

Keeping track of medical mistakes  
Hospitals join new commission, agree to report their errors

By PETER KORN Issue date: Fri, May 19, 2006  
The Tribune

---

When the Oregon Legislature decided in 2003 to create the Oregon Patient Safety Commission, they didn't make it easy for Jim Dameron, the commission's administrator.

The commission was created to save lives by getting hospitals to report medical mistakes and issue reports so other hospitals could learn from those mistakes.

About half of all U.S. states have programs requiring hospitals to participate and report mistakes, but the Oregon program is voluntary. Also, the Legislature did not give Dameron funding to run the commission. The idea was that participating hospitals would pay a fee to be part of the reporting system, and the money from the hospitals would run the program.

Some national health care experts scoffed at Dameron's quest — getting hospitals to voluntarily join a program to admit their mistakes, and paying for the privilege.

The experts were wrong.

As of Wednesday, Portland's three largest hospital systems — Legacy, Providence and Oregon Health & Science University — had enrolled in the commission's reporting program. In fact, 44 of the state's 57 hospitals have agreed to participate.

### **Prominent cases raise alert**

Nationally, the movement to reduce medical errors gained traction in the late 1990s after a series of well-publicized tragedies. In 1994 Betsy Lehman, a 39-year-old breast cancer patient and Boston Globe health columnist, died after receiving the wrong dose of a chemotherapy drug. In 1995 a surgeon in Tampa, Fla., amputated the wrong leg of a patient.

In 1999, the National Academies' Institute of Medicine issued a landmark report that claimed between 44,000 and 98,000 people die in hospitals each year as a result of medical errors. Another report, by the Agency for Healthcare Research and Quality, said that approximately 7,000 of those deaths every year are the result of medication errors alone.

As medical care becomes more sophisticated, hospital mistakes are inevitable, experts say. One study from the University of California-San Francisco Medical School showed that the average intensive-care patient received 178 "activities" per day, each of which carries a chance for error.

But the real problem, said Glenn Rodriguez, chief medical officer for Providence Health and Services in Oregon and chairman of the Patient Safety Commission, runs deeper than bad judgment on the part of individual doctors and nurses. Or even complex delivery treatments.

More fundamental, Rodriguez said, is that health care workers traditionally haven't come forward to admit their mistakes so that changes could be made.

"There is a culture of secrecy and shame that's sort of a professional tradition," Rodriguez said. And according to Rodriguez, that culture has collided head-on with public attitudes toward hospitals.

"The public perception of health care systems has declined quite a bit over the last 15 years," Rodriguez said. "One of our really big challenges is to build public trust that we really are

committed to public safety.”

Rodriguez believes the patient safety commission can help do that, at least for those hospitals that participate. But he says getting health care workers to report their mistakes to the commission will take a significant amount of trust.

In order to alleviate hospitals’ concerns that the reports could be used in malpractice lawsuits against them, the commission has promised that all reports will be kept confidential. Analyses sent out by the commission will not publicly identify individual hospitals.

But one of the most controversial parts of the legislation that created the commission is a requirement that hospitals tell patients in writing about serious harmful events in their treatment.

That, Dameron said, was a major hurdle to overcome when he was selling the plan. Many hospitals already maintain policies about informing patients when they have been the victim of a mistake, but few do that in writing. And admitting mistakes in writing, Dameron said, raises the red flag of legal liability. “They have to get used to this,” Dameron said.

And yet, 44 hospitals, serving more than 90 percent of the state’s patients, have signed on to report their mistakes.

Keith Marton, chief medical officer of Legacy Health System, estimates Legacy will spend between \$25,000 and \$30,000 each year in staff time to handle the detailed reporting the program requires. That money is in addition to the \$25,000 annual membership fee Legacy will have to pay to participate.

### **Learning from mistakes**

Dameron said he thinks there are a number of reasons he has been successful in getting hospitals to enlist. “There really is a desire to change the culture, to talk of a culture of safety,” he said.

Peter Rapp, executive director of Oregon Health & Science University hospital, said the clincher for his facility was the desire to learn from other institutions. As an example, Rapp said, he anticipates the reports that come back from the committee will contain valuable information on how better to use hospital equipment. “If somebody’s doing something better we’ll steal that idea as fast as we can,” Rapp said.

But Dameron also said there were inducements beyond the obvious. He said hospitals don’t want a mandatory reporting system similar to those in other states. And the legislation that produced the Oregon Patient Safety Commission included a provision that the entire system would be reviewed in 2007 with the possibility of making participation mandatory.

With most of the state’s hospitals on board, Dameron’s attention now turns to getting those hospitals to report their mistakes — even confidentially. In other states, that has been a major hurdle, with some hospitals reporting few serious problems at all.

“Ultimately, the hardest part of this is we’re trying to change the cultures of 57 different hospitals,” Dameron said.

And with hospitals on board, Dameron already has begun working on expanding his beachhead. Nursing homes are next, and retail pharmacies right after that, Dameron said.

[\*Email peter korn\*](#)