

# DEAD BY Mistake

## Calls for medical error reporting reforms heard across country

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Mandatory national reporting of medical errors should be a top priority in Congress, said Rep. Jim McDermott, D-Seattle, a key subcommittee chairman who helped write the current healthcare-reform legislation.

"Dead by Mistake," a Hearst Newspapers investigation of medical errors published last week, brought to light an issue that is "right there at the top of the list" of problems that should be solved, McDermott said.

The Hearst investigation showed that even though nearly 200,000 people die each year from medical errors and infections in hospitals throughout the country -- and hundreds of thousands more suffer debilitating injuries -- there is no concerted effort to track the carnage.

Car accidents, airplane incidents and workplace injuries are regularly accounted for, but there is no national system for tracking deaths from medical care.

Around the country, state legislators and other officials reacted to the series by seeking reforms.

- In New York, the chairman of the State Assembly Committee on Health, Richard Gottfried, D- New York City, called for hiring more hospital inspectors to assure that hospitals accurately report adverse events.
- In Connecticut, Attorney General Richard Blumenthal, along with the chair of the state Senate's health committee, called for overhauling the state's reporting rules to make data on errors more transparent to consumers.
- In Washington, Democratic State Sen. Karen Keiser, chair of the Senate health committee, incensed by the under-reporting of medical errors in the state, said she and a Republican colleague will sponsor legislation to put more teeth into the reporting bill -- making clear that the reporting must be mandatory.

While hospitals are required to report "adverse events" in Washington, Hearst Newspapers revealed that only a trickle of reports have come in. Keiser said she will also pressure the health department to enforce the current law. In addition, she said she will help find a way for the reports to be analyzed. State law required that a consultant be hired to analyze the error reports, but it never happened because not enough money was appropriated for the task.

### Readers, organizations respond

Hundreds of readers responded to the series, which profiled 30 victims of medical errors.

"Those individuals are not just numbers," said Melanie Mann, who plans to download the photos of the victims and display them at her next patient safety training workshop at the Jackson Health System, a network of hospitals and doctors in Florida.

"Sometimes we think they are just another part of the mortality statistics, but they are not," said Mann, a registered nurse. "These are real people that we affected because we didn't do things we are supposed to do in our practice of health care."

"It's important to keep this before the public, the public makers and organized medicine to keep the heat on," said Jim Rathlesberger, executive officer of the California state Board of Podiatric Medicine.

The Pittsburgh Regional Health Initiative, in response to the Hearst series, unveiled its proposal for a federal commission empowered to regulate hospitals.

Though not a fan of regulation, Karen Wolk Feinstein, president of the Pittsburgh nonprofit, said hospitals have had long enough to reduce medical errors and have failed.

"It is appalling how many people are still victims," Wolk said.

There should be a federal commission of doctors, researchers and patient safety experts to review the most common errors and recommend proven solutions that would become federal regulations, she said.

For example, there could be regulations for marking a surgical site or a checklist for inserting a catheter. Both are known practices for avoiding medical errors -- wrong site surgery and hospital-acquired infections -- but their use is not widespread.

"It's not going to solve all of this but I believe it would save lives, and I think it could be set up in way that would be very inexpensive," Wolk said.

Consumer Union, a longtime advocate of reporting, renewed its call for vigorous public disclosure of medical mistakes and allowing patients to see what is happening at their local hospitals.

"The series did a great job of highlighting stories that show the human face behind the problem and I think that is a key part of bringing about change," said Lisa McGiffert, who directs the Safe Patient Project for Consumer Union

Consumer Union supports nationwide "MVP" reporting: mandatory, validated (meaning hospital data is audited) and public disclosure at a facility-specific level. Most state reporting systems currently divulge only statewide information, which McGiffert called useless.

"We are Consumer Reports. Can you imagine if we said 'Okay, we looked at all the cars and 10 of them are really good and 5 of them aren't,' and we didn't tell you which ones?"

### **Timing is vital**

Nationally, with healthcare Topic A in Congress, timing becomes a key factor in efforts for change.

McDermott said the nation needs public reporting -- but the issue must wait until the debate over national healthcare reform ends.

The issue of patient safety and national reporting is a "hornets' nest" in the current healthcare debate in Congress because of the fear of backlash from doctors, said McDermott, who is himself trained as a physician and psychiatrist.

Doctors and medical associations have previously blocked medical error reporting proposals, partly out of fear that it would spur medical malpractice litigation, and partly from a distaste for oversight. McDermott strongly disagrees with them, but respects their influence.

"Frankly, I think the medical associations have not been acting in their best interest by resisting that," said McDermott, who along with Ron Paul of Texas is the most senior among 15 medical doctors in Congress.

The American Medical Association would not respond to McDermott's call for public reporting, but sent a statement saying the group supports the current federal system of voluntary reporting.

"The AMA championed the passage of the patient-safety legislation to create a system where healthcare professionals can report errors in a voluntary and confidential manner so that future system errors can be avoided as we learn from past mistakes," said Dr. James Rohack, president of the American Medical Association in a written statement.

McDermott said he attended 100 hours of Ways and Means closed-door sessions regarding healthcare reform. He never recalled a proposal for national reporting of medical errors being mentioned. Everyone, he said, was fearful of adding measures to the already controversial bill that would increase dissent.

"When you go to war, you take on as few enemies as possible, or stir up as few hornets' nests as possible," he said. "We need to get everybody in the country covered, first (with medical insurance). Once we do that, we can go back and look at how many bad events are happening."