



Mandatory Reporting of Medical Errors: Sound Prescription or Policy Malpractice?

by Dr. Alfredo G. Esposto

Summary

President Clinton and other politicians have greeted the release of a report on deaths caused by medical errors with calls for greater government oversight of doctors and hospitals. But another government medical bureaucracy will only make health care less accessible and likely do nothing to reduce medical errors.

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Mandatory reporting of medical errors would put bureaucrats, not medical professionals, in charge of dictating national goals for patient safety.

Governments thrive on crises, whether real or exaggerated. A crisis offers self-interested politicians and bureaucrats a justification for new programs and regulations that give them greater influence over our society and economy. The latest example of this phenomenon is the call for a new government bureaucracy sounded by many politicians following the recent release of a report on medical errors by the Institute of Medicine, a quasi-governmental agency.

The report disclosed that between 44,000 and 98,000 Americans die each year due to preventable medical errors—mistakes made by health professionals. In response to these alarming figures, President Clinton and members of Congress are proposing to force doctors and hospitals to record and report to the government any and all medical errors. On its face, such a proposal sounds reasonable, but it is important to first put the report's numbers into perspective and then examine the likelihood that another government medical bureaucracy will be able to help matters.

The numbers, while indeed disturbing, represent for the average patient a one-eighth to one-third of one-percent chance of dying from a preventable medical error when he enters a hospital. The risk of an adverse event also varies depending on what the patient's medical needs are. The risk is, for example, two to three times greater for surgical than for non-surgical procedures. Furthermore, only about half of the deaths attributed to medical error can be considered "negligent" errors—that is, the result of the health professional or organization not following the reasonable and customary standard of due care.

Of course, *any* chance of dying from a preventable medical error is serious, as the families of those who die can attest. And as the Institute of Medicine points out, 44,000 deaths from medical injury is greater than the number of people who die from automobile accidents, workplace injuries, or AIDS every year. But even so, the relatively low risk hardly qualifies as a "national crisis" requiring government action, as some irresponsible politicians warn.

What would mandatory reporting do? It would require the creation of a cumbersome new government agency to collect and manage the reports. It would put bureaucrats, not medical professionals,

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in charge of dictating national goals for patient safety. And it would probably require states to set up their own agencies to collect information and enforce standards of safety.

Why is this a bad idea? Consider the reality that medicine is more an art than a science. The doctor, like the artist, is not sure of the final product of his efforts until the work is finished. He may have to try many things before he gets the result he is looking for. Sometimes a treatment works; sometimes it does not; and occasionally it is accompanied by adverse results. But we accept the risk of medical care because the certain outcome of not seeing a doctor is chronic illness or death.

Mandatory reporting of errors cannot lower the inherent risk of medical treatment, but it very well may make doctors think twice before trying an uncertain treatment, which may be a patient's last chance for recovery. So along with any reduction of injuries and deaths that a mandatory error reporting system *might* bring, we can expect to see an *increase* in chronic illnesses and deaths as more cases are labeled "hopeless." Furthermore, if history is a guide, it will not be long before government uses the information it collects to justify further regulation of the physician-patient relationship—a sure prescription for poorer quality health care.

Supporters of mandatory reporting do not necessarily believe that keeping a watchful eye on health care providers will reduce the number of medical errors. They may believe, however, that the information collected will help others to develop new procedures and methods to reduce the probability of errors. But innovation also involves risks, and physicians and other medical professionals are less likely to take risks—even in their patients' best interests—when the government is looking over their shoulders. In addition, hospitals, health and malpractice insurance companies, and patients' rights groups already have resources and incentives (in the form of malpractice liability and consumer demand) to collect and use information to help reduce medical errors.

Both the federal government and the state of Michigan should resist the urge to impose a potentially harmful error reporting system on doctors and hospitals in response to a perceived "crisis." Such a prescription is closer to quackery than to sound public policy.

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