

## Doctors' mistakes

Ninety-eight thousand people die every year from medical mistakes, but the circumstances of these deaths are, by law, closely guarded secrets. Consumers can often learn more about a toaster they want to buy than a doctor who will operate on them.

Current mandatory error reporting systems are not working. Peer review—when doctors share information with each other—suffers from confidentiality laws that block information from public scrutiny.

Mandatory governmental reporting systems record errors—Connecticut saw 14,783 in 1996—but it usually takes a court subpoena or Freedom of Information Act request to get information.

And the National Practitioners Data Bank and other systems grant only authorized users access, such as hospitals.

*We need to restore patient confidence by demanding truthful and open medical reporting.*  
**What you can do:** Ask your U.S. Senators and Representative to support mandatory public disclosure of medical errors—which should be made available to victims and their families so that appropriate claims can be pursued.

### *When medical errors go undisclosed, no one wins*

#### *The system fails a broken wrist*

A critical care nurse says that her father, a physician, "died from a broken wrist." Following surgery for a broken wrist, he developed an infection that started in his wrist and migrated to his spinal column. As the infection worsened, he complained of back and neck pain. Orthopaedic surgeons diagnosed him with back strain and prescribed physical therapy. **No physician asked for basic vital signs or lab tests that would have indicated the developing infection. In the intensive care unit, the patient was cared for by a nurse who had no ICU training and an intern barely months out of medical school.** No one recognized the problem until it was too late. The patient suffered cardiovascular collapse and died 18 days later.

**The hospital's review of the case found nothing wrong.**

***The patient's daughter said, "While hospital management seems to strive for better patient care, they tend to cover up the very mistakes that can serve as valuable learning tools."***