The Oregonian

Experiment calls on good hospitals to get better

Tuesday, January 31, 2006

O regon hospitals will embark on a bold experiment in self-improvement this year -- that is, those hospitals brave enough to volunteer.

Particularly for smaller hospitals, it could take some courage to step up, but enlightened self-interest will also motivate many of them. Although some key aspects of this experiment will be swaddled in secrecy, one thing will be unavoidably public. Everyone will know which of Oregon's roughly 60 hospitals sign up to participate, and which ones politely decline.

Next month, if all goes as planned, the Oregon Patient Safety Commission will begin enrolling hospitals in a voluntary, confidential program of reporting their serious medical mistakes. Those could include "wrong-side" surgeries, medication mix-ups or other preventable errors that result in death or serious injury. With exquisite tact, the commission has described this gamut of problems as "adverse events."

The Oregon Legislature created the patient safety commission three years ago with the specific charge of establishing a reporting system for such events, identifying them, learning from them and ultimately decreasing their incidence. Conventional wisdom (at least our own) insists that the best way to do that is fully in the light of day, with reporting mandated, not volunteered, and no secrecy.

But the hypothesis behind this Oregon experiment is that the all-too-human impulse to duck often gets in the way of the human striving to improve. As The Oregonian's Don Colburn reported last fall, the idea is that Oregon hospitals will be more inclined to report their mistakes in an atmosphere that emphasizes improving instead of "naming, blaming and shaming."

Imagine a system in which hospitals avoided repeating not only their own mistakes -- often no small achievement in itself -- but also each other's. A feedback loop of relentless self-improvement may sound idealistic, even improbable. But when hospitals are scared to death to expose their errors, such a push for improvement isn't just improbable. It's impossible.

When hospitals don't share this kind of information, mistakes aren't just made, they're replicated. More patients are harmed. In 1999, a groundbreaking report from the Institute of Medicine estimated that preventable hospital errors cause as many as 100,000 deaths a year.

Oregon hospitals have a great deal to gain by participating in this experiment. If they do, they'll be listed on the commission's Web site, and if they don't, people will wonder: Hmmm . . . why not?

Participating is a good way for hospitals to show they care about improving patient safety. It's also a good way to actually improve.