

# Patient safety gets real

*By David Rosenfeld  
Oregon Health News*

For the first time, hospitals have begun disclosing their medical errors to the Oregon Patient Safety Commission. But the 18 errors reported during the first eight months of the patient safety program might not tell the whole story, said Jim Dameron, administrator. "We believe there were more than 18 adverse events during that time period."

Thus far, 51 of Oregon's 57 hospitals have enrolled in the patient safety program. The six choosing to watch from the sidelines are Lake District, Holy Rosary, Santiam, Curry General, Lower Umpqua and North Lincoln hospitals.

Because of confidentiality provisions, it is not known where the 18 errors occurred. What is known is that six of the mistakes were so severe that the patients died; five led to serious injury and seven caused the patients moderate to no harm.

What factors could have led to the underreporting? "Hospitals are trying to figure this out," said Dr. Roy Magnusson, medical director at Oregon Health & Science University Hospital. "There's a gearing-up period and we have to give hospitals some time."

Issues of trust and usefulness still exist, Dameron said. When errors occur, hospitals may be leery of providing patients with written disclosures, which the commission requires, for fear that they could open the door to litigation.

The commission's complex rules may also be creating some confusion, said Dr. Glenn Rodriguez, commission chairman and chief medical officer of Providence Health System. Commissioners cautioned about assuming too much from the initial reports. "It seems really early to be making any value judgments," said Dr. Bruce Johnson, a surgeon at River Road Surgery Center.

Although precise details were not revealed, the errors were broken down by type:

- an object such as a sponge left in a patient's body after surgery led to five errors;
- an unexpected clinical event caused three mistakes;
- surgery performed on the wrong patient or the wrong body part was responsible for two cases;
- a device problem caused two errors;
- a fall caused two cases, and
- surgical procedures, the most common category, were responsible for 10 errors.

In closed meetings, the commissioners will be privy to detailed explanations but hospital names will not be revealed. Pharmacies and nursing homes begin reporting next year.