



BRIDGEPORT HOSPITAL

YALE NEW HAVEN HEALTH

**TESTIMONY OF
Michael Ivy, MD
Bridgeport Hospital
Before the Public Health Committee
March 1, 2010**

**SB 248, An Act Concerning Adverse Events
At Hospitals and Outpatient Surgical Facilities**

Good Afternoon. My name is Michael Ivy and I am the Vice President of Performance and Risk Management at Bridgeport Hospital. I am here today to express serious concern with Senate Bill 248, An Act Concerning Adverse Events at Hospitals and Outpatient Surgical Facilities.

I am a trauma and critical care surgeon by training, and I have practiced at 4 hospitals in the State of Connecticut; Yale-New Haven, Bridgeport, the VA, and Hartford Hospital. I have been in my present role at Bridgeport Hospital for the past two years, and I chose to become involved in quality improvement and risk management because I know I can make a difference. I am skilled at getting people to collaborate and improve the systems they work in. I am passionate about my work, and I don't think there is anything I can do that is more important than this work.

Like most surgeons my age and older, I was trained to think that errors were the result of an individual failing to do his work competently. It is now clear that only rarely are the mistakes that harm people in healthcare truly individual errors, instead they are the result of a system that is flawed. The recurrence of a mistake can be minimized or prevented by fixing the system itself. It also turns out that if we can get enough openness in our hospitals, where our employees and physicians feel safe in reporting "errors" or "near misses," we can identify the "system" problem and fix it before someone is seriously harmed. That openness occurs when staff members believe we have a "just" culture and know that they will not be punished for mistakes that do not warrant punishment.

We work to improve safety and quality every day at Bridgeport Hospital – that is the most important thing we do. This year, we have worked hard to establish a "just" culture at the hospital, and we are starting to reap the benefits of that work. We want to keep this openness so we can learn from our mistakes and proactively prevent adverse events. Senate Bill 248 threatens to destroy that culture by setting back the culture of openness and inhibiting the progress we are making. This legislation will not make things better; it will only slow us down.

While I believe the proposal is well-intentioned, as written, it will not improve the State's current adverse event reporting system, and would likely work as a disincentive to reporting events and improving patient safety. Confidentiality in adverse event reporting is essential to the process. The primary purpose of reporting is to learn from experience, not to impose punitive sanctions and penalties. Adverse event reporting is a critical first

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step toward taking corrective action. It is proven that confidential systems encourage, rather than discourage, reporting of adverse events.

To conclude, at Bridgeport Hospital, our highly skilled patient care teams provide safe, high quality patient care to thousands of Connecticut residents. When errors occur, I can assure you that we promptly and thoroughly investigate them to identify the cause, learn from our findings, and most importantly, prevent recurrence.

I respectfully urge your opposition to SB 248 which would likely erode the safety culture we have worked diligently to foster as a means of improving patient care. Thank you for your consideration of our position.