sporadic and inconsistent.

**STATE COMMISSION ON PATIENT SAFETY
ROUND ONE RECOMMENDATIONS
May 12, 2005**

Some states were prohibited from releasing certain data by statute. Some can release certain data but do not do so because of concerns about completeness, reliability, and/or misinterpretation. Some do not release data to alleviate hospitals' and practitioners' fears that reporting and public disclosure of error information will lead to increased claims of medical malpractice. Key findings of this report included:³⁶

- There is no evidence to show what level of data disclosure advances the patient safety agenda. More research is needed to guide state officials in making informed decisions.
- Under reporting is a serious issue.
- Reasons for under reporting are numerous and include facilities' lack of internal systems to identify events, uncertainty about reporting requirements, a culture of non-reporting, a lack of enforcement at the state level, bureaucratic burden, competition and market share, fear of publicity, and fear of liability. It was specifically noted that *"It is simplistic to assume reporting would increase if data were protected; however, some degree of protection may be necessary to create an environment conducive to reporting."* P. 31
- The trend among states introducing new mandatory systems is to: a) establish them in statute (versus regulation), b) offer strong comprehensive protection of reported data, and c) release data only in aggregate form.
- Some states do not make data easily accessible to the public. It may be provided on a request only basis and requesting it may require an intricate understanding of how and where to request the information. The data may be provided in a raw form without any accompanying analysis to assist with interpretation.

The patient safety centers in existence when the Flood Tide Forum completed its report did not handle mandatory reporting systems for patient safety data. Five of six (FL, MD, MA, NY, and PA) housed mandatory systems for reporting serious adverse events separately within state regulatory agencies. Oregon has no mandatory reporting system and the Oregon Patient Safety Commission will be creating a voluntary reporting system for serious adverse events as part of its mission. Table 10 reproduced in the end notes describes the reporting system within each of the six patient safety centers and how protected.³⁷

Pennsylvania: Pennsylvania has attempted to address the inevitably intertwined issues of medical malpractice and patient safety through a comprehensive legislative initiative that combines tort and insurance reforms with patient safety initiatives and reporting requirements. This statute includes a provision for a discount in medical malpractice liability insurance premiums for facilities that can demonstrate a reduction in serious events following the adoption of recommendations made by the state's patient safety center. There is a detailed protocol for the initiative that involves two state regulatory agencies (Departments of Health and Insurance).^{38 39}

**STATE COMMISSION ON PATIENT SAFETY
ROUND ONE RECOMMENDATIONS
May 12, 2005**

Missouri: In its July 2004 report to the governor, Missouri's Commission on Patient Safety recommended: Missouri should provide statutory protection for patient safety activities to encourage healthcare organizations and professionals to voluntarily report information and participate in the peer review / quality improvement process. It also consciously decided to not submit draft language on statutory changes but recommended that the legislature:

- Create protections for information shared among healthcare organizations and professionals that is designed solely for improving patient safety and healthcare delivery systems. (This allowed the legislature flexibility to choose whether to expand peer review protections to cover patient safety or create new statutes that relate only to internal patient safety activities. Creating separate statutes would leave intact current case law on peer review and remove patient safety from the disciplinary process, although the two functions will often overlap.)
- Expand the qualifications of members on peer review/patient safety committees to allow full participation by licensed healthcare professionals not listed in the statute, non-licensed professionals like risk managers and other employees who play key roles in safety improvements.
- Eliminate cumbersome requirements for appointing peer review committees.
- Protect patient safety data, documents and information reported to the Missouri Center for Patient Safety from use in civil, judicial and administrative proceedings.
- Protect the job status of healthcare professionals and organization employees from reprisal for reporting errors internally and to the Missouri Center for Patient Safety.⁴⁰

Michigan: Information on the current statutes in Michigan as regards peer review protections and whistleblower protections is included in endnotes 12 and 25 attached to recommendations B1.a and B1.d. Time constraints did not allow exploration of "in-the-field" peer review issues in Michigan that could be related to protection of patient safety data and the staff reporting and analyzing it. It may be important to do so.

Some general guidelines for developing comprehensive protection of data as an integral part of system-authorizing statutes

NASHP counsels that protections in statute and an integral part of the reporting system will likely provide the most reliable protection. They note that, "Ideally, protection provisions would be sufficient to allay fears of those reporting events that the adverse event information would be used against them, while enabling states to achieve some goals of the reporting system: to spot trends, enhance patient safety through the identification and correction of practices that result in errors or adverse events, provide valuable information to those conducting research on patient safety and evaluation of reporting systems, and inform consumers generally about the safety of their health care system. Thus, while the statutory provisions should be comprehensive and protect data from compulsory disclosure, they should also be explicit about exceptions and allowable uses of the data."⁴¹

**STATE COMMISSION ON PATIENT SAFETY
ROUND ONE RECOMMENDATIONS
May 12, 2005**

There is yet another NASHP publication that may be important to review that was not available as the above was being completed: *State-based mandatory reporting of medical errors: An analysis of the legal and policy issues.*

Pros: ⁴²

- Increased reporting would place the state and individual organizations in a better position to make needed changes in the health care system overall and their own systems to enhance patient safety and provide useful information to the public.
- As providers get valuable feedback from reporting systems and see favorable results, reluctance and fear of reporting may decrease.
- The time may be right to address the adversarial medico-legal environment of health care.
- Federal legislation may assist the process of protecting patient safety information and activities.

Barriers:

- Malpractice concerns of health care practitioners and facilities
- Adversarial orientation of practitioner and facilities to acknowledgement of medical errors that colors many views of peer review
- Under-reporting of medical errors, adverse events, and near misses that stands in the way of showing how data could be used for system improvement relative to patient safety
- Lack of a system orientation to practice of health care delivery
- States need resources to improve their systems in order to meet public expectations of a patient safety system. While the IOM recommended that funds be provided to states to create reporting systems, funds are not now available. In some states data that would otherwise have been analyzed and released to the public have not been because of a lack of resources. In other states, reporting systems have been established by law but are not operating due to lack of funds.⁴³

Additional Comment/Concerns:

- It may be simplistic to assume that reporting will increase if data is protected.
- Statutory provisions, especially with powerful stakeholders, are difficult to repeal. Need to link such to evaluation of the strategies and to a sunset date if not proved to be effective in meeting the goal.
- Federal legislation may trump state efforts.
- A state-level institutional focus could be a good idea for study of what will best meet Michigan's needs around protecting patient safety data and those who report it, collect it, analyze it, and disseminate the findings.

**STATE COMMISSION ON PATIENT SAFETY
ROUND ONE RECOMMENDATIONS
May 12, 2005**

Implementation Steps:

- Develop consensus among major health care players in Michigan regarding what the objectives of a legal framework for patient safety would be and how it would interface with peer review
- Identify a state-level institutional focus to study the issues around protecting patient safety data and the people who interface with the data and make specific recommendations for solving the issues

Cost: TBD

Implementation Target Date: TBD

Grade: TBD

Endnotes

¹ Compiled from 9 of 19 recommendations (from 8 informants) coded 26 (PeerProtect) or 15 (Collaboration) plus evidence provided by one informant.

² Recommendation – Testimony source 213-W (health care provider) “I will argue in my testimony that developing a “culture of safety” in hospitals, state regulatory agencies, third-party payers, and our legal system can help to reduce medical errors better in the long term, ... [W 8-10] I can make some recommendations, based on my personal experiences. [W 136-137] 5. In the near future, we will be implementing a recognition program to encourage reporting of errors. Only if people feel safe to report, can we identify issues that may be occurring system-wide, and approach it from that standpoint. Changes need to be made in our legal and licensing systems, so that healthcare providers are held accountable, but not punished unless there is criminal activity or gross negligence. [W 168-174] [I]n order to improve patient safety, we need to promote an environment where healthcare providers feel safe to report actual errors, whether or not harm is caused to patients, in addition to “near misses,” where an error is prevented from reaching the patient.. We need to promote an environment in which the first response is not to assign blame, censure, or sue, but to look at how and why an error occurred, and take steps to avoid the error in the future.” [W 128-133]

³ Recommendation – Testimony source 103-O (hospital) “It’s absolutely essential that when these events [clinical errors] occur people are comfortable to report them openly, to participate in very detailed in-depth root cause analysis of the underlying reasons for the event. I would like to suggest as one part of this that the medical-legal climate is a barrier to this open reporting and would urge that [medical-legal climate] to be one focus of many.” [O 38-46]

⁴ Recommendation – Testimony source 205-B (health care provider) “Recommend that the state legislature pass legislation that will establish a privilege of confidentiality for all reported patient safety information (e.g., Oregon) [W 163-165]. To achieve that goal [to prevent harm to patients and not to prevent human error], there must be uniform, unambiguous, and assured confidentiality of patient safety information.” [W 179-180]

**STATE COMMISSION ON PATIENT SAFETY
ROUND ONE RECOMMENDATIONS
May 12, 2005**

⁵ Evidence – Testimony source 205-B (health care provider) “Experience of VA noted regarding its nationwide internal and external reporting systems based on confidentiality protections [W63-80]. Specifically noted was that since initial implementation of the program in 1999, the rate of reporting patient safety information increased 30-fold, which has sustained that level of reporting to the present day [W77-80]. The importance of confidentiality in reporting is noted by comparing the number of reports filed within VA facilities vs. JCAHO [82-91] and the absolute number of Root Cause Analyses (4,500) and proactive risk analyses (300) 106-108]. ... while JCAHO’s system has been around since 1996, they’ve had 3,500 reports. I will contrast that to the VA, that we’ve had our system going since 1999. We have 140,000 reports, and yet we’re 4 percent of all the facilities in the United States. That’s a thousand-fold different in year. A thousand-fold different.” [O 692-704]

⁶ Recommendation – Testimony source 204-B (health care provider) “Sixth, re-design the professional peer review process to make it safe to conduct substantive review without casting aspersions.” [W 83-84]

⁷ Recommendation – Testimony source 608-W (insurer) “Patient Safety Legislation: The first step [to develop a voluntary system of reporting errors to a central repository [W40]] is for the State of Michigan to establish regulatory protection for reporting of medical errors for the purpose of improving patient safety on a statewide basis. This legislation should embrace all types of reporting, regardless of the cause or outcome.” [W149-53]

⁸ Recommendation – Testimony source 212-W (health care provider) “Mandatory, public reporting for the collection of standardized information about preventable adverse events is supported if legal protection is provided both to the organization and the provider(s).” [W119-121]

⁹ Recommendation – Testimony source 826-W (professional organization) “The MSA and the APSF also have serious concerns about the call to develop methods to identify and take action against “unsafe providers.” While we agree that methods should be investigated for assessing the performance ability and competence of health care providers, this is not a simple matter and will require considerable research.”

¹⁰ Recommendation – Testimony source 202-O (health care provider) “And also I think that the -- that the peer review process should be removed from the hospital where it occurs at. (O57-59). ...hospitals of similar size and of similar activity look at other hospitals of similar size and similar activity, peer review material, and judge them dispassionately and in an uninvolved fashion.[O60-63].

¹¹ Recommendation – Testimony 213-W (health care provider) “I will argue in my testimony that developing a “culture of safety” in hospitals, state regulatory agencies, third-party payers, and our legal system can help to reduce medical errors better in the long term, ... [W 8-10] I can make some recommendations, based on my personal experiences. [W 136-137]

6. St. John Health is implementing a training program for physicians about disclosure of unanticipated outcomes. We believe that full disclosure is the right thing. Partnering with our patients by fully disclosing errors, apologizing, offering fair compensation when appropriate, and sharing ways to improve processes so that the error will not occur again, should decrease the litigious environment in Michigan. The State Commission on Patient Safety should support changes to facilitate the changes in our legal and licensing systems. [W 175-183]

[I]n order to improve patient safety, we need to promote an environment where healthcare providers feel safe to report actual errors, whether or not harm is caused to patients, in addition to “near misses,” where an error is prevented from reaching the patient. We need to promote an environment in which the first response is not to assign blame, censure, or sue, but to look at how and why an error occurred, and take steps to avoid the error in the future. [W 128-133]”

¹² Compiled from 7 of 19 recommendations (from 7 informants) coded 26.00 (PeerProtect) or 15 (Collaboration) plus one report (see endnotes).

¹³ Recommendation wording started from the MI Public Health Code re peer review due to the stated desire of testimony recommendations to extend peer review protection to data related to patient safety leads here. Public Health Code 333.20175(8) “The records, data, and knowledge collected for or by individuals or committees assigned a professional review function in a health facility or agency, or an institution of higher education in this state that has colleges of osteopathic and human medicine, are confidential, shall be used only for the purposes provided in this article, are not public records, and are

**STATE COMMISSION ON PATIENT SAFETY
ROUND ONE RECOMMENDATIONS
May 12, 2005**

not subject to court subpoena.” Retrieved 5/2/05 from

<http://www.legislature.mi.gov/mileg.asp?page=getObject&objName=mcl-333-20175>

The statement re confidential and privileged information was added after reviewing Marchev, M. (December 2003). *Medical malpractice and medical error disclosure: Balancing facts and fears*. Portland, ME: National Academy for State Health Policy. Retrieved 5/1/05 from

http://www.nashp.org/Files/Medical_Malpractice_and_Medical_Error_Disclosure.pdf P.5 states “While offering protection to documents resulting from the peer review process, peer review protection is more vulnerable to requests for disclosure through the legal system. ... For these reasons none of the recently established reporting systems rely on existing peer review protections alone.”

Specific to the Michigan situation: Information from various sources appears to support the view that peer review protection may not be adequate for protecting patient safety information and all staff engaging in patient safety data collection and analysis activities, for example, 1) the Michigan Appellate Digest (12/6/02) regarding MCL 333.20175(8) “A statutory privilege should be narrowly construed consistent with its purpose.” Hospitals: “The purpose of the privilege granted to medical facility peer review records in the PHC is to assure that honest assessment and review of performance is undertaken by peer review committees.” Retrieved 5/2/05 from <http://courtofappeals.mijud.net/Digest/newHTML/22536321.htm> 2) DykemaGossett Health Law Developments – January 2005: [Based on *Feyz vs. Mercy Memorial Hospital*] The Michigan peer review statute protects only action taken by a person or committee that has been assigned a peer review function. [This] illustrates the benefits of listing in Medical Staff and Corporate Bylaws the various committees and individuals who are assigned a practice review function. Retrieved 5/2/05 from <http://www.dykema.com/healthcare/news/hlthlawdev0105.pdf> 3) Public Health Code 333.21513 - The owner, operator, and governing body of a hospital licensed under this article: (d) Shall assure that physicians and dentists admitted to practice in the hospital are organized into a medical staff to enable an effective review of the professional practices in the hospital for the purpose of reducing morbidity and mortality and improving the care provided in the hospital for patients. The review shall include the quality and necessity of the care provided and the preventability of complications and deaths occurring in the hospital.] Retrieved 5/3/05 from

<http://www.legislature.mi.gov/mileg.asp?page=getObject&objName=mcl-333-21513>

¹⁴ Recommendation – Testimony source 808-B (professional organization) “And a voluntary reporting system also that would complement the mandatory reporting system to identify errors. The information from the voluntary reporting system must be obtained by an independent entity and used to identify patterns of errors. The data collected related to patient and patient safety must be protected. [O 175-184] A clinical scientist and health services expert and experienced individual should be seated on the voluntary -- on this reporting committee. [O 189-191] Further recommendation to extend peer review protection to data related to patient safety and quality improvement gathered through voluntary reporting system.” [W 336-338]

¹⁵ Recommendation – Testimony source 826-W (professional organization) “We strongly endorse the recommendations for a voluntary reporting system and for enacting legislation, both nationally and at the state level, to extend peer review protection to data related to patient safety. The two must go hand in hand. [W 144-147]

¹⁶ Recommendation – Testimony source 302-B (educator) “We need to change the Public Health Code to assure that quality assurance (QA) activities undertaken in community pharmacy practice have the same protection from discovery as those done in hospitals. We also need legislative changes to permit creation of a peer review process designed to collect and analyze reports on medication errors that occur outside the institutional setting. [W 453-457, O 167-182] Under our current Public Health Code, those exist for medicine only, not for the other health professions, and we think pharmacy needs to be included in that. [O 182-185]

¹⁷ Recommendation – Testimony source 205-B (provider) See Endnote 14. [W 163-165; 179-180]

¹⁸ Recommendation – Testimony source 828-W (professional organization) “To foster continuous improvement in patient safety, legislation or public policy must create a “safe haven” for hospitals and

**STATE COMMISSION ON PATIENT SAFETY
ROUND ONE RECOMMENDATIONS
May 12, 2005**

hospital employees working toward improvement and protection against the use of information in legal proceedings. [W 98-101]

¹⁹ Recommendation – Testimony source 110-W (hospital) “Professional society improvement goals that will enhance healthcare organizations include: [W 102-121] Provide lobby efforts and advocacy for tort reform and liability protection within the healthcare industry to participate with the private/ public sector in patient safety efforts. [W 129-131] Professional groups need to play a strong role in tort reform and the application of peer protection for hospital participation within the current environment.” [W 103-104]

²⁰ Recommendation – Testimony source 608-W (insurer) See Endnote 7. [W 40; 149-153]

²¹ Compiled from 1 of 19 Recommendations coded 26.00 (PeerProtect) or 15 (Collaboration).

²² Recommendation – Testimony source 110-W (hospital) See Endnote 19 above. [W 102-121; 129-131; 103-104]

²³ Compiled from 1 of 19 Recommendations coded 26.00 (PeerProtect) or 15 (Collaboration).

²⁴ Recommendation – Testimony source 110-W (hospital) “There are several improvement goals the purchasers of care could focus on to assist the hospitals: [W 55-56] Provide a peer protection environment and process for disclosure requests of internal processes related to patient outcomes. (Much like the JCAHO process for sentinel events.) [W 60-62] We strongly encourage and believe in the promotion of a nonpunitive culture. The private sector can assist with this by promoting methods to peer protect disclosure of information that may be necessary for their use.” [W 45-48]

²⁵ Compiled from 1 of 19 Recommendations coded 26.00 (PeerProtect) or 15 (Collaboration).

²⁶ This recommendation originally requested enactment of specific whistleblower-type legislation to protect health care employees who report problems with provision of medical services during work stoppage situations. It appears that legislation passed in 2002 in addition to the Michigan Whistleblower’s Protection Act addresses the need but that health care workers may not know about this amendment to the Public Health Code which is why the recommendation is framed as it is here. Specifically, effective December 30, 2002, the Public Health Code (333.20180(1)-(7)) provides protection from retaliation against hospital employees who report an unsafe practice or condition. It states that a person employed by or under contract to a hospital shall not be discharged, threatened, or otherwise discriminated against by the hospital regarding that person’s compensation or the terms, conditions, location or privileges of that person’s employment if that person reports an unsafe practice or condition.

This protection is in addition to the protection for reporting a violation of the law under the WPA. If the unsafe practice or condition also violates the law, the person making the report will already be protected under the WPA and can follow the requirements for reporting the issue as noted above. If the unsafe practice or condition is not also a violation of law, the new amendment to the Public Health Code provides the protection for the person reporting the issue (note that the amendment does not define “unsafe practice or condition”). This distinction is important because there are some conditions that the hospital employee must follow in order to be entitled to the protection the new amendment provides.

Under the new amendment, the hospital employee must give written notice of the unsafe practice or condition to the hospital, and allow the hospital 60 days to address the matter. The hospital is required to provide a response in writing to the person who provided the written notice within the 60 day period. Once the 60 days have expired, the hospital employee may only report the unsafe practice or condition to the Department of Consumer and Industry Services if the employee has no reasonable expectation that the hospital has taken or would take timely action to address the issue. The hospital employee is protected from retaliation for reporting the issue both before and after the report is submitted to the DCIS, including the 60 day period. Therefore, the protection starts as soon as the hospital employee provides the written notice to the hospital.] Retrieved 5/3/05 from <http://www.minurses.org/Labor/handbook.shtml>

²⁷ Recommendation – Testimony source 404-B (consumer) “This written submission proposes that the State enact legislation and/or administrative regulations to protect the delivery of healthcare for the public during work stoppages at healthcare institutions. [W19-21] Such a legislative and/or regulatory scheme should focus on the period before a strike is initiated and the period during the strike. [W339-344]

b. Recommendations for State actions during a strike at a health care institution.

Once a strike has been commenced at a hospital, certain regulatory and/or legislative enactments are

**STATE COMMISSION ON PATIENT SAFETY
ROUND ONE RECOMMENDATIONS
May 12, 2005**

appropriate to assure the continued provision of quality and affordable health care: [W32-36]
Enact specific whistle blower type to protect health care employees who report problems with the provision of medical services. [W51-52; W384-385]

²⁸ Concern – Testimony source 608-W (insurer) “The fear of litigation is a limiting factor in the ability to aggregate and identify issues that have or could cause patient harm. If we (patient safety leaders) can timely identify errors and near misses we can prevent their recurrence through proactive patient safety approaches.” [W 154-157]

²⁹ Concern – Testimony source 213-W (health care provider) “We need to promote an environment in which the first response is not to assign blame, censure, or sue, but to look at how and why and [sic] an error occurred, and take steps to avoid the error in the future.” [W 131-133].

³⁰ Concern – Testimony source 212-W (health care provider) “Lack of patient safety legislation to provide such (legal) protection will be detrimental to the sharing of standardized information within and across health care organizations and/or between health care professionals.” [W 121-123]

³¹ Kohn, L. T., Corrigan, J. M., & Donaldson, M. S. (Eds). Committee on Quality of Health Care in American, Institute of Medicine. (2001). *To err is human: Building a safer health system*. Washington, D.C.: National Academies Press, 1999.

³² S544 Patient Safety and Quality Improvement Act of 2005

Retrieved 5/5/05 from <http://thomas.loc.gov/cgi-bin/bdquery/z?d109:SN00544:@@@D&summ2=m&>

³³ NCPS Tips – May/June 2002. Retrieved 5/3/05 from http://www.index.va.gov/search/va/va_search.jsp

³⁴ Connell, L. (2005, April 7). *Cross-industry application of an aviation model for confidential reporting*. Presented at the Michigan Health and Safety Coalition annual conference, Dearborn, MI. ASRS averages 2,900 reports per month with intake projected to exceed 34,000 in 2004. It has existed for 29 years, handled 640,000 reports, and never had a single breach of confidence.

³⁵ Rosenthal, J., Riley, T., & Booth, M. (2002). *State reporting of medical errors and adverse events: Results of a 50-state survey*. Retrieved 4/30/05 from

http://www.nashp.org/docdisp_page.cfm?LID=0560704C-4CAC-11D6-BCEE00A0CC558925

³⁶ Marchev, M., Rosenthal, J., & Booth, M. (October 2003). *How states report medical errors to the public: Issues and barriers*. Retrieved 4/30/05 from

http://www.nashp.org/Files/GNL52_medical_errors_reporting_for_the_web.pdf

³⁷ Rosenthal and Booth. P. 19

Table 10 Reporting system within the center

Florida	Confidential, voluntary reporting system for near misses.
Maryland	Confidential, voluntary reporting system for near misses and adverse events that do not cause harm.
Massachusetts	Is pursuing the possibility of a voluntary, confidential reporting system for near misses and complications in order to provide hospitals information to help in establishing best practices.
New York	Has legislative authority to implement a confidential, voluntary system but has not done so yet. Plans are under development for a <i>Hospital Report Card</i> .
Oregon	Confidential, voluntary system for serious adverse events
Pennsylvania	Mandatory, confidential web-based system for serious events, near misses, and infrastructure failures, with no identifiable patient or provider information. All licensed hospitals, birthing centers, and ambulatory surgical facilities are required to submit reports through a single portal. There is a statutory provision for submission of “anonymous reports” by health care workers who can demonstrate a facility’s failure to submit a required report. The reporting system automatically directs reports of serious events and incidents to the Patient Safety Authority and reports of serious events and infrastructure failures to the Department of Health. The system contains integral, facility-specific analytical and statistical tools for use by facilities to promote internal quality improvement and patient safety activities

**STATE COMMISSION ON PATIENT SAFETY
ROUND ONE RECOMMENDATIONS
May 12, 2005**

³⁸ Rosenthal, J. & Booth, M. (2004, October). *Flood Tide Forum: State patient safety centers: A new approach to promote patient safety*. Retrieved 3/28/05 from http://www.nashp.org/Files/final_web_report_11.01.04.pdf

³⁹ The medical malpractice issue is inevitably intertwined with the issue of patient safety data collection and reporting. Full and open disclosure of medical errors is seen as an essential step in addressing patient safety issues but conflicts among insurance companies, the medical profession, and trial lawyers often create a chilling effect on such efforts. Medical malpractice is not the same as medical error, yet the malpractice crisis has created an environment of distrust that spreads to include all efforts to improve patient safety. Doctors and hospitals resist reporting errors for fear of increased malpractice litigation.

A 2002 NASHP report presents the following points about the medical malpractice insurance crisis:

- The data are inconclusive regarding the causes of rapidly rising medical malpractice insurance premiums. While there are reported increases infrequency and severity of claims, the under-pricing of malpractice premiums throughout the 1990s, and a downturn in the stock market exacerbated by the 9/11 attacks are also to blame.
- The data are inconclusive regarding whether there has been an increase in medical malpractice claims greater than that which corresponds to population growth, an increase in the number of doctors and hospitals, or growth in technological advancements.
- Because of the reluctance to report errors, the data are inconclusive as to whether any increase in malpractice claims corresponds to an increase in incidence of medical malpractice or medical errors.
- The data are inconclusive regarding the efficacy of tort reform as a remedy for periodic malpractice insurance crises. Tort reform does not address the issue of patient safety.
- Medical errors are a serious and costly problem, killing between 44,000 and 98,000 people annually in the U.S. Total nation cost of medical errors is estimated to be between \$17 billion and \$29 billion annually.
- The great majority of patients injured by medical negligence do not file a malpractice claim and of those who do, only a third receive any compensation. (There is some feeling that litigation sometimes may simply be a symptom of distrust in an environment where all errors are kept secret.) Marchev, M. (2002, July). *The medical malpractice insurance crisis: Opportunity for state action*. Retrieved 4/30/05 from http://www.nashp.org/Files/gnl48_medical_malpractice.PDF

⁴⁰ Missouri Commission on Patient Safety. (2004, July). *Report presented to Governor Bob Holden*. Retrieved 4/13/05 from <http://insurance.mo.gov/aboutMD/issues/patsafety/PatientSafety.pdf>

⁴¹ Marchev, M. P. 9 provides a sample data protection statute.

⁴² Many of the pros and barriers were gleaned from Marchev.

⁴³ Markev, Rosenthal, & Booth