

Patients deserve to see hospital error reports

There is a phone call everyone dreads. Often, it comes in the middle of the night, shaking slumbering victims from their dreams into the reality of their worst nightmare. A loved one has died, and the world will never be the same. Natural death is hard enough to deal with, but loss from an accident, especially one that occurs when caregivers commit fatal errors, is almost unbearable. Families feel betrayed because those who were supposed to be saving the lives of their loved ones have actually taken life through their mistakes.

Fatal medical errors happen more often than one might think, and in a majority of states, hospitals are not required to report such mistakes to government agencies. Because reports are not available to the public, there is the possibility that patients could be unknowingly putting their lives at risk when they go to the hospital. They and their families have health care choices, and when their lives are in danger, patients have every right to know about the shortcomings of hospitals and their employees.

In a medical error report released by the Institute of Medicine last November, it was discovered that at least 44,000, and possibly up to 98,000, patients die from fatal medical blunders every year. Mistakes range from overdoses to botched surgeries. There have also been cases where doctors prescribed, pharmacists filled or nurses administered medicine that caused fatal allergic reactions. These errors were often the result of misread or unreadable charts and prescriptions. Hospital employees cannot be perfect. Where there are humans, there will be human error. However, 44,000 fatal human



HEATHER CORBELL

errors are grossly unacceptable.

Hospitals and medical workers have to be held accountable for their mistakes. The Institute of Medicine found that only about one-third of the states in the United States require hospitals to report fatal or serious medical errors to state agencies. That leaves almost 30 states where patients could unwittingly commit themselves to the care of incompetent providers. Last week, President Clinton attempted to put more supervisory power into the hands of the federal government when he unveiled a proposal to require mandatory reporting of such mistakes. His proposal is legally binding for the 500 hospitals that are administrated by the Defense Department, but is really intended to elicit a legislative response. A congressional bill could require reporting for all state-funded hospitals.

health care is not about statistics. It is about one patient with a life, a family and friends. If a patient dies, his or her life is worthy of justification. Just as people learn from the mistakes of history, so can the health system learn from the errors of medical workers in order to improve itself.

Reporting will also allow government agencies to work to improve conditions and the integrity of hospital employees. The public will be able to help by holding hospitals accountable and ensuring that mistakes are not ignored.

The president's plan was met with opposition from the American Hospital Association (AHA) and the American Medical Association (AMA). Both groups claim that public error reports will only increase the risk of lawsuits against hospitals and their employees. The AMA adds that hospitals in states with reporting

systems are not significantly safer than those in other states. There are, however, fewer errors in hospitals that are supervised by the state.

The primary concern of groups like the AHA and the AMA is that mandatory reporting will cause an increase in lawsuits against hospitals and hospital employees. However, a study in the *Annals of Internal Medicine* predicts that reporting systems will actually decrease lawsuits by patient families. Malpractice litigation is usually a result of anger. Families feel that they have been deceived by medical workers when mistakes occur and they are not informed. Hospitals that admit to their mistakes and offer just compensation are often able to completely sidestep the legal system. In most cases, honesty is the best administrative policy for hospitals.

Mediocre health care compromises the integrity of all American health systems, and it happens when those systems are allowed to make mistakes in

silence. Hospitals have to be supervised and called to account for their shortcomings. It is frightening to imagine that the nation could settle for any less than excellence from healthcare providers. The only way to know whether or not Americans are getting excellence is to let them know what they are getting.



Often, students will only study or learn what they will be tested on. A similar scenario seems to be happening in the hospitals where fatal medical errors are occurring. The only way to prevent mistakes in the future is to hold caretakers responsible now. Doctors and other medical workers who slip up and lose a few patients might start settling for mediocrity if they do not have to talk about their mistakes. They also might justify a little failure with a majority of success. But