Clinton panel rejects call for mandatory reporting of hospital errors

Jerry White
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Federal health officials commissioned by the Clinton administration have rejected recent recommendations by the National Academy of Sciences on how to reduce medical errors. The academy had recommended a new federal law that would compel hospitals to report all mistakes that cause serious injuries or death to patients.

Last November the academy's Institute of Medicine (IOM) revealed that medical errors in hospitals were one of the leading causes of death and injury in the US, killing between 44,000 and 98,000 people a year, or more than the number who die from highway accidents, breast cancer or AIDS. Even more died, the IOM report stated, as a result of mistakes in other health care settings, such as day-surgery and outpatient clinics, retail pharmacies, nursing homes and home care. Deaths from medication errors alone, both in and out of hospitals, kill more than 7,000 Americans each year, exceeding the number who die from workplace injuries.

The IOM's Committee on Quality of Health Care in America blamed the majority of errors, not on individual recklessness, but on “basic flaws in the way the health care system is organized.” Their report cited examples such as stockpiling of certain full-strength drugs in patient care units even though they are toxic unless diluted, as well as illegible writing in medical records resulting in the administration of a drug to which a patient has a known allergy. It also noted that the health care system was evolving so quickly that it often lacks coordination. For example, when several practitioners treat a patient they often do not have complete information about the medicines prescribed or the patient's illnesses.

The committee said, “Health care is a decade or more behind other high-risk industries in its attention to ensuring basic safety” and concluded that a substantial reduction in medical deaths, permanent disability and unnecessary suffering would require “rigorous changes throughout the health care system.”

One of the IOM committee's recommendations was for the federal government to establish a “nationwide, mandatory public reporting system.” Under such a system, the committee proposed, “hospitals first, and eventually other places where patients get care, would be responsible for reporting such events to state governments.” At present only one-third of all states have their own mandatory reporting requirements.

The academy presented its report to President Clinton on December 7. Clinton initially expressed support for the recommendations and instructed federal health officials to evaluate the proposals and report back to the White House by February 5.

The IOM's proposal about mandatory reporting requirements, however, was staunchly opposed by the hospital corporations, insurance companies and doctors' associations, which complained that a federal law would further expose them to lawsuits, liability and damages.

Dr. John M. Eisenberg, who is leading the administration's review of the IOM's proposals, has announced that federal health officials are not prepared to endorse mandatory reporting of serious medical errors. Eisenberg and the other officials said if hospitals were compelled by law to do so, they would be less willing to report medical errors for fear of legal action and the loss of business. They claimed that hospitals would be more likely to report such errors on a voluntary basis.

Dr. James P. Bagian, director of the National Center for Patient Safety at the Department of Veteran Affairs, said it was “premature” to compel private hospitals to follow even the minimal reporting required at government veterans hospitals. These hospitals must

report mistakes to the agency's regional offices, which in turn send the information to Washington.

Underscoring the real reasons Clinton's medical advisors opposed mandatory reporting, Dr. Bagian continued, “The community hospitals operate in a competitive environment where public embarrassment can have business implications.”

“If you're not careful here,” Bagian warned, “legislation could have a chilling effect on people's willingness and ability to report errors.” In other words, no law should be passed because the hospital corporations would simply violate it to protect their profit interests.

The initial proposal from the IOM, while insisting that the public had the right to know about serious medical errors, recommended that data on medical mistakes that cause no serious consequences remain confidential. Clinton's health care advisers supported this proposal and said that hospitals that investigate their own errors should not, as a rule, have to disclose the results of their internal deliberations or their analysis of the causes.

By opposing the mandatory reporting of fatal and dangerous medical errors, however, the Clinton administration is prepared to go to far greater lengths to protect the profit interests of the big hospital chains and insurers. They are explicitly saying that patients and their families do not have the right to know to whom they are entrusting their lives.

Responding to these proposals, Dr. Donald M. Berwick, a member of the National Academy of Sciences panel that issued the initial report, said mandatory reporting would “address deep public concern about whether the health care system is open and honest and accountable. Suppose an airline could crash a plane and not tell anybody about it. That would be wrong. Likewise, if people are seriously injured because of errors in medical care, don't they or their families have a right to know?”