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State bets on voluntary hospital policing

Medical errors - A panel considers moving away from "blame and shame" in trying to find why mistakes happen

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If a fledgling state panel has its way, most Oregon hospitals will soon agree to report and analyze all serious medical errors and notify in writing patients who are harmed.

The Oregon Patient Safety Commission is unique in the nation in its reliance on voluntary reporting. In effect, it bets that doctors, nurses and hospitals are more likely to disclose errors and share data if they can do so confidentially and without fear of penalty.

The commission on Tuesday approved a blueprint of proposed rules for how that would work. The public can comment at a hearing Jan. 10.

Medical mistakes in American hospitals kill 44,000 to 98,000 patients a year, a 1999 study by the Institute of Medicine found. Even the lower estimate means they cause more deaths than traffic crashes, breast cancer or AIDS.

State officials estimate that 500 to 1,200 patients a year die from preventable errors in Oregon hospitals.

The institute's report, "To Err Is Human," found that most serious medical errors result not from ineptitude or flagrant carelessness but from communication failure amid the complexity of today's health care systems.

The old approach -- expect doctors to be near-perfect and "beat up on the bad apple" when things go wrong -- no longer works, said commission chairman Dr. Glenn Rodriguez, who is chief medical officer in Portland for the Providence Health System. He called bad-apple doctors "minuscule compared to the system errors that grind on day by day."

The national debate on patient safety has shifted, Dr. Carolyn Clancy, head of the federal Agency for Healthcare Research and Quality, told Congress recently.

"The traditional response of 'name, blame and shame' not only does little to improve safety for the next patient, it may actually put the next patient at greater risk by encouraging mistakes to be hidden," she said.

The 1999 report spawned a variety of federal and state efforts aimed at catching systemic failures beyond the actions of individuals such as Dr. Jayant M. Patel, a former Portland surgeon under fire for surgical errors in Oregon and Australia.

"We can find patterns of failure in ways you can't if you just look at individuals holding the scalpel or the pill box," said Jim Dameron, the commission's administrator. "If you shut down every Jay Patel in the world, you will make the system marginally safer, but you won't fundamentally solve the problem."

System problems -- from on-the-job stress and sleep deprivation to overuse of abbreviations on medical

charts -- have "a bigger impact on whether you get out of the hospital safely," Dameron said.

The Legislature created the Patient Safety Commission in 2003 and charged it with "reducing the risk of serious adverse events occurring in Oregon's health care system and . . . encouraging a culture of patient safety in Oregon."

That's fancy language for "keeping safety in the forefront, so it's not just a reaction to the last mistake," Dameron said.

Even deciding exactly what constitutes a reportable medical error can be difficult -- the commission has a subcommittee on definitions.

"Adverse events," the Oregon law's term, range from a prescription for the wrong drug -- or the wrong dose -- to botched surgery.

Regulatory with a twist

Half of all states require reporting of hospital errors. Oregon's approach, through the patient safety commission, is more voluntary than regulatory -- but with a twist.

Hospitals can choose to participate -- or not. If they sign up, they must report in detail every serious error to the commission and tell the patient or family. By law, such notification cannot be used as an admission of liability in court, but it does not prevent a patient from filing a malpractice suit.

The commission is barred from sharing its data with other state agencies, including the Board of Medical Examiners, which will continue to license Oregon doctors and investigate complaints about their work. Information that individual hospitals report to the commission is confidential, subject to neither legal discovery in a lawsuit nor the state public records law.

The commission will not create hospital "score cards," but it will post statewide data and list participating hospitals on its Web site: www.oregon.gov/DHS/ph/pscommission.

"The carrot is, you get to be on the Web site," said Dr. Maureen Wright, quality control director for Kaiser Permanente Northwest and a panel member. "The stick is, if you're not, people will wonder."

Oregon's approach is being watched closely at the national level because it is the only voluntary reporting system in place, said Jill Rosenthal, project manager of the National Academy for State Health Policy. The mandatory approaches vary widely in what information they require and what they do with it.

Advocates of the voluntary approach say it's more important to look at root causes than to affix blame, Rosenthal said. "But critics say, 'We've trusted the hospitals forever to fix the problem, and we still have up to 98,000 deaths a year, so what makes you think they're going to fix it voluntarily?'

"It's hard to say who's right, because there's no model to show what works."

Governor's panel

Oregon's commission grew out of a task force named by Gov. Ted Kulongoski.

Ellen Lowe, a retired nurse and longtime consumer representative on the state Health Services Commission, served on the task force. She started as an advocate of mandatory reporting but decided that hospitals were more likely to share information about mistakes -- how they are made and how they might be prevented -- on a voluntary basis.

"It sounds corny, but I think we built a trust level," Lowe said.

The commission will pool hospital data in search of statistical patterns that reveal system errors. It will share those findings with hospitals and track the response.

Reporting of medical errors and "close calls" at the nation's 162 Veterans Affairs hospitals jumped 30-fold after officials made the reporting confidential and the results nonpunitive, said Dr. James Bagian, director of the VA's National Center for Patient Safety.

"When somebody screws up," Bagian said, "the three most important questions are: What happened? Why did it happen? And what can we learn from this?"

Oregon's new reporting rules eventually will apply not only to hospitals, but also to nursing homes, pharmacies and outpatient surgery centers.

The commission gets no state tax dollars and pays for its work through donations and fees paid by participating hospitals. Kulongoski appointed its 17 members, who include consumers as well as representatives of hospitals, doctors, nurses, nursing homes, pharmacies and insurers.

Like the airline industry, the commission also will collect data on "close calls" -- which experts say can be as revealing as mistakes that cause actual harm.

Oregon's system will build on a pilot project involving five centers: OHSU Hospital, Providence Hood River Memorial Hospital, Rogue Valley Medical Center in Medford, Salem Hospital and St. Anthony Hospital in Pendleton.

Each hospital disclosed to the commission staff its five most recent cases resulting in serious "adverse events" -- meaning a patient was harmed. For each case, the hospital walked the staff through what went wrong, how the problem came to light, lessons learned and what was done about it.

Dameron hopes to have the reporting form and final rules ready soon after the Jan. 10 public hearing, so hospitals can agree to start reporting errors by June. He expects most of Oregon's 59 hospitals to sign up.

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