The Bend Bulletin recently editorialized about the Commission's review of data from Oregon's hospital reporting program (see "Feature Stories / Bend Bulletin – 9/5/06" on our home page). Administrator Jim Dameron and Commission Chair Glenn Rodriguez continue the dialogue with this guest column, published in The Bend Bulletin on Sept. 12, 2006:

Give safety commission time to work

By Glenn Rodriguez, M.D., and Jim Dameron / *Bulletin guest columnists*

As you noted in your recent editorial, the Oregon Patient Safety Commission just released its first round of data on adverse events and medical errors.

Currently, 51 of 57 hospitals are participating in our reporting program. Every large and medium-sized hospital, every hospital system, every network has signed on. These 51 represent 98 percent of all hospital care in Oregon (see www.oregonpatientsafety.org for a list). As you said, a terrific start.

So what's next? Our mission is to reduce the risk of medical errors in Oregon. We are doing this by building a credible reporting program, by encouraging a culture of safety and by introducing best practices.

We are now piloting reporting programs for nursing homes and pharmacies. We are also in the first stages of implementing a similar program for ambulatory surgery centers. None of these organizations currently reports adverse events in a way that allows for sharing of quality improvement information. None can learn from the other. We are building something new.

So how can we do that? One answer hinges on the richness of the data we collect.

We go beyond a "check the box, error/no error" framework. We are gathering case-specific information that includes a narrative description of what happened, a detailed inventory of root causes and a concrete list of remedies. Hospitals are willing to share such information because we can guarantee their confidentiality and the confidentiality of their patients.

We are already putting such information to good use. Based on the information we've received so far, we have issued two "patient safety bulletins" outlining possible danger areas in hospitals.

We have also compiled a list of more than 50 action plans identified by participants as having merit. We still need to make sense of that list, but such an inventory has never existed before.

So what are the challenges to building a reporting program? One is the potential for under-reporting. If a hospital has nothing to share with the commission, should we praise that hospital for its perfection or chastise it for stonewalling and inattention to quality improvement?

Well, the answer will be on a case by case basis. But since we are asking hospitals to report on atypical, usually rare events, we need time to build up a case log. In addition, we believe it fair to allow hospitals time to come to terms with the commission - we are new, we are asking for legally contentious information, we insist that hospitals notify patients in writing of medical errors.

In your editorial you called for the conversion of the commission's voluntary system into a mandatory one. This is a much debated point. In fact, the commission was founded on a compromise to that very question.

The agreement is simple - start with a voluntary approach. If it works, terrific; if not, the Legislature is required to consider converting to a mandatory system. It's in statute. But we firmly believe that we have made a strong start, and - so far - can make a good-faith argument in favor of voluntary reporting.

That said, the public has every right to demand accountability of the Patient Safety Commission.

Please look on our Web site for a list of participating organizations. Please come to our meetings to ask questions. Please look for our annual summary of findings. Please read the public health officer's annual assessment of the integrity of the commission's reporting program.

Finally, in a fundamental sense, the Patient Safety Commission is trying to change the culture and patient safety practices of every health care organization in the state.

We strongly believe that we can create a forum for health care organizations to talk more openly about adverse events and how to prevent them. We strongly believe that "shame and blame," whatever its emotional appeal, has failed. We need a different approach.

Glenn Rodriguez is chair and Jim Dameron is administrator of the Oregon Patient Safety Commission.

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