

treatment ... or other documents, records, or data that exist separately from the process of collecting or developing information" for a safety record; "information merely by reason of its inclusion, report, or the fact of its submission" to a safety database or error-analysis system; and "information available from sources other than a report or submission" to an error-reporting system.

The squabble between Kennedy and others about data protections is substantive. One issue that currently blocks compromise between the two House bills is less germane. The House bills are part of a long-running jurisdictional feud between the Ways and Means and Energy and Commerce panels that seems to have escalated since Rep. **Bill Thomas** (R-CA) took the helm of Ways and Means and Rep. **Billy Tauzin** (R-LA) ascended to the commerce chair.

Ways and Means would make its error bill part of the Social Security Act. The panel's general jurisdiction is over revenue matters, including Social Security and some other social insurance programs, such as the portion of Medicare funded from dedicated revenues provided by payroll taxes. The Commerce committee would make error provisions part of the Public Health Service Act. Commerce generally presides over consumer and public health matters. Which act the language is added to determines who controls the issue on the House side in the future, and the two panels frequently struggle over jurisdiction on health matters.

Whether congressional wrangling does or doesn't end quickly, however, efforts to establish a safety-oriented culture in health care facilities are proceeding. Those involved in forwarding the efforts don't expect a speedy or easy victory, however.

States where error information seems wide open to legal discovery do seem to be tougher environments for reporting to flourish, says **Scott Laidlaw**, business leader of Philadelphia-based **DoctorQuality.com**, a developer of Internet-based systems for reporting and analyzing medical data. Making it "easy and blame-free" to report is a necessary prerequisite to collecting adequate data, he says.

Nevertheless, neither statutory mandates to report nor statutory protections for reporting is enough to make patient-safety systems an integral part of most health care facilities, he says. When New York state mandated reporting of error data a few years ago, for example, "it didn't drive a whole lot of prospects our way," even though DoctorQuality's product allowed instant forwarding of relevant reports to the state database, which also requires electronic submission.

Today, real institutional commitment to a reporting culture exists only in pockets. Among the sales staff at DoctorQuality, the watchword is, "Go find the clients that get it," Laidlaw says. Nevertheless, ultimately most will want in, once the current vanguard of institutions demonstrates that reporting and analysis produce concrete system fixes that actually increase efficiency and safety, he predicts. The company is developing new products that will give facilities access to such safety innovations developed by others. And, "ironically, it's these later-generation products" that will bring in the lion's share of customers.

Consistent national statutory protections for shared data will help establish the climate for change, but time will be required, says **Nancy Wilson**, MD. Trouble comes if impatience rules and "we assume that any one solution will address all performance and quality of care issues," says Wilson, a former VA physician and master of public health who is vice president and medical director for clinical services for the national hospital network **VHA Inc.**

Statutes that would be antithetical to the cause of patient safety are any "that prohibit the collection, analysis, and distribution of objective clinical data" — vital for policy development — "by allowing attorneys to drill down and produce details" for use in creating class action suits, for example. That's the view of **Jay Wolfson**, professor of public health and medicine at the **University of South Florida** in Tampa and director of USF's federally funded **Suncoast Developmental Center for Patient Safety Evaluation and Research**.

"The goal of public policy is to produce better outcomes using objective data," says Wolfson. It's unnecessary for attorneys to force analysts to reveal identifying details connected with such data because "adverse outcomes" worthy of a lawsuit "are manifest," he says

A better way to improve accountability is to make trustees legally responsible for putting in place systems that track errors and amend processes so as to decrease them, says Wolfson. He adds that he thinks chances are good for Medicare and Medicaid, at least, to impose such a requirement in the relatively near future. With such a scheme in place, courts could then decide whether a given facility's error-response system was a reasonable attempt to improve safety, he says.

Accountability is important, says **Brian Shea**, a manager in **Cap Gemini Ernst & Young's** Boston-based health consulting practice. "I hate to say this, but in states where you have more malpractice pressure, there seems to be more real impetus to change." Nevertheless, "you don't want malpractice to drive the system," so additional ways to create accountability must be found.

In fact, however, neither carrots nor sticks will succeed in creating a whole system that's truly oriented toward improving safety, says Shea, a pharmacist who's been a member of Leape's Harvard Adverse Drug Event Study Group.

What's needed instead is "cultural change" that gets every provider at the bedside personally engaged in a search for system improvements. To achieve that, "people need to know that they can make a difference" by reporting and analysis.

Only slow and patient work will produce that change, however, and history doesn't confirm that a good outcome is inevitable, Shea laments. When it comes to improvement strategies in health — from evidence-based clinical outcomes to total quality management — "we have the attention span of a gnat."

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