39767 Chaffer Court
Clinton Twp. , MI 48038

November 30, 2004

Diane Valade
Michigan Health and Safety Coalition
27000 W. 11 Mile Road – B 713
Southfield, MI 48038

Dear Ms. Valade:

Attached are my written testimony for the Commission on Patient Safety that includes:
Five copies of each bound -
Demographic information
Executive summary
Narrative and
Appendix (Bibliography)

If there is any questions about this submission, please do not hesitate to contact me by phone 586=286-7902 and by Email- lsndiego@sprynet.com

Sincerely,

Dr Leticia J. San Diego

Beyond IOM:

Developing and Implementing

Interventions for Medical Error

Reduction and Patient Safety

Dr Leticia J. San Diego, CLS, HHS
Health & Human Services Consultant

About Dr Leticia J. San Diego:

Dr. Leticia J. San Diego is the founder and president of Health Care Management Development Center, a client focused resource for health care organization, POC, and POL's. Provides consulting services, educational services and publication to assist improving the quality, safety and efficiency of human and health services to help in meeting the standards of regulatory agencies.

Educational background includes B.S. in Psychology and Medical Technology, Masters of Art in Health Care Administration, Ed.D. in Educational Leadership, Ph. D. in Health and Human Services Administration (graduated with Distinction of Highest Honor).

Professionally, Dr. San Diego is an active member of ASCLS (American Society for Clinical Laboratory Science) and its affiliates MSCLS (Michigan Society for Clinical Laboratory Science).Her distinguished services to the profession includes serving as Advisor to NCCLS

(National Committee on Clinical Laboratory Standards), member of the AMT Consultant Evaluation

and Certification Committee, ASCLS Editorial Review Board and Consulting Editor of CLS Journal, member of the ASCLS Publication Committee, ASCLS Consultant Scientific Assembly Chair, Region IV Leadership Development Chair, MSCLS Government Affairs, MSCLS Leadership Development,

President Elect, and President 2003-2004, Past President and General Chair for 2005 Meeting.

Leticia has received honor and distinguished awards- including the Omicron Sigma Honor Roll, the ASCLS Presidential Award, nominated to the 1999 ASCLS Member of the Year Award, awarded with the Consultant Forum Outstanding Achievement Award, Keys to the Future Award. Congressional and Vice Presidential Awards from U. S. Legislature, Gubernatorial Award from the State of Michigan. Inducted to the Alpha Mu Tau Fraternity for her outstanding services and professional achievement. In 1994, Leticia, an author, was the recipient of the prestigious international award and scholarship for her book entitled "IAMLT :Linking CLS to the 21st Century Technologies". AMT (American Medical Technologists as well, awarded Leticia with a Certificate of Recognition for her development of a premier certification program for the laboratory consulting profession. She is also the recipient of the ASCLS Kendall Professional Achievement Award in the Consultant Forum Scientific Assembly in 1999 and 2002, 2004, recipient in Philadelphia 2003 national meeting , the Education and Research Award in Laboratory Administration. She was recognized by both Michigan House of Representative and Senate with a Special Tribute for her services to the people of Michigan awarded April 7, 2004 awarded by Governor Jenifer Granholm and Representative Paul Gieleghem.

Leticia Co Chaired the 2000-01 Medical Error and Patient Safety Task Force and Co authored the ASCLS Position Paper on Medical Error and Patient Safety. She made many public presentations about Medical Errors and Patient Safety Interventions nationally as well as in Michigan conferences She also authored and publish articles on Patient Safety on the Newslinks, the official newsletter of the Michigan Society for Clinical Laboratory Science. She co author of the ASCLS Body of Knowledge , both the original and the 2004 revised edition.

Her most remarkable publication "Effective Management Strategies for ALS(Amyotrophic Lateral Sclerosis: A Quest for Cure. Understanding Clinical Syndromes and its Amelioration". Dr San Diego recognized the utility of the Single Case Model for presenting her patient story, but in fact research was secondary to the aim of providing the highest possible care over a long time span. In addition to the knowledge directly applicable to the medical management of ALS patients, her contacts with other

researchers led to a third valuable contribution to knowledge and possibilities that could initiate future research toward finding ALS cures with immense benefit to mankind.

Dr. San Diego can be reached by E-mail at lsndiego@sprynet.com, by phone at 586-286-7902 or by mail at 39767 Chaffer Court, Clinton Twp. , MI. 48038 U. S. A.

Executive Summary

Beyond IOM: Developing and Implementing Interventions For Medical Error Reduction and Patient Safety

Medical Error Problems of an Epidemic Proportion

Safer health care is a shared goal, wherever the services might be, by both people and organizations in Michigan. Currently, a great undertaking to assemble the best information available on reducing medical errors and improving patient safety is an important first step in organizing recommendations for Michigan's health care delivery system.

Health services researchers estimate that between 44,000 and 98,000 Americans die each year as a result of medical errors. It is the eight leading cause of death, more than automobile accidents, AIDS or breast cancer. Errors in health care are at unacceptable levels, an epidemic proportion. This statistics as reported by the Institute of Medicine in each publication of "To Err is Human: Building a Safer Health care System". The cost of such preventable errors in the U. S estimated to be between $ 17 billion, other errors cost $29 billion each year, a total of approximately 38 billion. What is more alarming is the most recent new study reported by HealthGrade in mid 2004 that found 195,000 Americans died on average due to potentially preventable hospital errors in 2000, 2001 and 2002 each. One in every four hospitalized Medicare patients who experienced a patient safety related incident during that time in fact, died.

At the First National Summit of Medical Errors and Patient Safety held in Washington, D. C. in September 2000, QUIC (Quality Interagency Task Force) defined **error** as a failure of a planned action to be completed as intended or use of a wrong plan to achieve an aim, and can include problems in practice, products, procedures and systems. **Patient Safety** on the other hand involved initiatives structured to prevent adverse outcomes from medical errors. It involves actions that prevent, recognize and mitigate errors.

State of Michigan Response to Medical Error and Patient Safety

In the light of the impact of medical errors on patient safety in health services and consumers of health services in Michigan a legislation was introduced recommending the creation of a Governor's Commission to study the problem within the state and make appropriate recommendations. I was involved with the legislation from the time it was first introduced and provided testimony in every single hearing. What a coincidence that on May 27, 2004, the day Governor Jennifer Granholm signed the bill, I was at her office to receive the Special Tribute she and Honorable State Representative Gieleghem recognized me for my medical and health care services to the people of Michigan.

My perspectives on patient safety are shaped by my experiences as a consumer of health care whose father was a victim of medical errors as well as an expert professional developing position papers and public presentations on reducing medical error and recommending interventions.

The objectives of this testimony are:

- To comment briefly on IOM and most recent studies and challenges medical errors raise

- To present the case of my father the victim of medical errors, errors that occurred in practice, products, medication and systems. Only by knowing and identifying the errors that we can device initiatives to prevent them and save money and lives
- My recommendations and initiatives we can easily implement in our state to reduce medical errors and improve health services in Michigan and protect the public

I commend the commission for responding to this issue of medical errors and patient safety on a timely basis. As we learned from IOM report, medical errors manifest themselves in an imperfectly designed system, in which mistakes are easily made. Reducing errors and improving overall quality of the health care system in Michigan will demand the collaboration and participation of all stakeholders. Out state will need the collaboration of professional groups to develop the infrastructure necessary to create solutions. Improvement efforts are necessary in developing explicit benchmark and reporting formats, training and convening functions across the health care system.

Reducing Medical Errors

To fix the medical error problems it is necessary to be alert to signs and symptoms of the occurrence of errors. Medical errors cannot be address until we know more, how many, what kind and where the root causes of errors. The commission already initiated a solicitation of testimony to collect data to identify and analyze problems as well as suggest measures and remedies. I had the opportunity to provide an oral testimony and recommendations to minimize error improve health services in the continuum of health care in our state during the hearing held at the Blue Cross Blue Shield in Southfield, as well as this written testimony and recommendations.

Conclusion

The issue of medical errors and patient safety is of great importance to Governor Granholm, the legislature and her administration are critical and timely. Key strategies in the reduction of medical errors are to focus on three elements, the structure of the system, procedure and the practitioner in the practice field that are knowledgeable with skills, expertise, credential, certification and license. It is essential to assess how well the process and structure of care and to measure the outcome achieved to identify areas of improvement. It is also necessary to communicate the outcome in a useful understandable format to help improve health care decision making. It is important that the information is available in the public domain. While investment may be required to ensure reduction in medical errors and patient safety, it will reap substantial dividends in the long term and payoff will be savings in money and thousands of lives.

It is an honor and a great opportunity to be able to discuss the issue of patient safety and able to recommend initiatives. As the Public Health Code 119 states and I quote “if the Governor chooses to designate and existing organization or initiatives shall include, but is not limited to the individuals with education and experience and expertise in health and human services, health care consumers, providers, and payers. And as a consumer of health care, a scientist and a health and services consultant, I will be able to assist and do my part on this important endeavor. Our journey has just begun. Let us all walk hand in hand to fight the battle of medical error together.

Dr. Leticia J. San Diego
Health and Human Services Consultant

Magnitude of Medical Errors

U. S. health care is not satisfactory says IOM (Institute of Medicine).IOM concluded that errors are the outcome of problems in the health care systems. IOM recommended four critical steps in reducing the risk to patients from errors in health care delivery.

The IOM Recommendations are:

- To create a national focus on medical errors and introduce leadership for improving health care
- To generate systems to collect data on errors that are occurring and learn from those mistakes to reduce errors
- To increase expectations about performance of the health care systems
- Promulgate safer practices in the delivery system

Recognizing the Context of Medical Errors- the Evidence Case

The lack of standardized definitions of medical errors and difficulty in recognizing mistakes hinder our understanding of the problems. It is unlikely we can ever know the accurate frequency with which errors occur in the health care setting, because we must rely on human to recognize mistakes that were made and to distinguish to bad outcomes of appropriate care and to report them. The professional culture is more of a challenge than the intricacy of improving patient safety. The “naming, blaming and shaming” ways to dealing with errors obstruct medical error reduction. This approach is counter productive, as experienced by this patient safety advocate. This led to a “conspiracy of silence” where errors are not discussed and professionals covered for each other’s mistakes for fear of reprisal. There was no other alternative to correct this current culture but to litigate.

The information of the case presented here are facts presented at the trial. The patient and family’s identities are concealed to ensure privacy. It is important to note that litigation did not commence until a year after the death of the patient to make sure that emotions did not overrule accusations of the physician, hospital and others who committed the mistakes that caused the wrongful death of a beloved patient. Only after the facts were gathered, charts examined meticulously, medication, pharmacologic and physiologic properties, reaction and interactions with other drugs scientifically studied, all angles were checked, and no stone left unturned and no doubt and no doubt errors were committed, that the litigation proceeded. Lawsuit was filed in order to prevent future medical errors from happening to save lives. The U. S. Court found the physician guilty of the wrongful death of this patient and the hospital neglectful of care.

Terms and Definitions

Adverse events- undesirable and unintended incidents in care that may result in adverse outcomes or may require additional care to thwart an adverse outcome

Sentinel events- events in which death or serious harm to the patient has occurred.

Clinical response to errors, such as the number of times an antidote was given or a measure intended to counter an unintended consequence was used.

Hazard - anything that can cause harm.

Near misses – those events in which unwanted consequences were prevented because there was a recovery by identification and correction of the failure. Such recovery could be planned or unplanned barrier.

Risk – the likelihood that somebody or something will be harmed by a hazard, multiply the severity of the potential harm.

It is also necessary to understand medical errors in a wider context of problems in health care quality. These situations can be identified as:

Overuse of service – service will unlikely be beneficial.

Under use of service –with holding of potentially beneficial service.

Misuse of service- when a service is inappropriately used.

Epidemiology of Errors

Errors can be identified by causes, types and close calls in clinical settings such as acute care, ambulatory care, long term care, pre hospital care and emergency care. Types of medical errors include:

- Knowledge deficit –such as physician unfamiliar with medication and drug reaction
- Diagnostic error such as misdiagnosis leading to a wrong choice of therapy, failure to use an indicated diagnostic test, misinterpretation of test results and failure to act on abnormal test results
- Equipment failure – such as defibrillators with dead batteries or intravenous pump whose valves are dislodged or bumped, causing increased doses of medication over too short a period.
- Infection such as nosocomial and post surgical infections.
- Blood transfusion related injuries such as transfusing a patient with an incorrect blood type or transfusion not necessary due to high hemoglobin causing circulatory overload
- Misinterpretation of other medical orders, such as failing to give a patient a salt free meal as ordered by physician.

There were 176 hospital personnel who handled the patient (victim) during his short admission to the Emergency Care and each and every one of them contributed to the errors of practice, procedure, products and systems.

The patient was ambulatory when he was admitted to the ER. Identification bracelets were provided with all the pertinent information on one, and the second RED bracelet indicated his name and identification number and the medication he was allergic to, which was ERYTHROMYCIN. He was assigned to a booth. Nurses checked his vital signs. The ER doctor checked him. The patient's chief complaint was difficulty in breathing. Xrays were taken, and blood samples drawn. Xray's report came back with the finding of a slight lower lobe pneumonia. Patient was told he would be admitted to the Medical Ward. The ER doctor informed the patient while waiting for his room to be ready, that he would start his antibiotic drip, and asked him if he was allergic to any medication, the patient answered very clearly "Erythromycin" and showed his bracelet that confirmed his allergies. The daughter at his side seconded "Dad is allergic" to erythromycin". The doctor held his arm and looked at the red bracelet to confirm and went out of the cubicle. When he returned, he had a pouch of reconstituted antibiotic and

started hanging the I.V. and infusing the patient with antibiotic. When the drip began and looks to be dispensing properly the doctor went out of the cubicle. The daughter attempted to see what was hung to enter in her journal as she always records, the doctor did not indicate what antibiotic he planned to infuse the patient. She did not get close to the I.V. to check, when the patient went into anaphylactic shock. This ER doctor did not even recognize the episode was anaphylactic shock. He said "he is only regurgitating". The daughter insisted he was in anaphylactic shock and pleaded to remove the I. V. line. The event went rapidly, anaphylactic shock was so severe and patient coded blue. It was later that the daughter found the patient was infused with the antibiotic ZITROMAX. Zitromax is a derivative of erythromycin and differs chemically from erythromycin in that a methyl- substituted nitrogen atom is incorporated into the lactose ring making it more POTENT than erythromycin.

An adverse event is an injury caused by medical management rather than by the underlying disease or condition of the patient. Some adverse events are not preventable and they reflect the risk associated with treatment, such as a life threatening allergic reaction to a drug when the patient has no known allergies to it. However the patient who receives anti biotic he is known to be allergic to, goes into anaphylactic shock and dies represent a preventable adverse event.

To fix medical error problems, it is necessary to be alert to signs and symptoms of occurrence of errors. Our state is the best place to begin the development and implementation of reporting and safety initiatives. Medical errors cannot be addressed until we know more, how many, what kind and where the root cause of errors. To do that and to track progress data must be collected and to analyze the problems as well as suggest measures and remedies.

What Can Be Done With Medical Errors?

IOM calls for the development of a nationwide system of reporting that includes both mandatory and voluntary reporting systems included in the recommendations.

Mandatory Reporting systems-

Collection of standardized information by State governments about adverse events that result in deaths and injury or serious harm to the patient. Reporting initially be required by hospitals and eventually of other organizations and ambulatory delivery settings. State government can also play important role in analyzing and disseminating findings. It should be mandatory to address serious, preventable, identifiable adverse events with no identification of patients, or health care professionals.

Voluntary Reporting Systems

Voluntary reporting in our state base on existing option focusing on selected areas such as medications, surgery, and pediatrics or using sample techniques to collect the full range of information from limited subset of health providers. Research to determine the best way to develop a voluntary reporting system to complement the mandatory systems that can identify potential precursors to errors to prevent patient harm. Further recommendation to extend peer review protection to data related to patient safety and quality improvement gathered through voluntary reporting system. Voluntary reporting aims to solicit reports on near misses or close calls with data kept confidential.

Intent of Reporting System

The intent of a reporting system whether it is mandatory or voluntary, is to make improvements by better understanding the causes of errors. Systems to evaluate and improved processes of care also needs to be established. The system should provide a continuous input within an institution so that errors can be perceived and rectified as early as possible.

People make safety. Improving safety depends on understanding the details of technical work, how error and failure and how success is achieved.

To encourage reporting by facilities it is essential to:

- Protect confidentiality and create punitive sanctions for failure to report
- Build a data base to provide useful information that facilitates direct access
- Share best practices
- Risk management review of errors
- Distribution of summary data
- Web site information
- Counseling, technical assistance
- Valid measurements and intervention
- Focus on long term solutions
- Quality goals incorporated with business strategies

Strategies to Reduce Medical Errors:

- A no fault procedure with no negligence presumption
- Institutional liability for integrating the delivery system, insurance based on facilities and not individual practitioners
- Mandatory reporting for patients for compensation purposes
- Establishment of statewide data base of analysis of errors
- Epidemiological; analysis of compensatory events

Raise the Standards for Medical and Health Care Professionals

New ways methods of changing the delivery system in ways that can reduce hazards, risk including innovations in information and educational changes.

- Physicians must have continuing education and seminars as new medications are continually developed before dispensing medications and drugs.
- Use of technology in the form of bar code that would identify medication in which a patient is allergic to by matching bar code on hospital identification bracelets.
- Develop programs introducing healthcare professionals to error analysis and the challenges of practicing technically complex environment
- Licensure of laboratory personnel, as well as all health care practitioners should be a number one priority in our state to reduce medical errors.

The **Michigan Society for Clinical Laboratory Science (MSCLS**) will collaborate with certifying, accrediting and licensing bodies to review current information on medical errors in the context of current practice requirements in the state. MSCLS will also assist

in formulating strategies in the area of error prevention and inclusion of error management education in curriculum of health care professionals.

Health care institutions and health care organizations should collaborate in the design and development of positive patient identification systems. Positive patient identification, will address significant aspect of pre-analytic errors. A system of specimen identification such as bar coding, to be initiated in the first visit or admissions would reduce the clerical and identification errors associated with laboratory tests.

There must be collaboration with health care professionals to develop strategies to raise awareness in preventing errors in pre-analytic and post analytical testing process. Mechanisms should be designed to study the scope of medical errors within the laboratory setting and would identify and reduce such incidents. These tools should reflect scientific evidence-based information as well as personal experiences, and licenses.

Education and Training Strategies

Development of curriculum by technical schools and training faculty is needed to identify effective to identify effective training methods in improving patient safety. There should be emphasis on processes for credentialing and licensing. Understanding and sharing of success stories will more effectively be used for training and educational purposes and to adapt lessons from other areas of health care and industry that have shown to reduce errors and improve patient safety. There is a lesson to be learned from industry such as the Ford Motor Company's training program for new engineers. The company recognizes that much training will be obsolete quickly and so it developed methods to retrain their technical staff to keep their skills current. Ford recognizes that a newly hire engineer 's knowledge will be obsolete 50 per cent obsolete within the first year and has programs in place to address those changes.

Health care institution provide an environment that is safe and conducive to the well being of the patients and care givers, and other participants in the care of the patients. The environment should include adequate space, instrumentation, supplies, support staff, ergonomically sound design and personal protective equipment available should a need arise.

System Initiatives

The health care system is an intricate process involving interactions among health care practitioners and technology. Humans in the health care system can always make mistakes in any phase of the care processes. The systems must be structured to prevent, detect and handle human errors. Different errors require different intervention. Improvement of System Processes Must:

- Focus on problem review and elimination of error rates as a measurement tool
- Non punitive approach
- Computerized bar coding identification and ordering processes as well as reporting results and medication dispensing
- Involve consumer inpatient safety initiatives
- Improved access to confidential patient information

Oversight by State agencies and accrediting organization is essential to ensure that safety practice derived from reporting programs are addressed locally by hospitals and

health care institutions and there is publication of outcomes. There should be an authority within the State agency to review the information and enforce the policy.

Lessons Learned From Industry to Prevent Errors

The health care community can learn from industries that have significantly lessened the rate of mistakes. The aviation industry was once charged with accidents but has successfully decreased the level of errors and could serve as a model for developing a safer health care system. The aviation industry has developed and pursued dimensions that analyze and ameliorate the system in which the errors occur, but do not blame the individual. The aviation industry developed guidelines, automation, teamwork simplification, and standardization of many factors in the aviation systems. This industry has acknowledged that humans are not perfect and they do make mistakes. Our health care systems must take similar steps.

Communicating Safety to Consumer of Health Care

Organizations can facilitate communication of safety to consumers through:

- Establishing a Web site to provide convenient and effective tools to assist various audiences and users of health services in identifying and gaining access to multiple current services. The web site should provide links to every existing resource.
- Creation of forums for focused discussion involving key opinion leaders in patient safety
- Development of educational materials that will be useful to consumers of health care.

Enhancing Public Awareness of Patient Safety

Educate and motivate consumer of health care to use quality information by:

- Developing and implementing a comprehensive consumer education campaign to raise public awareness about the importance of quality information and patient safety
- Conducting educational efforts aimed at key stake holder groups to inform them of the same issues intended for consumers so they can support and reenforce the educational processes
- Creating an information exchange clearing house disseminating best practice resource designed to reduce medical errors for implementation by others
- Evaluating the impact of consumer information efforts

Beyond IOM : Strategies and Interventions:

To advance the IOM recommendations the Commission on Patient Safety, the coalition , health care system , organization and network of health care providers must demonstrate a test reporting strategy and patient safety interventions. Changes in public policy and oversight of health care delivery system that foster improved safety, provision of information to the public and purchasers of health care that will reduce risk of the patient.

Health Care organizations and providers must lead in:

- Development of techniques of identifying medical mistakes for improving safety and reposting them to a data base that promotes analysis of errors
- Development of concepts of what information is useful and needed in reducing the risk to the patient
- Development of innovations in information technology and educational exchanges emphasizing the importance of safety
- Development of initiatives to assess the effect of working conditions in patient safety – how the environment impact health care professional practice to improve patient safety. This include the effect of fatigue, stress, sleep deprivation and shift work in cognitive ability and relationship to errors and patient safety and how the interactions with the built in environment impact the provision of safe care

Strategies and action plans for building a stronger, safer health system capable of delivering state-of-the-art health care to all citizens of Michigan through:

- Restructuring the care process based on best practices
- Utilization of information technologies to improve access to clinical information and support clinical decision, health related applications for internet such as consumer health information
- Evolving effective health care team
- Harmonization of care across patient services and setting over time
- Embodiment of performance outcome measurements for improvement and accountability
- Redesign the way health care professional are educated with emphasis on safety improvements
- Redesign the way health care professionals are educated with emphasis on safety improvements
- Modify the ways in which health care profession are regulated to facilitate the needed change in aiming for a safe health delivery system
- Multi disciplinary health care leaders develop strategies for restructuring health care education to be consistent with the principles of the 21st century health systems and assessing the implications of this changes

The **Michigan Society for Clinical Laboratory Science** proposes the development of new job classification in health care institution: Patient Safety Administrator or Patient Safety Managers.

JCAHO (Joint Commission on Accreditation of Hospital Organizations) Recommendations:

A national patient safety campaign sponsored by JCAHO was launched focusing on health care networks. The program “Speak Up, Help Prevent Errors in Your Care” is designed to raise consumer awareness and involvement and is supported by Center for Medicare and Medicaid Services (CMS) . Research has shown that the patients who participate in decisions about their health care are more likely to have better outcomes.

It is also good for the commission to know that there are outstanding hospitals in our state already doing a great job in the battle against medical errors. Included in this submission of testimony is a patient safety pamphlet from Bronson Hospital in Kalamazoo, Michigan. The hospital is leading in patient safety initiatives by encouraging patients to be involved in their health care. Hospital personnel identifications also at Bronson are imprinted with safety goals as reminder of patient safety at all times. A sample of Bronson Hospital's safety brochure "The Patient's Role in Patient Safety Safety It's O. K. to Ask is attached including contact information.

Conclusion

The issue of medical errors and improving patient safety and the recommendation of the Institute of Medicine is critical and timely. Key strategies in the reduction of medical errors is to focus on three elements, the structure of the system, procedure, the practitioners in the practice field that are knowledgeable with skill, expertise, credential and certification. It is essential to assess how well the processes and the structure of care to measure the outcome achieved to identify areas of improvement. It is also necessary to communicate the outcome in a useful understandable format to help improve health care decision making. It is important that the information is available to the public domain. While investment may be required to ensure reduction in medical errors and patient safety, it will reap substantial dividends in the long term and the payoff will be savings in money and saving lives. Beyond IOM, the Michigan Commission on Patient Safety, professional groups and health care providers are committed to the best practices and interventions to minimize the medical errors in the continuum of health care.

In conclusion, the commission and coalition of experts can enhance the battle against the epidemic of medical errors and has a significant role to play as providers, educators, regulators, disseminators of public information. I am very positive any funding for patient safety initiatives will be worth spending to save lives and money as well. The commission and professionals will be essential in maintaining public trust and sustain an environment that promotes excellence, trustworthiness, lawfulness and accountability of practitioners to meet the standards of integrity expected by the public. Thank you for giving me the opportunity to discuss the issue of patient safety of which I am very passionate about. It is an honor to be able to provide some recommendations for patient safety for the citizens of Michigan.

Bibliography

1. IOM Report , To Err is Human: Building a Safer Health Care System, NAS, 1999
2. QUIC Report to Pres. Bill Clinton, Doing What Count for Patient Safety, 2000
3. San Diego, et al, ASCLS Position Paper on Medical Error and Patient Safety, 2001
4. San Diego, L. J., Developing and Implementing Interventions for Medical Error Reduction, Presentation to the AACC /ASCLS Annual Convention, Chicago, Ill 2001
5. San Diego, L. J. Medical Errors, Where Do We Stand?, Presentation to the Annual MSCLS Meeting, 2001
6. San Diego, L. J. Testimonies to the Health Policy Committee, Michigan Legislature, on " Creating a Governor's Commission on Patient Safety", Proceedings from 2000, 2001, 2003.