

11 The Commission is pleased to welcome our  
12 seventh participant, Dr. San Diego.

13 DR. SAN DIEGO: Good afternoon, and thank  
14 you, Dr. Simmer and all Commissioners, for giving me  
15 the opportunity to address the Commission on this very  
16 important issue of patient safety.

17 I'm Dr. Leticia San Diego from Clinton  
18 Township in Macomb County, a clinical laboratory  
19 scientist and a doctor in health and human services  
20 administration, and also advisor to the National  
21 Committee on Clinical Laboratory Standards, as well as  
22 past president of the Michigan Society for Clinical  
23 Laboratory Science.

24 Today I would like to provide you with  
25 perspective on patient safety as an expert

1 professional scientist and a health and human services  
2 consultant, but also as a very passionate supporter of  
3 patient safety.

4 I was involved in this legislation from the  
5 very beginning, from the first time it was introduced,  
6 and provided every single testimony on the hearings on  
7 this legislation.

8 What a coincidence that on May 27 this year  
9 the Governor signed -- when the Governor signed this  
10 PA 119, I was at her office to receive this special  
11 tribute from her and signed by her and the Honorable  
12 State Representative Paul Gillingham, recognize me for  
13 my medical and health services to the people of  
14 Michigan.

15 And my perspective on patient safety are also  
16 shaped by my experiences as a consumer of healthcare,  
17 whose father was a victim of medical error, as well as  
18 developing position papers and many articles and  
19 presentations about patient safety. I developed the  
20 position papers for the American Society for Clinical  
21 Laboratory Science on patient -- medical error and  
22 patient safety.

23 Dr. Simmer, my objective -- the objectives of  
24 my testimony today are three-fold: Represent the case  
25 of my father, the victim of medical error; and ask you

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1 listen as I relate the incident, the facts and records  
2 presented to the court during the litigation and  
3 hearing, which, of course, I won.

4 This is the errors you will find occurred in  
5 the single admission, errors occurred in practice, in  
6 products, in medications, in procedure, and in the  
7 entire system. This is such a good case, but I  
8 brought the court papers, but due to time limitation I  
9 will not bore you with these errors, but I would  
10 include it in my written comments later on.

11 Secondly, to comment briefly on IOM and the  
12 most recent studies and challenges, medical errors  
13 raised.

14 And the third is my recommendations and  
15 initiatives we can easily implement in our state to  
16 reduce medical errors and improve health services in  
17 Michigan.

18 Now, with evidence presented in the IOM  
19 report, with its credit synthesized and assembled,  
20 which was evidence in a way that brought medical  
21 errors to the public attention and scrutiny it richly  
22 deserved.

23 The fact is that medical error is the eighth  
24 leading cause of death in the U.S., and even  
25 conservative estimate of the death toll from medical

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1 error is very alarming.

2 Dr. Simmer and all Commissioners, what is  
3 more alarming is the most recent new study by Health  
4 Grades in mid October 2004 that found that 195,000  
5 Americans died on average due to potentially  
6 preventable hospital medical errors in 2000, 2001, and  
7 2002.

8 When in every hospitalized Medicare patients

9 who experience a patient safety related incident  
10 during that time in fact died.

11 The private companies surveyed encompass 37  
12 million records and is the first to examine prevalence  
13 and economic impact of medical errors and injuries  
14 that occurred during Medicare hospital admissions  
15 nationwide from 2000, 2001, and 2002.

16 Investigators estimated cause of such errors  
17 are at more than \$6 billion per year. Whereas the IOM  
18 study extrapolated national findings based on three  
19 states, the Health Grade study examined three years of  
20 Medicare data in all 50 states and Washington,  
21 including Washington, D.C.

22 I commend this Commission for responding to  
23 this issue of medical errors and patient safety on a  
24 timely basis.

25 The newly compiled Health Grades report will

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1 even more heighten the public awareness of medical  
2 errors. As we learn from IOM report, medical errors  
3 manifest itself, themselves, in imperfectly designed  
4 system in which mistakes are easily made.

5 While the entire healthcare team must share  
6 the responsibility for reducing errors and addressing  
7 safety issues, the Michigan Society for Clinical  
8 Laboratory Science and myself as president, a  
9 scientist and a health and human services consultant,  
10 has taken the opportunity to provide leadership in  
11 this area.

12 In its report, IOM outlined four initiatives  
13 to prevent error and improve patient safety. Mainly,  
14 develop a national forum to form leadership, research  
15 tools and strategies to enhance the knowledge base  
16 about patient safety.

17 Second, identify and learn from medical  
18 errors through mandatory and voluntary reporting  
19 systems. Raise standards and expectations of  
20 improvement in safety through action oversight of  
21 organizations, purchasers, and professional groups.

22 Implement safe practices at the delivery level,  
23 delivery of care.  
24 The Michigan Society for Clinical Laboratory  
25 Science, state affiliate of the American Society for

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1 Clinical Laboratory Science, is committed in reducing  
2 errors by supporting the IOM recommendations.

3 Clinical laboratory scientists are a single  
4 group of healthcare practitioners who are educated in  
5 quality control and it is part of their everyday  
6 testing services, and they can take a leading role in  
7 the development of positive error management.

8 Laboratories can collaborate with other  
9 professionals to look for avenues to investigate,  
10 survey, study, and improve processes in the  
11 pre-analytical and post-analytical phase of testing.  
12 This would involve cooperation with other  
13 professionals who may be providing specimens or  
14 samples or even the doctors, recipients of these  
15 reports.

16 During the first International Summit on  
17 Medical Errors and Patient Safety held in Washington,  
18 D.C. in 2000, in which a Blue Cross Blue Shield member  
19 and I were stranded at the airport due to the fact  
20 that our flight cannot take off because of the severe  
21 weather in Detroit, so we were stranded there and I  
22 get to know one of your employees in Detroit.

23 During that International Summit on Medical  
24 Errors, error is defined as the failure of plan of  
25 action that can be completed as intended or use of

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1 wrong plan to achieve an aim. Errors can include  
2 problems in practice, products, procedures, and  
3 systems.

4 Patient safety, on the other hand, applies to  
5 initiatives designed to prevent adverse outcomes from  
6 medical errors. An enhancement of patient safety  
7 includes activities in preventing errors that are

8 known and visible to mitigate the effects of error.  
9 Now some recommendations. A mandatory  
10 reporting system that can be implemented in our state  
11 to be regulated and to be standardized that provide a  
12 standardized documentation of adverse or sentinel  
13 events that could be a link to accountability and made  
14 available to public.  
15 Adverse events are undesirable and unintended  
16 incidents in care that may result or may require  
17 additional effort, care efforts, for an adverse  
18 outcome.  
19 And adverse outcomes are the undesirable,  
20 unintended outcomes of care, such as death,  
21 disability, or temporary disability.  
22 And a voluntary reporting system also that  
23 would complement the mandatory reporting system to  
24 identify errors.  
25 The information from the voluntary reporting

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1 system must be obtained by an independent entity and  
2 used to identify patterns of errors. The data  
3 collected related to patient and patient safety must  
4 be protected.  
5 This consultant can provide assistance in the  
6 planning, implementation, consultation, and evaluation  
7 of programs addressing errors reduction and producing  
8 directives for the future.  
9 A clinical scientist and health services  
10 expert and experienced individual should be seated on  
11 the voluntary -- on this reporting committee.  
12 New methods also of changing the delivery  
13 system in ways that can reduce hazards, including  
14 innovations in information and educational changes.  
15 Physicians must have continuing education and exams,  
16 as new medications are continually developed before  
17 dispensing. And technology in the form of bar codes  
18 that would identify medication in which a patient is  
19 allergic to by matching a bar code on the hospital  
20 identifications for the patient.

21 DR. SIMMER: Dr. San Diego, if you could  
22 please summarize.

23 DR. SAN DIEGO: I am ready now. There must  
24 be collaboration with healthcare professionals to  
25 develop strategies and raise awareness and healthcare

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1 institutions must provide an environment that is safe  
2 for all patients and workers, as well.

3 Dr. Simmer, if medical errors were a disease,  
4 we would call it an epidemic. If errors were a  
5 disease, we would attack it with the best research  
6 possible. We would support. We would put resources  
7 in translating the research into practice. Medical  
8 errors erode confidence in healthcare.

9 And in conclusion, the commission and  
10 coalition of experts can enhance the battle against  
11 this epidemic of errors and has a significant role to  
12 play as providers, educators, regulators, and  
13 examiners of patient information.

14 Thank you for giving me the opportunity for  
15 testifying today. And as this Public Health Code  
16 states, and I quote, "Designate of the initiative as  
17 the Governor chooses is not limited to individuals  
18 with education and experience and expertise in health  
19 and human services, healthcare consumers, providers  
20 and patients."

21 As a scientist and health and human services  
22 consultant, we will do our part to be -- to play a  
23 significant role in the -- of patient safety. Patient  
24 safety is not for an individual. It is all our  
25 concern in saving money and saving lives is the goal

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1 of patient safety.

2 I am now delighted to answer some questions  
3 you might have.

4 DR. SIMMER: The Commission only asks  
5 clarifying questions, and I don't see that we have  
6 any. So thank you very much, Dr. San Diego.

7 DR. SAN DIEGO: Thank you.