House
Legislative
Analysis
Section

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# COMMISSION ON PATIENT SAFETY

**House Bill 5897 (Substitute H-1)**
**First Analysis (12-5-00)**

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

## *THE APPARENT PROBLEM:*

Though not all medical errors result in harm to the patient, many do. Such errors are considered to be adverse events that should be preventable, and can include problems in the way medicine is practiced, in products used, in procedures used, and in the systems in place in hospitals and private practices. For example, a diagnostic error from a misinterpretation of test results or failure to use an indicated diagnostic test can lead to a misdiagnosis of a patient's condition, which in turn leads to choosing an inappropriate treatment. As appropriate treatment is delayed, a patient's medical condition can worsen, leading to more costly treatment, missed days from work, or even death. Medication errors, whether from drug interactions or adverse reactions to prescribed medicines, also can have serious health effects and result in death. According to a report on medical errors from a study conducted by the Institute of Medicine (IOM), annual deaths in the U.S. from preventable medical errors now surpass the number of deaths from car accidents, breast cancer, and AIDS. The total annual cost to the nation in lost income, disability, and health care costs from preventable medical errors ranges from $17 billion to $29 billion.

It is believed that the analysis of medical errors could have a beneficial impact on improving patient safety. In the IOM report, entitled To Err is Human: Building a Safer Health System, committee members recommended that a comprehensive approach be taken to address the issue and sufficient pressure put on health care organizations and providers to improve patient safety. According to the committee, if such actions were taken, reductions in medical errors could be cut in half, if not more, over a five-year period.

Though the IOM study calls for national action, some believe that action at the state level could also dramatically increase safety for patients, whether medical care is provided in a hospital or nursing home, as outpatient treatment, or in a doctor's office. Many believe that, in light of the overall impact that medical errors have on the safety of health services, the governor should appoint a commission to study the problem within the state and make appropriate recommendations.

## *THE CONTENT OF THE BILL:*

The bill would amend the Public Health Code to create the Governor's Commission on Patient Safety within the Department of Consumer and Industry Services. The 20-member commission would meet and appoint a chairperson within 30 days after the members were appointed by the governor. A commissioner would serve for one year, and vacancies would be filled in the same manner as the original appointments. After the initial meeting, the commission would meet at the call of the chairperson or at the request of eight commissioners. Eight members would constitute a quorum for the transaction of business.

The commission would be charged with the systematic review of patient safety initiatives and study the causes of medical errors that occur in the continuum of care, including health facilities and private practices. A written report would have to be issued within one year after the commission's appointment. The report would have to contain recommendations for improvements in medical practice and a system for reducing medical errors, both in health facilities and in private practices.

Commission meetings, as well as notices of meetings, would have to be held in compliance with the Open Meetings Act. A writing owned, prepared, used, in the possession of, or retained by the commission in the performance of an official function would be available to the public under the Freedom of Information Act.

Members of the commission would be appointed from the following associations or their successor organizations:

• Two representatives from each of the following: the Michigan Hospital Association, the Michigan State Medical Society, the Michigan Osteopathic Association, and the Michigan Pharmacists Association.

• Two representatives of health care consumers.

• One representative from each of the following: the Emergency Physicians Association, the Michigan Nursing Association, the Emergency Nurses Association, the Emergency Medical Technician Association, the Michigan Society for Clinical Laboratory Science, the Michigan Academy of Physician Assistants, and the directors of the Departments of Community Health and Consumer and Industry Services or their designees.

• Two representatives of the risk management profession, one of whom who would have to be a representative of the Michigan Society of Healthcare Risk Management and one who specialized in physician office risk management.

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## *BACKGROUND INFORMATION:*

The National Academy of Sciences, of which the Institute of Medicine (IOM) is an associated organization, was created by the federal government as a private, non-governmental organization to be an adviser on scientific and technological matters. The 316-page IOM report entitled To Err is Human: Building a Safer Health System, can be found at the National Academy's website, www.nap.edu.

## *FISCAL IMPLICATIONS:*

According to the House Fiscal Agency, the bill would result in an indeterminate increase in costs to the state. The bill does not specifically provide for either per diem or expense reimbursement payments to commission members. However, it would likely increase administrative costs imposed on the Department of Consumer and Industry Services by a very slight amount. These costs could be met out of existing resources. (12-4-00)

## *ARGUMENTS:*

### *For:*

Death from a medical error has now become the eighth leading cause of death in the U.S., meaning that a person is more likely to die as a result of a medical error than from a car accident, breast cancer, or AIDS. The economic cost is staggering, averaging well over $17 billion annually from lost productivity, disability, and death. The social cost, though hard to quantify, is nonetheless profound, as family members are maimed, disabled, or killed by mistakes that are largely preventable. Medical errors include patients being given medications that they are allergic to, patients developing serious infections from unsanitary equipment or from healthcare workers who did not follow proper hand washing protocols, incorrectly read diagnostic tests, contaminated laboratory samples, and having the wrong limb amputated or organ removed. According to news stories, some patients have resorted to writing instructions on their bodies such as "remove the right leg only."

Not all adverse events in hospitals or from medical care provided in doctors' offices are from medical errors, and not all medical errors result in permanent harm or death. There are, however, enough deaths and serious effects resulting from preventable mistakes that consumers and health professionals alike are demanding that the health care delivery system be scrutinized and answers found to increase patient safety. Though the recent publication of an Institute of Medicine report on medical errors is sure to spur discussion on the national level, many feel that there is much that the state could do to reduce harm to patients.

The bill would be an important first step by establishing the Governor's Commission on Patient Safety. To having the backing and support of the governor lends authority and importance to such studies, as has been seen through the years by many important commissions that have studied the impacts of gambling, the needs of Michigan's children, and the sensitive issue of genetics research and privacy.

Under the bill, the commission would be charged with reviewing patient safety initiatives and studying the causes of medical errors. This study could reveal many important causes for adverse events that occur in hospitals, nursing homes, laboratories, pharmacies, and doctors' offices that could be targeted for improvement. For example, if illegible handwriting on patient charts or prescriptions is proved to be a major source of errors in treatment or in medications given, electronic systems could be devised whereby orders could be recorded, stored, and sent in electronic format. A systemic study of adverse events could also reveal problems with a piece of equipment used in a particular procedure and more reliable equipment could be sought out and used. Basically, a commission study could identify where breakdowns in safety are occurring and appropriate solutions could then be found to address and eliminate the problems.

The bill is good public policy. Consumers are losing faith in the health care system, limited health care

dollars are spent dealing with the adverse consequences of medical errors instead of being used to care for more people, and families are grieving the loss of loved ones who should still be alive. The information and subsequent recommendations that will come from the commission study will surely improve patient safety, reduce unnecessary spending brought about by medical errors, reduce expenditures caused by lost productivity and increased insurance costs, and reduce disability costs.

## *POSITIONS:*

The Michigan Osteopathic Association supports the bill. (12-4-00)

The Pronational Insurance Company supports the bill. (12-1-00)

The Michigan Society for Clinical Laboratory Science supports the bill. (12-4-00)

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#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.