July 17, 2000

The Honorable James M. Jeffords
Chairman
Committee on Health, Educat ion, Labor and Pensions
835 Hart Senate Office Building
Washington, DC 20510

Dear Senator Jeffords:

On behalf of the 115,000 members of the American College of Physicians-American Society of Internal Medicine (ACP-ASIM), I am writing in support of the "Patient Safety and Errors Reduction Act" (S. 2738). ACP-ASIM represents physicians who specialize in internal medicine, as well as students with an interest in the specialty. We are the largest physician specialty society and the second largest physician membership organization in the United States.

Last year's Institute of Medicine report revealed that medical errors are a leading cause of death in the United States, resulting in more deaths than motor vehicle accidents, AIDS, or breast cancer. The report emphasized that the problem is systemic in nature and requires a collaborative solution involving the medical profession, hospitals, patients, and government. We believe that the recommendations in your legislation would contribute significantly to reducing the number of medical errors.

We strongly support the recommendations in S. 2738 to:

- Establish a new Center for Quality Improvement and Patient Safety within the Agency for Healthcare Research and Quality (AHRQ). We concur with the mission of the Center as included in the bill to provide national leadership for research on patient safety, to develop public-private sector partnerships, and to serve as a national resource for research and learning from medical errors. It is vital to expand the knowledge base on the causes of medical errors and what strategies will be effective in reducing errors. Reporting alone will not reduce errors. There must be a national effort to analyze the data from the reports and to communicate what is learned to both providers and patients.
- Expand peer-review and confidentiality protections to encourage development of post-error review processes. In our view, the establishment of such protections is a pre-requisite for an effective reporting system. Information that is developed with respect to system shortcomings (root-case analysis) and subsequent analysis to prevent such errors in the future should not be "discoverable information" used in litigation. This privilege should not interfere with disclosure of information that is otherwise available. Patient and provider confidentiality is essential to encourage post-error review.
- Develop voluntary systems and learn from existing systems. Voluntary reports of problems that do not cause death or serious inquiry to the patient must be a key element of a national strategy to reduce preventable errors.

We look forward to working with you to gain support for this legislation.

Sincerely yours,

Sandra Adamson Fryhofer, MD, FACP
President