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News Release

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Washington, D.C. -- The Department of Veterans Affairs (VA), the American Hospital Association (AHA), the National Patient Safety Foundation of the American Medical Association (AMA), the American Nurses Association (ANA) and other national health-care organizations today announced the formation of a public-private partnership to improve patient safety. Saying that this is a problem that neither government nor individual private health-care organizations can solve working alone, Kenneth W. Kizer, M.D., M.P.H, VA Under Secretary for Health and the chief executive officer of the nation's largest integrated health-care system, called for the partnership to reduce medical care errors.

VA, AHA, AMA's National Patient Safety Foundation, and ANA, along with the Institute for Healthcare Improvement, the Joint Commission on Accreditation of Healthcare Organizations and the Association of American Medical Colleges, will launch a nationwide dialogue and sponsor a national summit on patient safety. Scheduled for 1998, the National Patient Safety Summit will bring together health-care providers, consumer advocates, medical educators, policy experts and regulatory organizations to develop solutions to this national problem.
"Medical treatment-related adverse events are a major unrecognized problem in this country. We need to have an intensive dialogue and take aggressive action to confront this issue. If we do not act now, I fear the situation will worsen due to the increasingly technical nature of health care, compounded by the rapidly changing environment in which medical treatment is provided," said Dr. Kizer.

The health-care leaders expressed frustration with current barriers to dealing frankly and openly with the issue. In particular, fear of litigation, sensational and anecdotal media coverage and the traditional medical culture make it difficult to acknowledge mistakes or system failures.

As part of the sweeping reengineering of its health-care system initiated by Dr. Kizer three years ago, VA has implemented a risk management policy that strives for zero errors. The new policy calls for continuous assessment of patient treatment, acknowledgment of errors when they occur, open and complete reporting of adverse events, system redesign based on analysis of these events and rapid dissemination of lessons learned.

In addition to implementation of this new policy, Dr. Kizer noted that VA would be taking other steps to reduce treatment-related adverse events, including:

- Helping fund the December 1997 Expert Working Group on Assembling the Scientific Basis for Progress on Patient Safety that is being organized by AMA's National Patient Safety Foundation;
- Establishing a new health system management fellowship aimed at developing clinical leaders in health-care quality improvement, with up to 12 positions targeted for the first year;
- Initiating a new requirement that all VA physicians and other clinicians complete at least 20 hours of continuous quality improvement education/training each year;
- Convening an Expert Advisory Panel on Patient Safety System Design that will focus on the transfer of information from non-health-care industries (e.g., aviation). The Committee will be chaired by James P. Bagian, M.D., a former astronaut who led the Challenger

investigation; and,

- Directing up to $5 million to fund new quality of care clinical research projects to be conducted at VA medical facilities.