

16 Okay. Thanks again. We're happy to welcome
17 participant number 17, Dr. Lawrence Abramson.

18 DR. ABRAMSON: Thank you for allowing the
19 testimony today. Like the previous participant, I am
20 an osteopathic physician and also have a degree in
21 public health, which is part of what brings me here
22 today.

23 I also serve as the president elect of the
24 Oakland County Osteopathic Medical Association, and
25 I'm not here in that official capacity today but only

1 from the perspective that hopefully in a leadership
2 position I will be able to help implement some of the
3 things that may come from the Commission.

4 My focus today is a little bit different, I
5 think. I came a little bit late. It may be a little
6 bit different, but it reflects a little difference in
7 terms of most of the discussion today has been around
8 large systems, around hospitals, healthcare systems,
9 large professional organizations.

10 And one of the areas that concerns me is that
11 I don't hear a lot of discussion about what goes on in
12 the site where most of the care is actually being
13 provided. We know that patients who are in acute
14 situations, obviously they're going to be treated in a
15 hospital. But most of the care is actually rendered
16 in individual small practices, whether they are
17 physician offices, other types of mid-level
18 practitioners and that type.

19 And I haven't heard much discussion about how
20 we're going to engage those areas in patient safety.
21 I think it's one area that is probably grossly
22 overlooked at this time.

23 As I've been doing this work -- I've been
24 involved in healthcare quality improvement for 17, 18
25 years now -- what I notice is for the most part when

1 you get into the physician or the professional
2 community, there really is very little activity or
3 knowledge or really profound knowledge in terms of
4 what I've heard discussed today in terms of quality
5 improvement, but more particularly in terms of patient
6 safety issues.

7 Patient safety obviously has become an issue
8 in the recent years since the IOM report; however, I
9 don't think that it's really been taken in by those
10 individuals who are in small environments just trying
11 to get through their individual day.

12 As I've been thinking about this and how I
13 realize that this testimony was going to be available
14 the last couple days, so my statements are really not
15 that well prepared; one of the thoughts that comes to
16 mind, whether it would be talking about physicians,
17 pharmacists, or any other type of licensed individual
18 in the state of Michigan providing healthcare
19 services.

20 I would think that in terms of granting those
21 licenses, there should be some type of required safety
22 education, at least on an annual basis. This is
23 something which is present in a number of other states
24 that I'm aware of, and I think this would be something
25 that would be of benefit.

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1 But as I thought about this in terms of a
2 regulation or a licensing requirement, it also dawned
3 on me that I'm not sure that this is really being
4 provided in our professional schools.

5 Healthcare safety is not something which is
6 easily discussed. It's not even easily defined. We
7 have the same problem in quality in healthcare;
8 defining what it is. We know when it's not there but
9 we don't know what it really is. So I would think
10 that it would be advantageous, listening to folks from
11 the pharmacy before. It needs to be part of that
12 curriculum.

13 It's truly important to us. How are the

14 people that are going to be following me? I'm an old
15 guy now, folks, and the people that are following me,
16 I want them to think about me as a safe -- they should
17 keep me safe.

18 Looking at it from a different perspective,
19 as a physician I think about how we communicate not
20 only between physicians but how do we communicate with
21 our patients. And one of the other areas that I see
22 an opportunity for improving patient safety is
23 learning how to communicate with our patients.
24 Learning how to talk to them in language they
25 understand so that when we get done giving them

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1 instruction, whether it's about their medication or
2 how to change a lifestyle, that it's in language that
3 they understand.

4 I saw a tremendous video that was provided by
5 American Medical Association Foundation which was
6 basically teaching you how to address a patient and
7 showing you where you think somebody really understood
8 and they didn't.

9 The example that was there was an individual
10 who was a pharmacy tech working in a hospital, sitting
11 down with his physician and having his medications
12 given to him and then being asked to recite back how
13 he was going to take his medications. Pharmacy tech
14 working in a hospital was not able to do that.
15 There's a patient safety issue.

16 We need to learn how to communicate with our
17 patients from whatever level our provider, whether
18 we're physicians, pharmacists, psychiatrist,
19 psychologist, mid-level providers, we have to learn to
20 communicate. We have to have that open and available.

21 I also agree with what we've heard earlier in
22 terms of having basically a culture of safety,
23 nonpunitive environment. I think it's essential.

24 And in terms of a reporting system, I know
25 that there's a lot of discussion about a voluntary

1 reporting system. I think that's a first step. I
2 don't think that if you talk about mandatory reporting
3 systems that you're going to have a lot of cooperation
4 if there's fear associated with the reporting.

5 My concern with those types of reporting
6 systems is a lack of vigor. We have voluntary
7 reporting systems in many of the places that I have
8 worked. It's haphazard, unstructured, and it doesn't
9 reveal the real opportunities to be able to do root
10 cause analysis or to be able to begin the study in
11 preparation for doing things like failure modes
12 effects analysis to prevent the errors in the future.
13 I guess that's my piece.

14 DR. SIMMER: Thank you. Do we have any
15 questions? Yes, Marge.

16 MS. FREUNDL: Dr. Abramson, am I hearing you
17 correctly that you're supporting a voluntary reporting
18 system but you're also saying that they lack vigor?
19 So do you have a recommendation on how to increase the
20 vigor?

21 DR. ABRAMSON: I think that the first aspects
22 of this, and the reason I support the initial concept
23 of a voluntary system, is to get people comfortable
24 with the idea. But until you truly have a nonpunitive
25 error reporting system, it's never going to give you

1 what you really need.

2 They have used here I'm sure the FAA model.
3 The wonderment of the FAA model is you're penalized
4 for not reporting something. You're even penalized
5 for not reporting a near miss. It's the near misses
6 where the power is to make this a safer system.

7 Once we've had the errors, it tells us we
8 were not able to identify a potential series of
9 problems. That Swiss cheese model, everything just
10 lines up right.

11 And the concept is step one, yes, start with
12 something voluntary, but if you start with something

13 voluntary and you get information and you get some
14 good data that tells you opportunities for
15 improvement, those opportunities for improvement have
16 to get back out into the community with a way for them
17 to get implemented; otherwise, it ends up being
18 something else, which is just another report in
19 another book on another shelf.
20 DR. SIMMER: Okay. Thank you again.
21 DR. ABRAMSON: Thank you for allowing me to
22 present today.

Addendum: February 22, 2005:

In addition to my original comments concerning the need for modifications in the health care education, I have been thinking lately that I missed one crucial constituency stakeholder. While I opined that healthcare students providers should all have some continuing educational requirement for patient safety (including systems theory), *in my opinion, this should expand to include individuals who serve on healthcare facility boards and to individuals employed by the state in healthcare regulatory capacities.* We all need to be on the same page so to speak. I don't know if other contributors in the hearings may have suggested these but in my way of thinking, it becomes essential to alignment of this initiative.

As an additional aside, I also support "usable" public reporting not based on Hawthorne effect focused study. Infection incident rates came to mind. The challenges here are extraordinary in establishing risk adjusted rates as seen in the attempts to do this in Florida (see article below).

Larry Abramson, DO

Pulling the covers off hospital infection rates

Patient advocates ask why it's taking so long to reveal the data, as required by state law.

By LISA GREENE, Times Staff Writer

Published February 21, 2005

Germes lurk in every hospital, creeping into surgical wounds, seeping into IV lines, hitching rides on dirty linens and unwashed hands.

Most hospitals would rather not talk about them, even though infections kill more than 80,000 Americans each year.

That makes it hard to tell which hospitals do a better job of stopping their spread.

Hospitals have traditionally closely guarded their infection rates. Even hospitals that report infection data to a federal database are promised confidentiality.

In Florida, that veil of secrecy is supposed to lift - but just how soon remains a question.

State health officials say it will be a year before they make hospital infection rates public, as required in a bill that became law last year.

"I'd like to do this tomorrow," said Alan Levine, secretary of the state Agency for Health Care Administration. "But I have to recognize that if we get it wrong, we'll take a step backward."

Rep. Frank Farkas, sponsor of last year's bill, is concerned by the delay. "I'm kind of bothered by "next year," he said.

But Farkas, R-St. Petersburg, said he needs to talk more to AHCA officials and plans to meet with them this week. "I'm disappointed they're not ready, but more important is to get the correct information and get it right."

Hospital administrators say making such rates public is more complex than it sounds, and done incorrectly could mislead consumers and create burdensome paperwork.

"We're trying to work on the consumer aspect," said Kim Streit, chairwoman of an AHCA committee working on the rates and a vice president at the Florida Hospital Association. "It's just not something that can be up and running in three months or six months."

Some patient advocates agree.

"This is something that requires an awful lot of thought and analysis," said Jay Wolfson, director of the University of South Florida's Suncoast Center for Patient Safety Research. Some data will become public this fall. AHCA is requiring hospitals to track and report how well they comply with basic measures to prevent infections, such as giving antibiotics before surgery and making sure staffers wash their hands.

Consumer advocates want to make infection rates public to give patients more power. Publicity also would pressure hospitals to try to lower their infection rates, they say.

"People will go somewhere else if you tell them there's an infection problem at that hospital," said Calvin Warriner, a Palm Beach lawyer. "It promotes infection control, because no hospital ... is going to ignore that."

Warriner represented more than 100 patients who alleged that they got infections after cardiac surgeries at Palm Beach Gardens Medical Center. They settled the lawsuit in December for \$31-million.

Infections are becoming a greater worry for hospitals as powerful bacteria that are resistant to most antibiotics become more common. In the past few years, even bacteria that can't be killed by vancomycin, once known as the drug of last resort, have appeared in a few U.S. hospitals.

Consumer groups, notably Consumers Union, have been pushing for disclosure of infection rates. Florida is among the first states in the nation to pass the requirement. Illinois, Pennsylvania and Missouri have done so as well.

But with few standards for what to document and how to count infections, state officials are trying to develop their own.

The federal Centers for Disease Control and Prevention is expected to come out with a report on the issue in the next few weeks. Streit hopes these standards will help states develop national measures, so hospitals can be compared from state to state.

"If we create one system in Florida, and they have it different in Georgia or Pennsylvania, then we haven't done any favors for consumers," she said.

One problem is what to count. Many hospital administrators want to count only the most serious infections, such as those in surgical wounds or central lines. Those carry the most risk to patients.

If hospitals are given broad instructions to count every infection, they would have to make workers write up the most minor incidents. In theory, that could include even one of the most common ailments, such as newborns' diaper rash, said Dr. Juan Dumois, infectious disease chairman at All Children's Hospital.

"You've got to decide what to look at," he said. "You've got some unimportant causes of (hospital) infections."

Hospital officials also worry that hospitals that are more vigilant about tracking infections may have higher rates because sloppier hospitals ignore them.

And officials at larger hospitals worry about infection rates being higher there than at small, community hospitals, where fewer surgeries take place and patients are not as sick. Several hospital officials pointed to the same place as an example: Tampa General Hospital.

It has Tampa Bay's only Level I trauma center, burn center and adult transplant program. Higher-risk patients often go there, and the sickest patients are transferred there from smaller hospitals.

"If you compare South Bay Hospital with Tampa General, I guarantee you South Bay looks better than Tampa General," said Levine, who was once South Bay's CEO. "But that's because Tampa General does all the high-risk cases no one wants to do."

Hospital administrators want a formula that accounts for such differences, so patients don't assume larger hospitals are worse.

Dr. John Greene, chief of infectious disease at Tampa's H. Lee Moffitt Cancer Center & Research Institute, said many of his colleagues in the field oppose making rates public for that reason.

Greene, however, supports it, and will tell anyone who asks that Moffitt's infection rate for surgical wounds is about 3 percent. Still, he said, not only does data have to be compared carefully, but hospitals need to use data to improve sterility, not punish staffers.

For example, stamping out infections involves some work that is simple: enforcing strict hand-washing policies and even requiring staffers to get rid of fake fingernails, under which germs can hide.

Other measures are more difficult. Cancer hospitals worry especially about mold infections so they must make sure any roof or wall leaks don't harbor mold.

Hospitals should work with problem doctors and wards to find and fix problems so people don't fear disclosing when infections occur, Greene said.

"If a surgeon has a high infection rate, we don't want to fire the guy, because it sends the message, "I won't report any infections,"" he said