

This legislation is the same as the measure my colleague, Robert Wexler of Florida, introduced in the House of Representatives this spring. But this is not the first time I've fought for the rights of our nation's reservists, or our nation's federal employees. In 1991, when so many of our brave reservists answered the call to fight for our country in the Persian Gulf, I sponsored similar legislation. During the Gulf War, Senator DURBIN, the other sponsor of this bill, who was then serving in House, introduced the exact same legislation.

Before and since then, I have been a part of many other efforts to make sure that those who work on behalf our country, both here and abroad, are not penalized simply for their service to our country. This legislation will help relieve the financial hardship being felt by so many of our dedicated citizens. It will allow those who stand ready to serve our country not to have to worry about how the bills at home will be paid while they fight to protect the way of life so many Americans enjoy.

We all hope that federally-employed military reservists achieve success in their military duty, and return safely to comfort at home. But our efforts abroad should not compromise the living standards of them or their families, and our efforts to relieve their plight cannot wait.

I strongly urge my colleagues to join me in standing up for our active duty citizens, the federal employees who serve our nation in peace and, as reservists, in war, by supporting this very important legislation.

HOLD TO S. 1805

Mr. GRASSLEY. Mr. President, I would like to inform my colleagues that I have lodged an objection to the Senate proceeding to S. 1805 or to any other legislation or amendment that converts temporary judgeships to permanent judgeships.

When there is a temporary judgeship on a court, when the temporary judgeship expires, the next permanent vacancy that occurs will not be filled and will be deemed not to be a vacancy, so that the total number of permanent judgeships allowed by law stays the same. On the other hand, the net effect of converting a temporary judgeship into a permanent judgeship is the creation of a new permanent judgeship for that court. The creation of new judgeships should not be taken lightly.

As you know, I firmly believe that the Federal judiciary should not be expanded prior to comprehensive congressional oversight. Congress has not held a single hearing in this Congress on whether additional judges are necessary for the Federal courts, and specifically has not evaluated whether there is a need to convert the temporary judgeships contained in S. 1805 into permanent judgeships. Arguments that the Judicial Conference has recommended these changes should be

scrutinized with care, the formula that the Judicial Conference utilizes to create judgeships is flawed and can be substantially manipulated. There needs to be serious congressional oversight of the numbers, which is our responsibility. We need to ensure that the courts are employing all appropriate methods to take care of their caseloads and to make sure that they are utilizing all efficiencies and techniques. Moreover, we should be looking at filling appropriate existing judicial vacancies before we create new judgeships.

VA COMMENDED FOR PATIENT SAFETY INITIATIVE

Mr. ROCKEFELLER. Mr. President, today I am proud to highlight the recognition given to the Department of Veterans Affairs for the high level of attention they have paid to patient safety in recent years.

The Institute for Government Innovation at Harvard University has announced that VA's National Center for Patient Safety (NCPS) will be one of five winners of the annual Innovations in American Government awards. An article in yesterday's Washington Post brings this achievement to national attention and details why VA's Center was the only federal recipient of the award.

It's apparent that the NCPS has cultivated a culture within VA that promotes communication and therefore enables health care staff to feel more comfortable about reporting medical errors or even concerns that they have about patient safety. VA launched this initiative in 1998, but it received a major push in 1999 when the Institute of Medicine released a report estimating that 44,000 to 98,000 Americans die each year due to medical mistakes.

This award demonstrates how VA has pioneered the establishment of the type of culture which must exist. According to the article, many health care providers in the private sector have started to model their patient safety models around that of the NCPS. This was a driving force behind the Institute for Government Innovation's decision to recognize VA's efforts by giving them this honor.

For a long time now, I have pushed VA to pay closer attention to patient safety, as it has been an issue of concern in the past. This is why I am glad to finally see VA on the cutting edge of patient safety, and being acknowledged for it. Our veterans deserve nothing less than highest standards of health care.

I ask unanimous consent that an article from The Washington Post, detailing VA's patient safety program and the award, be printed in the RECORD.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

[From the Washington Post, Dec. 13, 2001]

VA MEDICAL SYSTEM TO GET HARVARD INNOVATION AWARD
REPORTING, HANDLING OF HEALTH CARE ERRORS TO BE CITED

(By Ben White)

The Department of Veterans Affairs health care system, long derided as a bloated bureaucratic mess, will be singled out for praise today for its efforts to improve the way medical errors and close calls are reported by health care workers and handled by hospital administrators.

VA's National Center for Patient Safety (NCPS) will be the only federal program among five winners of the annual Innovations in American Government awards from the Institute for Government Innovation at Harvard University. The awards are to be announced today.

Gail Christopher, executive director of the institute, said the NCPS is helping foster a "healthier culture of communication" in which health care workers at VA's 173 medical centers are far more likely to report mistakes or close calls than in years past.

"It's sort of a breath of fresh air for workers who are used to being in an adversarial or litigious climate," Christopher said. "It meets a basic set of human needs, to strive for excellence while at the same time acknowledging the potential for human error. Its genius is really its simplicity."

VA officials say the program, begun in 1998, produced a 30-fold increase in the number of accident reports in just 16 months and a 900-fold increase in the number of reported close calls over the same period. These numbers reflect not an increase in mistakes, they say, but rather a big jump in the willingness of doctors, nurses and other workers to report problems.

The agency began to focus on the issue after a 1999 report by the Institute of Medicine estimated that 44,000 to 98,000 Americans die each year as a result of medical errors.

VA Secretary Anthony J. Principi said NCPS has created a centralized mistake-reporting system that helps staff analyze and address repeat problems while also establishing a new culture in which the emphasis is on addressing the root causes of errors rather than punishing those who make them.

"We look at entire systems now, not just, say, a nurse who [makes a mistake] because she is pressed for time," Principi said in an interview yesterday. He noted, however, that VA will still punish anyone who "intentionally and criminally hurts a patient."

In addition to the improved, confidential mistake-reporting system, NCPS has set up a voluntary external system, modeled after a NASA program, that allows any individual to report medical mistakes or close calls anonymously.

NCPS Director James P. Bagian said the anonymous system serves as a safety valve to make sure serious problems that VA health workers might feel uncomfortable reporting, even confidentially, do not slip unnoticed.

Bagian cited a flawed pacemaker and a potentially deadly ventilator as examples of problems the NCPS regime has helped identify and correct. But he said the biggest success has been the change in culture. VA health care workers now know they will be identified publicly and punished only if they deliberately cause harm to a patient, according to Bagian. If a worker simply makes a mistake, he can report it confidentially and a team will assess the case, addressing the cause of the error rather than the individual responsible.

"We no longer focus on whose fault it is," Bagian said, noting that the handbook explaining the new approach is written in plain