Creating Safer Healthcare in Chicago

CHICAGO PATIENT SAFETY FORUM

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S. 544 "THE PATIENT SAFETY AND QUALTY IMPROVEMENT ACT OF 2005"

On Friday, July 29th, President Bush set the stage for a new era in improving the health of all Americans by signing the Patient Safety and Quality Improvement Act of 2005, which sets up a structure for the confidential reporting of patient safety information.

The Chicago Patient Safety Forum, a multidisciplinary organization dedicated to reducing preventable medical errors in the Chicago area, strongly supports this new law as an important step in improving the health care of patients. Among those participating in the various committees, meetings, and research programs organized by the Patient Safety Forum, a common refrain has been the fear of lawsuits or reprisal as a response to the reporting of incidents where patients have been unnecessarily harmed.

This new law establishes procedures for voluntary, confidential reporting of harmful or potentially harmful events to independent patient safety organizations, or PSOs, which ultimately will culminate in a national network of patient safety databases. Researchers and other professionals will have access to patient safety data, which will have no patient or provider identifiers, for analysis and to make recommendations on ways to reduce patients' risks.

The new law, five years in the making, addresses issues in a 1999 Institute of Medicine (IOM) report that found at least 44,000 people die each year from preventable medical errors in US hospitals. The IOM concluded that these errors result primarily from problems created by today's complex health care system, such as the proliferation of drugs with names that sound alike and the increased likelihood for miscommunication when many individual practitioners care for a patient in multiple care settings. However, liability concerns frequently discouraged the surfacing of errors and communication about how to prevent them. The safety process used in other high-risk industries, such as aviation, and recommended by the IOM, centers on a culture that facilitates error identification, objective analysis and wide dissemination of lessons learned to prevent future error. The new federal Act establishes a mechanism that encourages the cooperation of all health care professionals – without fear of being sued or reprisal and without compromising patient's legal rights- to promote the development of best practices and systemic solutions to enhance patient safety.

The law, by itself, will not prevent all medical errors from occurring. However, it lays the groundwork for a greater analysis and sharing of the causes and lessons learned from such incidents and the best approaches to minimize any future occurrences. The Chicago Patient Safety Forum congratulates Congress and the President for enabling us to move more aggressively in addressing the important patient safety issues raised by the IOM.