AMERICAN BAR ASSOCIATION

ADOPTED BY HOUSE OF DELEGATES

AUGUST 11-12, 2008

RECOMMENDATION

RESOLVED, That the American Bar Association urges federal, state and territorial legislative bodies to adopt legislation establishing pilot programs that enable and encourage medical personnel to report hospital events which, if repeated, could threaten patient safety.

FURTHER RESOLVED, That the elements of such programs should include:

A. That medical personnel who report include, but are not limited to, doctors, nurses, and other hospital employees with patient care responsibilities, both public and private.

B. That the events reported are those which are medical in nature and did not result in harm to a patient but which might have resulted in harm;

C. That the reports be made, to the extent possible within the context of already existing reporting mechanisms within federal or state agencies and accrediting bodies, to an entity or entities designated by the federal, state or territorial legislative bodies, and be provided immediately to hospital administration and to risk management departments; and, with the exception of the identity of any individual or provider, be reported to the public.

D. That the anonymity of all persons making good faith reports is guaranteed by law;

E. That any person making a report in good faith shall be immune from civil liability and may not be required to testify in any civil proceedings about the contents of the report;

F. That a report made in good faith shall not be admissible or discoverable in any legal or administrative proceeding;

G. That a group of medical experts, such as the Institute of Medicine, shall be consulted to identify the types of hospital events to be reported;

REPORT

The Standing Committee on Medical Professional Liability (Standing Committee) has concluded that gathering and disseminating additional information will likely assist healthcare providers, hospital administrators and risk managers in minimizing risks.[1] Many hospital events which result in injuries to patients may be preceded by similar events which cause no harm. The Standing Committee believes that having non-injury-producing events reported and making elements of the data compiled from those reports available to the public will provide a sound basis on which healthcare providers can evaluate whether existing hospital procedures should be modified to improve patient safety. Avoidance of harmful events has the potential to significantly improve the quality of patient care and reduce medical malpractice litigation. A system similar to the one herein proposed has been in operation in the aviation industry for more than thirty years. It is credited with having generated invaluable, and otherwise unobtainable, information that has contributed significantly to airline safety.

Most hospitals have procedures requiring events that cause harm to patients to be reported internally. The data gathered may not always be shared with other hospitals, physicians or the public. However, data on past events that may threaten patient safety in the future are not routinely collected throughout the country. If such data were available to hospital administrators and risk managers, they would assist in evaluating whether existing practices and procedures should be modified to improve patient safety. This would be true even though a given hospital never experienced a particular non-injury-producing event.

The pilot programs contemplated by the recommendation depend on self-reporting by healthcare providers and all other hospital personnel. Doctors and other hospital personnel are in the best position to recognize an event has occurred and that, if repeated, a similar event might cause harm to a future patient. The Standing Committee therefore believes that for the proposed pilot reporting programs to be successful, good faith reporting should be encouraged by absolute guarantees of anonymity and civil immunity arising from the act of making such reports.

The Patient Safety and Quality Improvement Act (Act) was enacted in 2005. On February 12, 2008, the Department of Health and Human Services (HHS) released a notice of proposed rulemaking under the Act to establish a procedure by which hospitals, doctors, and other healthcare providers may voluntarily report information, including near misses, to Patient Safety Organizations (PSOs) on a "privileged and confidential basis, for analysis of patient safety events."

The State of Pennsylvania has also taken action on reporting of near misses. The Medical Care Availability and Reduction of Error (MCARE) Act established the Patient Safety Authority

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[1] The concept and certain aspects of the Standing Committee's recommendation and this report are substantially based on work by Professor Stephan Landsman, the Robert A. Clifford Professor of Tort Law and Social Policy, of the DePaul University College of Law.

(Authority) with a goal of identifying problems and recommending solutions that promote patient safety in hospitals, ambulatory surgical facilities, birthing centers and certain abortion facilities. The Authority promulgated regulations to implement a mandatory statewide Pennsylvania Patient Safety Reporting System. More than 400 healthcare facilities are submitting reports to the Authority. Thus, Pennsylvania is the first state in the nation to require the reporting of both actual events and near misses.

Some resistance to even voluntary reporting is to be expected if healthcare providers become concerned that their identities, and those of their hospitals, may become publicly known. Any person who makes a report must have confidence that his or her identity will remain completely confidential. Additionally, the reporting person must be equally assured that the hospital at which he or she works will not be identified in any manner. No hospital employee is likely to make a report if doing so carries with it the potential adversely to affect the reporting person, his or her colleagues, or his or her employer. This understandable concern reinforces the importance of the need for confidentiality and immunity from civil liability in making good faith reports.

State-wide systems for reporting non-injury-producing hospital events should be encouraged. Reporting to such an entity would help to preserve anonymity by reducing the likelihood that a report will be associated with a particular hospital. States should consider selecting or creating such an entity. Additionally, pilot programs designed by several states will likely result in the adoption of varying approaches, and the experience obtained in this manner can be evaluated. If evaluations demonstrate the pilot programs are beneficial, then best practices can be incorporated in later permanent programs.

The Standing Committee recognizes that lawyers are not best suited to the task of defining what constitutes an event that should be reported. Medical experts are needed to make these decisions. This is not to suggest that lawyers should be excluded from the process. The extent to which lawyers should participate in formulating this part of a pilot program should be decided by the individual states and territories. The recommendation suggests that states seek guidance from the Institute of Medicine, or other medical experts. Various groups of medical experts may differently define the events that must be reported.

Data that identify any individual or hospital, either directly or inferentially, must not be disclosed. However, making the balance of the data gathered available to the public is essential so that trends of adverse hospital events can be identified, additional patient safety programs instituted and the quality of healthcare improved.

Janice Mulligan, Chair
Standing Committee on Medical Professional Liability
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