

Safety commission takes first steps

By Bulletin Editorial staff

Medical errors have killed at least six people in Oregon hospitals this year. And the commissioners on the Oregon Safety Commission believe that is only a fraction of the total number.

The commission released preliminary data on medical errors in Oregon for the first time at its meeting on Tuesday. Of the 18 hospitals that have begun reporting errors, there were also five incidents in which an object, like a sponge, was left in a patient and three incidents of surgery in the wrong place. The commission is not releasing any specifics, so it's not clear if those incidents caused any of the deaths or where in the state they happened.

The commission began tracking medical errors this year. It will use the results to make recommendations so they won't happen again. It's starting with hospitals and is in the process of setting up procedures for nursing homes and pharmacies.

It's a terrific start. Hospitals are beginning to report sensitive information about patient safety. But ...

"I think we have a long way to go before we get them reporting everything we need to," said Commissioner Ray Magnusson, who is a doctor and the medical director for Oregon Health & Science University hospitals.

We agree. Only 51 of Oregon's 57 hospitals have agreed to participate in this voluntary program. And only 18 of those 51 have begun reporting. Some hospitals said they had nothing to report. Many commissioners said they just don't believe that.

According to the commission's staff, most hospitals want to participate and are figuring out what they have to report and how they will do it. One obstacle is the requirement that hospitals provide written notification of an error to a patient or their family. That's new for most hospitals and can raise red flags for hospital attorneys dreading lawsuits.

The only real power the commission has to compel hospitals to comply is public pressure. The commission could publicly kick a hospital out of the program. No hospital would want to be known for being dropped from a patient safety program.

At this point, the commission is choosing to work with hospitals and help them understand its requirements. Some of the definitions that the commission uses for classifying errors, for instance, are not the same ones used nationally.

The "be nice to the hospitals approach" is understandable, for a while. It's not easy for any organization to start handling sensitive information differently. But the commission can't allow hospitals to rest on their participation agreements. The commission should list on its Web site which hospitals are participating, which have agreed to but aren't and which have declined to participate. It could even post apologetic notes from hospitals about why they haven't started participating or why they aren't going to. We would like to read those.

All the hospitals in Central Oregon have agreed to participate. There's no way to know if they have done more than sign up.

That brings up some other points. We have argued before that participation in the patient safety program should be mandatory, not an option. It's unacceptable that hospitals can opt out. We wouldn't let an airline opt out of reporting accidents that kill or seriously injure people, and we'd insist that they participate in a program to reduce mishaps. Do we really want to let hospitals?

We also believe the public should be able to find out the types and frequency of errors committed at Oregon hospitals. The Patient Safety Commission strips out any information in its reports about patient identity or the medical staff involved. That's fine.

It also strips out what happened where. Jim Dameron, the administrator of the commission, has said it's not constructive to hold up individual hospitals "to blame and shame." Yes, it is. The public will be better informed and can put pressure on hospitals to improve.

Making the commission's program mandatory and more useful to the public is a job for the Legislature. One easy thing the commission could do now is post its general error data on its Web site. The Web site – www.oregonpatientsafety.org - has basic information about the commission. It would be a lot more useful with error data. Surely the commissioners want more people to know than just those who show up at its meetings.
