February 16th, 2023

Dear Chair Kropf, Vice-Chairs Andersen and Wallan, and members of the committee,

Thank you for the opportunity to provide my personal **support of HB 2919**. I commend Representative Nelson and Senator Gelser Blouin for introducing HB 2919.

I can't add to the public hearing testimony of Representative Nelson, Ms. Rachel Prusak, and Ms. Paige Spence, as I believe all the main points were adequately covered.

As a practicing nurse and patient safety specialist, I review medical errors daily. To help understand why errors happen, it is crucial to have a culture psychological safety to help our caregivers process the events as well as participate in the mitigation process. Unjustly criminalizing honest mistakes removes psychological safety and drives reporting of errors underground.

The patient safety profession is aware of the consequences of medical errors, both to patients and caregivers. In addition to RaDonda Vaught, the shocking stories of nurses Kim Hiatt and Julie Thao highlight the unjust criminalization of unintended human error. Nurses often experience the emotional consequences following errors, which is commonly termed as the "second victim." In Kim Hiatt's case, it led to her suicide.

It is up to us in the patient safety and risk management professions to find the true causes of errors that cause harm. Often, the healthcare system has significant accountability. Our caregivers are caught up in this system, which often impedes their personal safety practices. Rarely, if ever, is the healthcare system held criminally liable for medical errors; it often falls onto the caregivers.

I'll leave you with this timely quote from Dr. Lucian Leape: "The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes."

Sincerely,

Bill Schueler, MSN, RN, CEN, CPPS, WVTS, FAEN

Patient Safety Specialist