

Mr. Bagian James

Mr. Bagian: Okay. Thanks, Dr. Simmer. I'm Jim Bagian. I'm the Director of the V.A. National Center for Patient Safety. Dr. Ed Dunn is with me, as well, and he might make a few remarks in with this, as well.

Thank you very much for the opportunity to testify here today. I can't tell you how important we think the issue of patient safety is. We've been involved in this for quite some time and we think it can have huge impact on the quality of care and the safety of care we render to patients.

One thing I'd like to say at the outset is what the real goal is and, you know, maybe cast it slightly different, which I think IOM, in their Errors Human Report that came out about four years ago has since changed the way they looked at it -- or five years ago, and that is that the goal isn't to eliminate errors; the goal is to prevent harm to the patient, which is an important distinction but extremely important. What the patients care about is not being harmed.

The high reliability industries that are most talked about as being exemplar, such as aviation and nuclear power, do not talk about errors; they talk about prevention of harm, and it's quite different.

Error depends on the point of view you have. What we want is no harm. You want to design your system so when individual errors do occur they don't result in hurting a patient, and that's an important distinction. Though subtle, very important.

I think we know we have a number of accountability, and people have told me I have an accountability of practitioners and institutions. We think that's important; however, that's not the only question.

There are a number of accountability systems which currently exist and they are necessary. There's no question. However, we don't need yet another accountability system. What we need is a learning system.

Aviation went from 50 years ago having an exceedingly high accident rate, you know, and morbidity and mortality rate, if you care to look at it that way, to where they basically don't have these anymore.

In fact, this past week marked over the third anniversary where there has not been a major large jet aircraft lost in the United States in over three years. That's in over 13 million operations there haven't been one.

Where if we look at medicine, the mortality rate associated with hospital care runs between, depending on who you believe, a half and 2 percent of everyone who enters a hospital ends up dead just from the treatment, the way they've been treated. Far

different. You know, orders of magnitude different. So we think there's something to learn from the alliance of accountability systems which exist with voluntary systems.

Mandatory systems don't really get you where you want to go, and accountability systems don't. You need an addition of a voluntary one where people can report things, share this information with others in their own institution and elsewhere so people can learn from them how to make their own system safer.

This is not something to be solely mandated from a central area. It's a thing where the central authority, such as the State, can provide those protections, as has been done in some states already.

If you look at contrasting systems like, for instance, the Joint Commission, as an example, they have a system that is viewed by the participants pretty much, those voluntary, as an accountability system.

As a result, 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.

We think this is important by setting up a system that is patterned after systems which have been shown to work, where people can report without fear, you can get where you want to go.

To give you an example, I just want Ed Dunn to say a few words. He ran a system at a hospital. He can tell you how they can use that protection to do what they need to do.

Mr. Dunn: I am Ed Dunn, Director of Policy and Clinic Affairs for the National Center for Patient Safety, formerly practiced cardiovascular surgery for 20 years.

And I became involved with patient safety as an RWJ Fellow staffer for Senator Kennedy on Capitol Hill working on the Patient Safety Legislation.

One of the things we learned looking at states, like your own state, around the country is only about half the states have mandatory reporting law.

If you look at the yield from those reports, it's very, very small compared to what you would extrapolate from the IOM report from 1999. Very, very few reports. Most of them, frankly, are slips and falls from nursing homes. Not very many adverse events really get reported.

I ran a patient safety program for a public hospital system, Metro North Boston, for two years using the VA model, and we were able to do root cause analysis on adverse events that were reported because we claimed protection through the Medical Executive Committee Peer Review Law, but it had never been tested in Massachusetts.

And my point is that in most states it has -- this patient safety information protection has never been tested. And that's why states like Oregon and Florida and others are passing legislation to protect this information as a privilege of confidentiality.

My point in mentioning this is that we do our -- in two cases for sentinel events, adverse events that occurred in our health system, we did our due diligence and root cause analysis while the State Department of Public Health pursued the accountability side of the equation, and both worked in harmony and parallel and neither one contaminated the other, so it's very possible to do.

So my point is that mandatory reporting in states has been tried and tested for a long time in this country, and Massachusetts almost 20 years. The yield has really not changed in the last 20 years.

Mr. Bagian: Can I sum up for 20 seconds?

In summary, I think the important things are that it's not just error we want reported; we also want close calls. You want, of course, close calls where no one has been harmed and you can learn from it. Close calls happen anywhere from 10 to 300 times more commonly than the event they're a precursor of. So to only talk about adverse events, it's saying we only will learn once we hurt somebody. I don't think anybody wants that.

I think what the State can do is give protections that's clear and unambiguous about when confidentiality will be bestowed and when it won't so people understand that, and create an environment where a cultural change can flourish, because that's what you want. You want the change that's been seen in aviation, where people will report things because they know it will be fixed, not because we're going to punish people.

And I think if you set that up, the rest of the things that are on your agenda that you would like to attack can get there; but if we try to do it strictly by fiat, people don't change their culture by fiat. No one does.

If we can set up an environment where people feel safe to report, to really deal with the problems, we'll do that. And I think we can see -- and the VA is an example -- when we did this, we went from already being a good reporter to increasing our reporting by 30-fold, by 30-fold, and, you know, over a thousand-fold in the close call department. And they've resulted in many things that have had national impact about how things are done, how health care affects analysis, how reporting is done, things with airway management, many things that would never have come up had we not created that environment.

And I think the State is in an ideal position to do similar things. Thank you.