

23 DR. SIMMER: Thank you. We now welcome
24 participant number 18, Steven Winokur, M.D.

25 DR. WINOKUR: Thank you for the opportunity

1 to speak here today. I'm very enthusiastic about the
2 work that -- the endeavors that you are approaching
3 with respect to patient safety.

4 I am the Chief Patient Safety Officer at
5 Beaumont Hospital in Royal Oak, and we have worked and
6 continue to work very hard to provide the safest
7 possible care.

8 We've been recognized in some formal fashion
9 by both the American Hospital Association and the
10 Joint Commission for some of our efforts.

11 And I'd like to just share a few thoughts,
12 having some experience in the area, and it will be
13 somewhat redundant with some of the things that I've
14 heard here sitting in the audience the last half hour
15 or so.

16 The patient safety culture is I believe
17 fundamental to truly achieving the safe environment of
18 care. And there is a long tradition of punitive
19 response to clinical errors and adverse outcomes in
20 healthcare.

21 I think these issues have to be overcome by
22 leadership, by education, and by an infrastructure of
23 organizational policies that support a nonpunitive
24 reporting of errors.

25 Organizations absolutely must learn from

1 these events. These events are inevitable. Human
2 error is inevitable. And no system is going to be
3 absolutely perfect and eliminate entirely errors and
4 adverse events.

5 It's absolutely essential that when these
6 events occur people are comfortable to report them
7 openly, to participate in very detailed in-depth root

8 cause analysis of the underlying reasons for the
9 event.

10 I would like to suggest as one part of this
11 that the medical-legal climate is a barrier to this
12 open reporting and would urge that to be one focus of
13 many.

14 New and improved technologies absolutely have
15 to be part of the patient safety solution. My -- some
16 of the things that I'm most enthusiastic about in
17 terms of potential to reduce clinical errors would be
18 the electronic medical record and physician
19 computerized order entry for medications.

20 I think it's important to recognize that many
21 of these technologies are prohibitively costly. I
22 read just a few days ago an interview with David
23 Braylor [phonetic], the presidential appointee for
24 Health Information Technology nationally.

25 The interviewer made the point that in

139

1 Britain \$17 billion are being spent to network the
2 entire country in Britain, and relative to that we are
3 investing very modestly in the United States.

4 Any incentives or assistance that can be
5 provided to both healthcare organizations and
6 individual practitioners to implement these
7 technologies I think would be very valuable.

8 Just to study the events and come to
9 appropriate conclusions requires significant
10 resources, as well. There's always an immediate need
11 emotionally to do something after an adverse event,
12 but it requires a very sound understanding, a very
13 detailed root cause analysis of the true underlying
14 causes of any particular event, not only to involve
15 clinicians and people with a system mind,
16 particularly, but importantly to involve people with
17 formal training in biomedical engineering, human
18 factors analysis, sometimes even behavioral
19 psychology.

20 It's very unlikely, at least in my view, that

21 every organization could do this on their own. And I
22 would suggest as an analogy if each airline had to
23 develop their own National Transportation Safety Board
24 to study their close calls or accidents. That
25 certainly is not the way we do it. We have the

140

1 National Transportation Safety Board to primarily
2 study these events.

3 And perhaps something that the State could
4 assist with to develop some expertise, expertise to
5 help organizations study their events truly come to
6 appropriate conclusions and good solutions.

7 Similarly, so that each institution doesn't
8 have to reinvent the wheel, I think it's important to
9 develop a means where institutions can share their
10 solutions, share best practices.

11 I would suggest that the Michigan Hospital
12 Association has done some really outstanding work with
13 their Keystone ICU project to allow institutions to
14 collaborate together. And anything that can be done
15 through statewide efforts to encourage the sharing of
16 those practices I think would be very helpful.

17 My final comment is that other states have
18 done some very outstanding work. The State of
19 Missouri had public hearings I think similar to what
20 we are having here in Michigan. Wrote a very fine
21 report on their findings. Pennsylvania is doing some
22 very excellent work. And from what I understand,
23 they're doing some things I'm told with the Institute
24 for Safe Medication Practices to be able to share
25 their events with some knowledgeable group like that

141

1 and share in solution finding.

2 Those are some of my thoughts and some of my
3 comments. I see the stop sign.

4 DR. SIMMER: Yes?

5 MR. KELLY: Dr. Winokur, do you know of this
6 Missouri Health and Safety Coalition report? Have you

7 seen it or --

8 DR. WINOKUR: Yes, I've seen it and read it.

9 You know, it was about four to six months ago and I
10 can't recite it for you today. It was very well done.

11 MR. KELLY: Great. Thank you very much.

12 DR. WINOKUR: Thank you.