Hospital mistakes going public in 2008

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BY Jim Ritter Health Reporter

They're called "never events" -- inexcusable hospital foul-ups that should never occur but happen all too often -- say, a hospital operates on the wrong leg, or leaves behind a surgical sponge, uses the wrong blood type or kills a patient with a medication overdose.

Now, a new law will require Illinois hospitals and surgery centers to publicly admit if they commit any of 24 types of never events.

It could a public relations nightmare.

"There will be a lot of angst over public reporting," said Dr. William Barron, vice president of quality and patient safety at Loyola University Health System. "But I have not heard anyone state they will not comply with the act for fear of being publicly humiliated."

'NEVER EVENTS' GOING PUBLIC

Under a law that takes effect Jan. 1, 2008, Illinois hospitals must publicly report serious mistakes, known as "never events."

NEVER EVENTS INCLUDE:
*Wrong surgical procedure, or surgery done on wrong body part or wrong patient.
*Foreign object left in patient after surgery.
*Patient death or serious disability from contaminated drugs or devices.
*Infant discharged to wrong person.
*Patient death or serious disability after patient disappears for more than four hours.
*Patient suicide or attempted suicide resulting in serious disability.
*Patient death or serious disability from medication error or wrong blood type.
*Patient death from a fall.
*Care provided by someone impersonating a doctor, nurse or pharmacist.
*Abduction of a patient of any age.
*Sexual assault on a patient.
*Physical assault on a patient resulting in death or serious disability.

Indeed, the Illinois Hospital Association supports the new law and even helped write it.

The law will help hospitals learn from their mistakes and create a "culture of safety," explained the hospital association's senior vice president, Howard Peters.

6 errors at Mayo Clinic

The never events law takes effect Jan. 1, 2008. After each event, the hospital must analyze the cause and take corrective action. The names of patients and health care workers will remain confidential. The information cannot be used in malpractice lawsuits. And the state will not take disciplinary action for any mistakes.

Illinois is the fourth state to pass a never events law. Minnesota was the first. In Minnesota's initial 15-month reporting period, there were 99 never events at 30 hospitals, resulting in 20 deaths and four serious disabilities.

The famed Mayo Clinic reported six errors, including two fatal medication mistakes and one operation on the wrong body part.

In 31 Minnesota cases, objects used during surgery were left in patients. They include sponges, needles, broken screws and the tip of a marker.

Similar mistakes have happened in Chicago area hospitals in recent years, according to malpractice lawsuits:

*A surgeon at Rush University Medical Center left behind a surgical sponge in an elderly man's abdomen after gallbladder surgery.

*At the University of Chicago, a father of three died after receiving repeated chemotherapy overdoses.

*In lawsuits pending against the Loyola medical center and University of Illinois at Chicago hospital, patients Elie Ghawi and Rashida Aziz allege brain surgeons operated on the wrong side of their heads.

"Human beings are careless sometimes," said the patients' attorney, Keith Hebeisen of Clifford Law Offices.

'You should worry about it'

However, a landmark Institute of Medicine report concluded that most hospital mistakes aren't caused by a careless doctor or nurse. Rather, they result from a system failure.

The report estimated hospital errors kill between 44,000 and 98,000 patients a year.

A patient safety group called the National Quality Forum has developed the never events list.

The mistakes occur "more often than we would like to think," said the forum's spokesman, Philip Dunn. "You should worry about it when you go to the hospital."

Illinois' never events act is among several new laws that are opening up hospitals to public inspection. Other new laws will require hospitals to report infection rates, nurse staffing and mortality rates and provide information on 30 common procedures, including costs, infection rates and deaths.

Last year, the Illinois Legislature passed a law that requires hospitals to report hospital infection data to the state Department of Public Health. It takes effect Jan. 1.

Illinois hospitals will report infection rates in three categories: surgical site infections, ventilator-associated pneumonia and central-line-related bloodstream infections.

Those backing more public accountability from hospitals say that, reporting aside, there are simple ways to combat infections. Studies have shown that infections can be cut in half if health care workers take simple precautions such as washing their hands regularly.

"There's an evolving cultural change," Barron said. "It's all about transparency in health care, which by and large is a good thing."