



**Testimony of Robert Englander, MD, MPH, Senior Vice President,  
Quality and Patient Safety, Connecticut Children's Medical Center  
To the Public Health Committee  
Regarding *Senate Bill 248, An Act Concerning Adverse Events  
at Hospitals and Outpatient Surgical Facilities*  
March 1, 2010**

Senator Harris, Representative Ritter, members of the Public Health Committee, thank you for the opportunity to speak with you today. I am Dr. Robert Englander, Senior Vice President for Quality and Patient Safety at Connecticut Children's Medical Center and I am here to speak about *Senate Bill 248, An Act Concerning Adverse Events at Hospitals and Outpatient Surgical Facilities*.

Like other hospitals in the state, Connecticut Children's is committed to reporting, investigating, and preventing adverse events. However, Senate Bill 248 does not improve upon the system currently in place, and in fact potentially works as a disincentive to reporting events and improving patient safety. The primary purpose of reporting is to learn from experience, not to impose sanctions and penalties. As we have learned from the well-documented experience of the aviation industry, public disclosure of events does not drive improvements in safety. Non-punitive reporting systems serve the best interest of the patient by encouraging reporting of adverse events as a first step in taking corrective action.

In health care, as in other industries, good people make mistakes for which they are very sorry. In addition, many adverse events as defined by this proposed legislation are unpreventable and yet can be the source of learning for both individual institutions and health care systems. Senate Bill 248, as written, could drive errors into secrecy and that does not benefit anyone. Punitive measures have a chilling effect on adverse event reporting. The national trend in improving patient safety focuses on creating a culture of safety where events are reported, rather than ascribing blame and punishment for errors. There are other, more appropriate mechanisms to ensure accountability of healthcare facilities and professionals. We cannot lose sight of the purpose of an adverse event reporting system: to identify trends of problems and remedy them, which improves patient safety and quality of care.

Connecticut Children's Medical Center is committed to transparency, accountability and creating a culture of safety for all of our patients and families. I urge your committee to reject Senate Bill 248 but also to recognize that a process that encourages reporting without the assignment of blame and punishment is the first step towards making changes that result in improvements. Creating and maintaining systems that encourage collaboration between and among hospitals, and allow our health care system to gain understanding of best practice and learn from mistakes will yield better patient safety outcomes more expeditiously than this bill as written.

Thank you for your time and consideration of this important matter.