Press Release: September 12, 2017
From: Clifford A. Rieders
Pennsylvania Patient Safety Authority
Tuesday, September 12, 2017
Summerdale, PA

Remarks by Clifford Rieders to the Patient Safety Authority

Note: Cliff Rieders, a Founder of the Patient Safety Authority, asked the Senator not to reappoint him after his latest term expired December 31, 2016. At the Board meeting, Physician General Rachel Levine presented Cliff to the Board at a public meeting and gave to Rieders a Keystone-shaped plaque entitled "Pennsylvania Patient Safety Authority Recognition Award Presented to Clifford A. Rieders, Esquire, in recognition of your valuable contributions while serving on the Pennsylvania Patient Safety Authority's Board of Directors to improve patient safety in Pennsylvania healthcare facilities. March 2002-September 2017, Pennsylvania Patient Safety Authority, 'signed" Rachel L. Levine, MD, Chair, Pennsylvania Patient Safety Authority Board of Directors."

Remarks by Cliff Rieders:

I am not very good at accepting awards. I always figured that a person's work speaks for itself. I guess I got that from my father, who did not know any organization that he was not willing to serve on.

This has been a labor of love for me. Many thank yous are in order. The first "thank you" goes to the Pennsylvania legislature for enacting the Patient Safety Authority. This plaque will go right next to the pen from Governor Schweiker, which hangs on my wall and which pen commemorates the signing of House Bill 1802, "Medical Malpractice Reform," March 20, 2002. At that time, I vowed there would be no additional burden created to prevent legitimate claimants from suing for medical malpractice without a Patient Safety Authority. A Patient Safety Authority had been recommended by the Institute of Medicine in November 1999. Pennsylvania was the first state to establish it. I fought long and hard, as President of the Trial Lawyers, for a Patient Safety Authority, and I was proud of its enactment.

I also want to thank Stan Smullens, MD, Emeritus of the Jefferson Healthcare System. We started off as somewhat opponents, perhaps banging heads. I figured that

he was a representative of the medical industry, and I was representing the innocent victim. With the passage of time, I found Stan to be a gentleman, colleague, friend, mentor, and thoroughly decent person. He cares about patient safety. He has served as Vice Chair and Interim Chair previously.

It is also important to thank Dr. Rachel Levine, who has brought a sense of professionalism, order, and competence to the Patient Safety Authority. In fact, she is one of the reasons why I have decided not to be reappointed. I mean that, of course, in a positive sense. Knowing that the Authority is now run so well by well meaning and sincere people gives me great comfort. Also, "thank you" to Regina Hoffman, our new Executive Director, who has also helped professionalize the organization. No list of "thank yous" would be complete without thanking Howard Newstadt, whose books, recordkeeping and orderliness has made this a well-oiled bureaucracy. "Thank you" to Ms. Plesce, fellow Board members, ECRI staff, and others. I can truly say I have never worked with a nicer group of people, more committed to a good cause.

The long-range plan devised by Executive Director Hoffman and the work of Rachel Levine, MD, represent a watershed in the history of the Patient Safety Authority. There certainly is much work to be done, and to that end, I have given a list of 18 suggestions and thoughts to Rachel Levine. Hopefully, once you have read those, you still will be willing to circulate them to the Board.

I have seen the Patient Safety Authority go from a quasi-political institution to one dedicated mainly to enhancing patient safety. We have had worldwide impact. That does not mean our job is completed. We must remember to keep the emphasis on "patients." It is, after all, the "patient" safety authority. This is all about better healthcare at a reasonable cost.

I will continue to be available to the Patient Safety Authority. When I was done being President of the Trial Lawyers, my friend, Billy Goodrich from Pittsburgh, put his hand on my shoulder and said, "Now you are an elder statesman." I have enjoyed the role of "elder statesman" in the many organizations that I have served. I will enjoy that role with the Patient Safety Authority. Any of you know that you can call upon me any time. I will always be there for the Patient Safety Authority as a friend and a patient advocate.

I have begun the next stage of my evolution with respect to patient safety. I have founded Patient Power, an umbrella organization of patient advocacy groups in Pennsylvania. There are many small patient advocacy groups in Pennsylvania, but they need to be organized. Hopefully we will get to work with the Patient Safety Authority as partners. We are up and running. We will file for 501(c)(3) status with the federal government, establish a website, and interface with an organization such as Healthcare

Quality Containment Council, the Department of Health, the Patient Safety Authority, and others.

This is a propitious moment for me. There are too many people to thank fully, and I do not want to take up any more of your time. Being a founder and developer of the Patient Safety Authority, and working with uniquely capable upstanding people, has been a great honor and pleasure. I am a strong believer in establishing new leadership in organizations. We have done that with people like Eric Weitz and my successor, Veronica Richards, two idealistic and principled trial lawyers.

Dan Glunk, MD, from Williamsport, has brought important peer review analysis to our work. I hope that Dan will continue to offer useful commentary in this respect.

While I would like to go through and mention each Board member by name, I will save you time by once again thanking you for the tremendous respect that I have received from this group and the responsibility that you have bestowed upon me. I hope that I am worthy of your confidence, as we all continue to work in the interests of patient safety in the affordable healthcare environment.

Respectfully submitted,

09.08.2017

Patient Safety Authority Issues

Matters of Concern Going Forward

1. Informed consent being the key to when serious events are reported and our guideline on that. Are we going to be doing a follow-up guideline? How are we going to deal with the fact that many medical care providers think that once they have provided informed consent, should the warned-of event occur, it is not unanticipated and therefore "serious event" reporting is unnecessary. See my op-ed on the subject and the letter to the Editor from Dr. Ginsburg.

2. Many in the healthcare industry believe that informed consent means that there is no unanticipated event and therefore, the "serious event" need not be reported. This means the family does not get notice. What is really at the core of this, often, is the "ego" of the doctor or reporter and the fear that telling the patient or his/her family the truth may result in a lawsuit. In fact, the opposite is true. Legitimate peer review studies have shown that when patients receive truthful information, they are less likely to initiate litigation. Most of the people who call us are simply for the "peer review" and "root cause analysis" that doctors and hospitals should be doing.

3. Many think serious event letters are a joke. Many do not even use the words "serious event" and give no information whatsoever. Some use the terminology "unanticipated event." The problem is that the form letter was originally written by the Hospital Association of Pennsylvania, which is essentially a lobbying group for the hospitals. The form should have been devised by the Patient Safety Authority, and should be passed upon by the Patient Safety Authority.

4. People should have the right to express their opinions on the Patient Safety Authority, and should they have to give a heads-up on what those opinions are? Even public opinions which are balanced seem to incur discomfort from certain components of the Patient Safety Authority. Those opinions should be encouraged in order to assure that the Patient Safety Authority stays on the cutting edge of medical developments.

5. Pregnancy childbirth related death. I took this up with Dr. Levine and she said yes, it was disturbing and we need to do something about it. Needs follow-up. Why did this healthy mother die after childbirth? The date of the article is May 15, 2017.

6. Pennsylvania does not have a maternal morbidity and mortality report, according to Dr. Levine. We do have the mandatory child death report. There have been discussions with the Department of Health with stakeholders such as the Pennsylvania Chapter of the American College of Obstetrics and Gynecology about a maternal morbidity and mortality report, but it would require legislation. Not sure that is correct and is something we ought to discuss further. Once again, this is evidence of the fact that we defer to the lobbying groups and special interest groups.

7. More public information so people can choose the safest hospitals.

8. Dealing with the fact that certain parts of the state always show higher serious event reports and we attribute to the fact that they are better reporters, but we do not know that to be true.

9. Articles published by ECRI, our contractor, touting achievements and making claims that could not necessarily be substantiated from a peer review point of view, such as enhanced safety in certain aspects.

10. Resolution of bedsore issues.

11. How do we evaluate on an ongoing basis ECRI?

12. Infection benchmarks under Act 52. While that may not be precisely within our orbit, certainly infection control is something that we are concerned about and we need to be more cognizant of the legislative mandates.

13. Electronic medical records issues. Lack of compatibility, access, inconsistency, tyranny of drop-down menus, inability to communicate between systems, duplication of records, carrying forward information no longer accurate or relevant, cut-and-past issues, metadata, costs.

14. Making sure that the Patient Safety Authority maintains its independence and does not become captive to any hospital or healthcare system group.

15. Providing systemic failure information to the Department of Health.

16. Doing much better with respect to whistleblowers. We still have a number of whistleblowers that is so low, that the system is of questionable viability.

17. Annual report. Making sure that it is principled, accurate, and even self-critical rather than merely a self-cheering section.

18. Speculative evaluation of data. There have been attempts now and then to correlate data the Patient Safety Authority receives with the number of lawsuits. This is a very slippery slope and has no peer review basis. In order to know for sure whether what we show as a drop in serious events can be correlated with decreased lawsuits or payouts, one would have to know if the event resulted in a serious event letter. The facts of the event would have to be compared with the lawsuit filed, meaning that there would have to be a way of tracking what is reported to the Patient Safety Authority with any legal action taken by the patient or the patient's family. Any lesser approach, certainly the ones that I have head bandied about, would be highly speculative. Likewise, attempts to correlate cost of healthcare with reportable events needs much work. We know from a apocryphal point of view that healthcare costs keep going up, yet they should be level or going down if there are diminishing medical errors in hospitals. Perhaps it would be a good idea to pick a discrete area like falls and see if decrease in the number of falls reported can be correlated with lawsuits concerning falls and healthcare costs associated with treating patients who fall in hospitals and other facilities. A proper paradigm needs to be set up in advance of trying to understand this data and its relationship to costs/lawsuits.