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Mandatory Error Reporting Discourages Disclosure of Information

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March 17, 2005 — In response to pressure for greater hospital accountability for medical errors and to spur efforts to prevent them, 21 states have created systems that call for mandatory reporting of major errors to regulatory agencies. Some states, such as Massachusetts, disclose the names of hospitals at which such major errors occur, while other states keep those data confidential.

But a new study finds that instead of encouraging more reporting of medical errors, a majority (69%) of hospital leaders believe that mandatory reporting systems that share error-related information with the public actually discourage the reporting of such events within hospitals. And nearly three fourths (73%) thought that a mandatory system would have either no effect or a negative effect on patient safety in their hospital.

An even higher percentage (79%) of hospital leaders said that mandatory, nonconfidential systems encouraged lawsuits against hospitals, the study found. It was published in the March 16 issue of *JAMA*.

Two key findings emerged from the study, noted lead author Joel S. Weissman, PhD, an associate professor in the Department of Medicine and Institute for Health Policy at Massachusetts General Hospital in Boston. The first was hospital leaders' "concerns about these systems leading to lawsuits and having a chilling effect on internal reporting" of medical errors, he said.

"The other message is that they'd like to see more value from these system," such as more dissemination of aggregate data by states to help hospitals learn how to prevent or minimize the likelihood of serious errors. Such data-sharing has not yet occurred in Massachusetts, noted study coauthor Catherine L. Annas, JD, director of patient safety at the Massachusetts Department of Public Health in Boston. "It's definitely a goal," she said.

To assess hospital leaders' opinion of state medical error reporting systems, study researchers conducted a survey of hospital chief executive and chief operating officers from two states (Massachusetts and Colorado) with mandatory reporting with public disclosure, two states (Pennsylvania and Florida) with mandatory reporting without public disclosure, and two states (Texas and Georgia) without mandatory systems. Since the survey was conducted in 2002-2003, both Texas and Georgia have enacted mandatory systems, the study noted.

In addition to their perceptions of the effects of mandatory reporting systems on error reporting, the likelihood of lawsuits, and overall patient safety, respondents were also queried about their attitudes on releasing reports of error incidents to the public. They were also asked about the likelihood of reporting incidents to the state or to an affected patient based on hypothetical clinical scenarios that varied the type and severity of injury caused to the patient.

Although 79% of hospital leaders worried that mandatory, nonconfidential reporting would lead to a greater likelihood of lawsuits, that concern was not shared as widely by respondents from those states where such systems were already in place, the study found. One third of respondents from states with mandatory, nonconfidential systems said such systems had either no effect or discouraged the filing of lawsuits.

To a certain extent, "familiarity breeds acceptance," Dr. Weissman said of the fractured opinion. Hospitals in Colorado and Massachusetts "are not inundated with lawsuits." And "even if a story about a medical error at a hospital made the front page of the newspaper, there would be a follow-up story about amelioration" of the mistake, he said, noting the recent example of involving infants who received a Tylenol overdose at Brigham and Women's Hospital in Boston.

While hospital leaders' perceptions of mandatory reporting on error reporting, the likelihood of lawsuits, and patient safety were fairly uniform, they were more mixed on the questions of releasing reports of error incidents to the public and to patients, the study found.

When a "moderate or minor" injury, described in the study's three clinical vignettes, occurred in mandatory, nonconfidential state, for example, responses ranged from 22% to 69% in saying that they would "always or usually" report the incident to the state or the patient. In contrast, responses from hospital officials in states where that information was confidential ranged from 43% to 89% in saying that they would always or usually report the incident.

The differences in reporting, according to Dr. Weissman, may depend on clinicians' decision to report fewer incidents of minor injury if the information does not remain confidential. Responses also may vary due to the differences in regulatory definitions among states about what constitutes a reportable event, he said. "Some of the language is not really definite, and that certainly could be behind part of it."

Hospitals need more consistency in the type of information to be reported to state authorities so there are no hidden "disincentives" to report, noted Leslie Kirle, MPH, study coauthor and senior director for clinical policy and patient advocacy at the Massachusetts Hospital Association. Mandatory reporting has served its role of fostering accountability, she said, but "the jury is out on its impact on quality of care."

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