Thank you for the opportunity to testify here. I am President and CEO of a nonprofit organization, the Institute for Healthcare Improvement, whose mission is to accelerate improvement of health care systems. I am also Clinical Professor of Pediatrics and Health Care Policy at Harvard Medical School.

I am here today as a representative of the Institute of Medicine of The National Academies. I serve on the IOM's governing Council, and I was a member of the IOM's Committee on Quality of Healthcare in America, which wrote the two landmark reports on quality, To Err Is Human and Crossing the Quality Chasm. I believe that these and subsequent IOM reports on quality offer this nation, and this Congress, a superb blueprint for the redesign and improvement of our American health care system.

I am going to focus on the To Err Is Human report mainly: What does it say? What should we do? And, how can Congress help?

That report has three major findings:

- First: Many Americans are injured by the health care that is supposed to help them. Tens of thousands, in fact, die from injuries caused by their care and treatment, rather than from their diseases. The IOM's estimate is between 44,000 and 98,000 such deaths per year in hospitals, alone.

- Second: Only a tiny fraction - perhaps two or three percent - of these injuries are due to incompetence, carelessness, sabotage, or gross negligence on the part of individuals. They tend, instead, to come from latent hazards built right into the systems of care. The more complex the systems, the bigger the hazards. Put otherwise, the IOM finds that most patient injuries, if they are due to human errors, are due to those kinds of errors that are part of daily life - human factors - and therefore those errors are in some sense, inevitable. If we fired every single doctor and nurse who made a mistake today, the error rate in America health care would be the same tomorrow. Mostly, the people are good, but they work in flawed systems.

- Third: Errors can be reduced, but not eliminated. Injuries are different; they can be eliminated, or nearly so. From other industries and from good theories, we know that it is possible for very complicated systems to be very safe - much safer than health care - by providing technological and cultural supports that make human error less likely to do harm. The problem is that health care has not yet invested anywhere near enough time, talent, and money in trying to become much safer. We lack both the technologies and the culture that could make us safe.
To get safer, health care has to change. To get much safer, it has to change a lot.

On the technology front, we must modernize our information systems, make the electronic medical record a routine feature of all health care, and simplify our procedures and practices by removing unnecessary steps, unnecessarily complicated equipment, and senseless variations in practice from place to place. We need to integrate information across boundaries, so that we do not drop the ball when the patient moves from one hospital to another, or from the office to the hospital to the nursing home and back home. We need to develop registries and systems for remembering patients' drugs, diagnoses, and preferences. We -both the care providers and the public - need to understand that in health care, more is not always better - in fact, it is very often worse. And that even in this wonderful age of biomedicine, simpler care is often safer care.

As tough as the technologic challenges are, the cultural changes we need may be even tougher. There are safe cultures, and there are unsafe cultures. The properties of a safe culture include the following:

- Safety is a top priority, from the top, all the time; no injury - none - is regarded as inevitable;

People talk openly about hazards, errors, injuries, and other threats to safety. A fearful organization - where people feel that they have to hide their own mistakes - cannot be a safe organization;

- Communication and coordination are high priorities; people value teamwork above all;

Innovation is constant, and new ways to make things safer are rapidly incorporated into practice.

From this cultural viewpoint, most health care organizations do not exhibit a culture of safety. Becoming much safer is not yet a top priority for clinical leaders, executives, and Boards. Other, apparently more pressing, issues of organizational finance and survival occupy their attention. Few seem to believe that major improvements in patient safety will help them become more vital, resilient players in their markets. Financially, safety in health care does not yet pay off.

In fact, we still do not even talk about it much. People in health care are fearful about discussing injuries to patients, near misses, and errors. They are afraid of lawsuits, embarrassment, and mistrust from colleagues. Most injured patients never know that it happened to them. Communication and coordination are not taught as skills in professional training, nor are they well-supported by proper investments of time and leadership attention. Nor have we yet invested enough in innovations to modernize our safety systems, especially innovations related to electronic patient records and prescribing systems. Health care systems are complaining about the costs of modernizing their patient record and drug order systems. In short, with respect to the needed cultural changes, we are stuck in "neutral" too often and in too many places.
Since the IOM reports, awareness has grown that health care safety ought to be a top priority. But, actions have lagged well behind awareness.

And yet, I am an optimist. People are waking up. Today and tomorrow, the National Patient Safety Foundation is holding a conference here in Washington with hundreds of clinicians and health care leaders attending to learn about how to improve from some of the greatest experts in the world. Federal systems, like the Veterans Health Administration, the Department of Defense's medical care system, and the Bureau of Primary Care in the Health Resources and Services Administration, are making widespread progress in improvement. My organization -- the IHI -- is announcing this afternoon the launch of a free, open, web-based support system - "QualityHealthCare.org" - to help anyone, anywhere, who wants to improve care, and we are beginning with patient safety as the prime focus.

Congress has helped, but you can help even more. Here is how.

Continue your review, support, and encouragement of leading work on patient safety in Federal agencies that give or fund care, including the Veterans Health Administration, the Military Health Care System, HRSA, the Indian Health Service, and CMS. Urge -insist - that these systems become benchmarks of safety for the nation.

- Keep the spotlight on safety with hearings such as this, and in your own individual work, so that the public will for change grows.

- Help us reduce the toxicity of our current unfair, inefficient, and illogical malpractice liability system, which today produces too much fear and waste, and which fails to compensate most injured patients at all. The IOM has called for one or more statewide demonstration projects on medical tort reform, and Congress should do what it can to make sure these actually take shape. (A recent report from the Florida Governor's Select Task Force on Health Professional Liability Insurance includes some creative ideas for one such demonstration.) A tort reform demonstration trial should have, in my personal opinion, the following five elements: (a) immediate disclosure of injuries to patients and families; (b) apology; (c) fair and reliable compensation to injured patients and families (analogous to a workers' compensation system); (d) learning from injuries and near misses so that hazards are continually reduced; and (e) fixing the locus of responsibility for all of this at the enterprise level - holding executives, Boards, and leaders accountable for improving safety, rather than generally blaming individual clinicians. (Of course, in the very rare instances when the injury is the result of bad intention or clear and gross individual incompetence or negligence, action to correct individuals should be prompt and precise. We must keep in mind, however, that the vast majority of injuries do not have this property.) Finally, tort reform experiments should be time-limited tests - at first perhaps three or four years long. The changes should become permanent only if the new system achieves measurably higher levels of fairness, compensation, and safety than the current one.

- To help bring health care into the modern electronic era, please establish a national program to produce, within the next two years, a simple, publicdomain electronic medical record that any hospital or physician's office in the nation can get and use.
Such a record should have a problem list, a medication list, registry functions, and the ability to interface and exchange information helpful to individual patient care.

- Continue to fund ambitious, path-finding patient safety research through the Agency for Healthcare Research and Quality and other related research programs.

Above all, please continue to be the voice of the American people, expressing our shared concern about the current, unacceptable levels of injuries to patients. Insist that the health care system become safer, and create rewards for those systems that invest authentically in that goal, and consequences for those that do not.