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PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

Hearing on

Patient Safety: Instilling Hospitals with a Culture of Continuous Improvement

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Good morning and welcome to today's hearing.

In the 19th Century Edward Jenner's discovery pushed the boundaries of germ theory and disease. The use of antiseptics and anesthesia in surgery increased public health levels and sanitation. And, in the end, the simple act of washing one's hands transformed modern medicine by saving lives by preventing the spread of disease.

The topic today deals with how we can reduce errors that negatively impact patient safety. It is not just a discussion about systems – in fact, it's a basic discussion about how do human beings interact with the systems that are created to underscore the primary obligation of medicine: To protect the safety of patients.

That is, in my mind, the premise of our discussion today, and the testimony of our witnesses.

To be sure, there must be strong, dynamic and rigorous systems in place to ensure the safety of a patient from the moment they enter our nation's hospitals – to the time they leave.. There is an opportunity for us to discuss that today, and even more opportunity for us to implement systems that will accomplish this task.

This opportunity was pointed out in a study issued by the Institutes of Medicine three years ago entitled *To Err is Human: Building a Safer Health System.* Today's witnesses are at the forefront of the effort to achieve these improvements.

However, before we get to the discussion of systems, we need to recognize that one of the key ingredients to the future of our health care system is a single word: Confidence.

Americans must have complete and total confidence in their health care systems if we are to ensure progress is made in this nation to keeping our people not only safe, but healthy.

Americans must have confidence that not only is medical technology among the best in the world, but that the people using it are the most highly trained and skilled.

Americans must have confidence that their health care providers – doctors, nurses and others – are not only equipped to manage their care, but that they are committed to the highest standards of medical professionalism and ethics.

Finally, Americans must have confidence in the institutions of health care. We must be certain, beyond a shadow of a doubt, that every possible attempt is being made to ensure that we emerge from our health care experience at a hospital or clinic in a better condition than we entered it.

The basic premise of the Hippocratic Oath, to do no harm, must reflect not just the deliberate efforts of health care providers, but must also extend to the practices and procedures they implement to ensure the totality of the health care experience is safe from beginning to end.

From the onset of washing hands, to the discovery of drugs to prevent disease and pestilence, medicine has been constantly improving and always innovating.

Such improvements must continue to be the hallmark of our health care system.

First, it obviously is a critical component of patient safety and health. Improved care saves lives.

Second, it increases the quality of care, speeding recovery and improving outcomes.

Third, it reduces cost, allowing more individuals to afford quality health care.

Fourth, it eases the acute shortage of health workers such as nurses and lab technicians that many areas face.

This subject could not be timelier for Minnesota. Last week the Minneapolis paper reported the tragic death of two-year-old Briana Baehman. Briana died as the result of a hospital mistake.

Ironically, this mistake happened in one of the Minnesota's best hospitals, a hospital with an excellent record of quality improvement and a firm commitment to increasing patient safety. Our first witness today will also remind us that the consequence of error can often be fatal.

Today's hearing is not meant to focus blame, or to concentrate on tragedies for the sake of sensationalism. On the contrary. These tragedies are painful reminders that human error is a function of human growth. We learn from our mistakes.

Unlike most of us, doctors and nurses are in the unenviable position where their mistakes can easily have fatal consequences. While we can never achieve perfection, the good news is that we can do much better. We can develop a system in which errors are prevented and their consequences minimized.

However, the reality is that we will never conquer human fallibility.

As I said, today's experts are at the forefront of the nation's efforts to instill a culture of quality and implement a system of continuous improvement. I believe that their success or failure will determine the level of confidence Americans have in their health care system, and thus, the future of our health care system.

At its most fundamental level, today's topic is the key to the future of our medical system: how do we ensure confidence and patient safety in our health care system through better performance from the nation's health care system, especially its hospitals?

There are proven management practices that have many names including lean manufacturing, balanced scorecards, and Six Sigma. Although Japanese companies such as Toyota and Sony made many of these practices famous, they were originally developed by American experts such as W. Edwards Deming. Today most of the world's leaders in productivity are American companies such as GE, 3M, and Honeywell.

The experts we hear from today will tell us that we can get these same improvements from the health care sector if we adopt some of the same management practices. Like any other institution, hospitals are basically human endeavors.

While we cannot legislate away human error, we can develop system for minimizing the chance of error by improving communication, standardizing practice, and learning from mistakes. Doing this depends on a number of things, however. One is the willingness to study and eliminate barriers to better performance. These barriers may take the form of human resistance to change, the lack of a team culture, or liability concerns about sharing information. By themselves, each barrier may make sense, but when they stand in the way of better healthcare, we need to examine their continued usefulness.

Second, we need to work with those institutions, organizations and agencies that are prepared and committed to go that next step towards ensuring ongoing confidence in the safe care of patients in our health care system.

I am pleased that one of those people who are here today to talk about what they are doing to ensure a system that will provide for monitoring and improvement of patient safety in Minnesota is Commissioner of the Department of Health Dianne Mandernach'.

The State of Minnesota is one of the first in the nation to begin implementing a system of data collection, working with the Minnesota Hospital Association, to ensure accurate reporting of information related to patient safety.

I want to thank the Commissioner for being here today, and for the work and leadership she has provided on other issues, including SARS, in the State of Minnesota.

In the end, in every area such as long-term care, medical practice, and product development, we need to and can do better. And the tools for doing so are already at hand. The health care industry can and must undergo the same type of transformation toward a culture of quality and system for continuous improvement that the manufacturing sector has recently experienced. Our experts are here to tell us that that is being done and with our help it can be done faster.

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