

Ms. Jean Friend

Ms. Friend: Okay. My name is Jean Friend, and I'm a member of a consumer coalition representing OWL, the Older Women's League, the voice of midlife and older women, many of whom you see in the halls of our state hospitals and long-term care facilities. If you've been to a long-term care facility lately, you know that 60 to 70 percent of those residents are women. If you've been to a hospital lately, you will also notice that most of those clients are women.

They are often without a close relative, usually quite ill, in grave need of fail-safe systems to protect them.

I also speak as a sister of a woman who was put in a wheelchair because of a medical error, so this is very personal to me.

Today I am presenting testimony for the Michigan Consumers Health Care Coalition and Advocacy Network, which began in 1993 to give voice to consumers, both those who are covered by our public and private insurance systems and those outside, or an exclusive coverage system.

All or more -- all are more or less vulnerable until we partner together to build treatment and a communication system that will ensure patient safety so that adverse events do not cause harm.

Until we develop a culture of a patient safety, the system which impacts patients and family will continue.

In my sister's case, this did not happen in this state, it happened in another state, but I will tell you that how it affected her, how it affected a family, I will always remember and continue to remember.

When I call her, I am concerned if she doesn't answer. Is she on the floor? Is she able to -- to contact someone if she needs help with grocery shopping. Just the matter of getting gas. She has to plan her week around getting gas for her car. These are the things that happen to people who are impacted by medical error.

To the issue of systematic change and accountability is what I address today. First, we need a system in each state that will be responsible for patient safety. This Michigan Commission is the first part, but it will be meaningless if it becomes another dusty-covered report on somebody's shelf.

It is critical that these bodies that involve health care consumers include families and health care professionals. Families need to be involved at every step of the way. When this happened to us, we had nowhere to turn. We did not know who to contact.

Of course the hospital at that time did not want to admit any responsibility. We have got to move beyond that and help families until responsibility is addressed and accountability is addressed.

We need reporting of adverse events to make sure that whatever happened does not happen again. That's my biggest concern about what happened to my sister.

I mean, luckily we have -- she was able to get some systems in place so that she is living as well as she can, but to make sure that this doesn't happen to someone else's sister, to someone else's daughter is the reason why I'm here today.

The reason why we have a safe environment in this country is that we have developed these systems. If there's an airplane crash, there is a system that looks at the crash, determines what happened, and makes any changes in policy to address that particular incident.

Look at highway safety, same thing. If there's an accident, there is a review of what happened; and if there was a problem with the road, with the car, with different kinds of things that could have affected that accident, those are dealt with.

With product safety we have -- the reason why we have safe products for children is because we addressed flammability of pajamas, we addressed cribs that were not safe for children.

The same thing needs to be happening with our patient safety system in our residential and clinical settings. Health care deserves no less accountability.

A surgical incident which happened to my sister should be as much of a priority as to how a baby stroller affects a baby, where a hundred thousand lives a year were reported due to errors.

Third, local consumers should be nurtured and used as partners to help local families solve the system's problem.

Again, when my sister was released from the hospital, she could not take care of herself, but there was very little review of the hospital about what her care was going to be when she was sent home.

Now, luckily we were able to help her and she had enough money to hire help for the time that she needed it, but how many families do not have those kinds of resources?

Her prescription costs when she left the hospital were over \$700 a month. Now, luckily she worked for a hospital and she was able to cover those prescription costs, but how many, after going in to what was considered a rather routine surgical operation, would be able to come up with \$700 a month within a short period of time?

As you can tell, this is a very personal issued to me, and I would hope that Michigan, like it has always been in the past, be the forefront of systems that help and provide safety for patients and their families in this state.

Mr. Wagenknecht: Jean, back when you were talking about the reporting of errors, are you advocating mandatory reporting or voluntary reporting.

The Witness: No, I think there should be mandatory reporting.