House
Legislative
Analysis
Section

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GOVERNOR'S COMMISSION ON PATIENT SAFETY

House Bill 4537 as passed by the House
Second Analysis (9-10-02)

Sponsor: Rep. Paul N. DeWeese
Committee: Health Policy

THE APPARENT PROBLEM:

In December 1999, the National Academy of Science's Institute of Medicine released a report on patient safety as part of its ongoing special initiative on health care quality. Extrapolating from two regional studies of hospitalizations—one conducted in Colorado and Utah and one in New York—the report suggests that "deaths due to medical errors exceed the number attributable to the 8th-leading cause of death. More people die in a given year as a result of medical errors than from motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516)". The report advises that the actual number of medical errors may be significantly higher for two reasons. First, the studies cited only involved hospitalized patients and thus do not tally the medical errors that occur in other settings. Second, to identify an error as an error, some adverse effect must occur and be traced to some human action that is isolable as the cause. Particularly disconcerting is the report's suggestion that health care as an industry is ten years behind other industries in its attention to safety issues.

No one would disagree with the report's judgment that "[w]hether a person is sick or just trying to stay healthy, they should not have to worry about being harmed by the health system itself." The possibility of death or serious harm due to improper treatment, rather than the patient's underlying condition, is a fairly significant reason to take the issue of patient safety seriously. It is far easier, however, to overlook the less obvious costs of medical errors. Remedying conditions brought on by medical errors often requires additional, emergency care, which can be extremely expensive. Also, the time and resources spent on the victim of a medical error reduce the amount of time and resources that health care professionals have to spend on other patients. Further, much of the harm associated with medical errors defies easy measurement; consider, for instance, the difficulty of factoring the public's loss of trust and patients' diminished satisfaction into a cost-benefit analysis.

The report's title "To Err is Human: Building a Safer Health System," articulates two operating premises of the institute's work. First, although humans—including medical professionals—inevitably make some mistakes, mistakes are frequently identifiable and preventable. In the report's own terms, "[i]t may be part of human nature to err, but it is also part of human nature to create solutions, find better alternatives and meet the challenges ahead." In general, the report advocates various efforts to learn more about medical errors. More specifically, the report recommends that "[a]ll adverse events resulting in serious injury or death . . be evaluated to assess whether improvements in the delivery system can be made to reduce the likelihood of similar events in the future." Despite the difficulty of detecting errors that do not result in serious harm, the report also suggests that the analysis of such "minor" errors can vastly improve the quality of health care. Second, while it is arguably possible to attribute all medical errors to the errors of individual health care providers in theory, practical solutions to the problem must acknowledge the role of the health care *system*—or "nonsystem" as the report refers to it—in perpetuating, or at least creating the climate for, errors. The report is careful to note that there needs to be some clear means of holding accountable individual health care professionals who commit serious errors or commit errors frequently. Still, the report observes that many of the problems derive from the complex interaction of health care providers, insurers, regulatory officials, and others who collectively constitute the health care delivery system. Committee testimony corroborated this need to focus on the health care system.

Legislation has been introduced to create a commission on patient safety in Michigan. Members of the commission would be appointed by the governor, and would be required to consult with various organizations with an interest in patient safety.

THE CONTENT OF THE BILL:

The bill would add a new section to the Public Health Code to create a "governor's commission on patient safety" in the Department of Community Health. The governor would appoint members to the commission for one-year terms, and the commission would be charged with studying reports of medical errors committed in health facilities and in private practice and reviewing information from other patient safety initiatives.

Consultation and input. The commission would be required to consult with or seek input from the public and all of the following organizations (or their successor organizations):

- the Michigan [Health and] Hospital Association;
- the Michigan State Medical Society;
- the Michigan Osteopathic [Physicians and Surgeons] Association;
- the Emergency Physicians Association;
- the Michigan Nurses Association;
- the Emergency Nurses Association;
- the Michigan Association of Emergency Medical Technicians;
- the Michigan Pharmacists Association;
- the Michigan Society for Clinical Laboratory Science;
- the Michigan Academy of Physician Assistants;
- the Michigan Society of Healthcare Risk Management;
- the Michigan Association of Health Plans;
- the American Society of Clinical Pathologists;
- the Michigan Physical Therapy Association;
- the Michigan Speech-Language-Hearing Association;
- the American Dietetics Association;
- the National Association of Social Workers, Michigan Chapter;
- the Mental Health Association of Michigan;
- the Michigan Occupational Therapy Association;
- the Health Care Association of Michigan;
- the Michigan Association for Local Public Health;
- the Michigan Hospice and Palliative Care Organization;
- the Michigan Society of Anesthesiologists; and
- the Michigan Home Health Association.

Commission operation. The commission would meet and appoint a chairperson within 30 days after all its members were appointed, and subsequently would meet at the call of the chair or the request of a majority of the commission. A majority of the commission would constitute a quorum for the transaction of business. Commission business would have to be conducted in public (and public notice of the time, date, and place of commission meetings would have to be given) in compliance with the Open Meetings Act. Commission records (writings "prepared, owned, used, in the possession of, or retained by [the commission] in the performance of an official function") would have to be made available to the public under the Freedom of Information Act.

Report. Not later than one year after the commission was appointed by the governor, it would be required to issue a written report that contained recommendations for improvements in medical practice and a system for reducing medical errors, both in health facilities and in private practice.

MCL 333.20188

BACKGROUND INFORMATION:

Among other things, the report provides a useful set of definitions of terms used (sometimes incorrectly) in discussions of patient safety. *Safety* is defined as freedom from accidental injury. The report distinguishes between two general types of errors: errors of planning and errors of execution. An *error of planning* is "the use of a wrong plan to achieve an aim", whereas an *error of execution* is the "failure of a planned action to be completed as intended". An *adverse event* is an "injury resulting from a medical intervention, or in other words, it is not due to the

underlying condition of the patient". The report further explains that "[w]hile all adverse events result from medical management, not all are preventable (i.e., not all are attributable to errors). For example, if a patient has surgery and dies from pneumonia he or she got postoperatively, it is an adverse event. If analysis of the case reveals that the patient got pneumonia because of poor hand washing or instrument cleaning techniques by staff, the adverse event was preventable (attributable to an error of execution). But the analysis may conclude that no error occurred and the patient would be presumed to have had a difficult surgery and recovery (not a preventable adverse event)".

The full report is available online at: stills. nap.edu/pdf/0309068371/pdf_image.

FISCAL IMPLICATIONS:

The Department of Community Health has estimated the cost of the commission at approximately $250,000. (9-6-02)

ARGUMENTS:

For:

Although many people believe that the Institute of Medicine's report on medical errors brought welcome attention to a serious issue, critics of the report suggest that at least some of its claims are overstated. Still, health care professionals stress their concern for the well-being of their patients and their desire to see a reduction in medical errors, regardless of how many there currently are. One medical error is one too many. The report was not issued as a "terminal project"; rather, it was a clarion call for individual states to evaluate the success and failures of the health care system as it operates within their boundaries. Since no comprehensive study of the issue has been performed in Michigan, it is important to conduct such a study now. Proponents' commitment to garnering input from a wide variety of organizations with interests in the issue of patient safety is reflected in the successive drafts of the bill, each of which has included more groups than its predecessor. This is important not only because it ensures the representation of different perspectives but also because it encourages a comprehensive, systematic approach to the problem.

Response:

While the health associations and organizations listed in the bill generally support the establishment of a commission on patient safety, they have raised various concerns about the bill's details. First, some people believe that the issue is significant enough that it requires ongoing attention rather than just a one-year commission. However insightful the commission's report may be, newly developed technologies will always raise the potential for new types of medical errors. Either a permanent commission or the Department of Community Health should study the issue and formulate policies to deal with the issue on a continuing basis. Second, many groups would prefer to be guaranteed representation on the commission, as was proposed in the original version of the bill. As the bill is currently written, the commission would simply have to seek input from and consult with the associations and organizations. Without knowing the exact composition of the commission, it is difficult to know how seriously any individual group's input will be considered. Third, the bill, perhaps inadvertently, leaves off certain groups such as dentists and dental surgeons. A truly comprehensive plan to improve patient safety should be all-inclusive.

Reply:

With respect to the first consideration, if in the course of its investigation and consultation the commission determined that ongoing attention was necessary, it could recommend a strategy for long-term oversight. Second, although it is understandable that each group would like to be represented on the commission, supporters of the bill want to avoid creating a commission that would be too large and unwieldy. Third, successive versions of the bill have each included more health associations and organizations than their predecessors, suggesting that the bill's supporters are willing to consider the merits of including other groups in addition to those currently listed. Groups who have been left off the bill's list could greatly further the cause of patient safety by calling legislators' attention to the importance of their role in articulating a comprehensive assessment of the problem and to their potential contributions to a workable solution.

Against:

The Department of Community Health shares proponents' concern for patient safety but estimates the cost of the commission to be approximately $250,000. This is a significant consideration given the current budget crisis.

POSITIONS:

The Michigan Health and Hospital Association supports the bill. (8-6-02)

The Michigan Osteopathic Association supports the bill. (8-6-02)

The Michigan Pharmacists Association supports the bill. (8-6-02)

The Michigan Home Health Association supports the bill. (9-6-02)

The Michigan Association for Local Public Health supports the bill. (9-6-02)

The Mental Health Association of Michigan supports the bill. (9-10-02)

The Michigan Association of Physician Assistants supports the bill in concept. (8-6-02)

The Department of Community Health has no official position on the bill. (8-6-02)

The Michigan Society of Anesthesiologists supports the bill. (9-10-02)

Analyst: J. Caver

■This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.