

Secondly, when this report came out, I learned that 22 States—if you look at what the report recommends, it recommends mandatory reporting of serious mistakes and errors, and 22 States have that in place and presumably don't have any more significant lawsuit or medical malpractice problems than the rest of the country as a whole.

And regardless—you know, once you know about a problem, you're under a moral obligation to deal with it. So you can't—whatever the consequences are, we have to go forward.

Finally, I do not believe that the kind of systematic improvement in safety training and processes, hospital after hospital after hospital, clinic after clinic after clinic, and in outpatient settings, will increase liability. No one can begrudge the improvement of processes. That still won't establish or fail to establish liability in a particular case. So I don't see that as a problem.

But whatever the problems are, they're not nearly as important as saving thousands and thousands of lives that obviously are there to

be saved now. And that's what all these people behind us are saying. And I think they reflect the overwhelming views of doctors, hospitals, nurses, and everybody else in the health care system.

So this is a good day for America, not only because of this report but because of the response to this report.

Thank you very much, and I'll see you tomorrow.

NOTE: The President spoke at 11:45 a.m. in the Rose Garden at the White House. In his remarks, he referred to Dr. Kenneth W. Kizer, M.D., president and chief executive officer, National Quality Forum; W.K. Kellogg Foundation president and chief executive officer William Richardson, chair, Institute of Medicine Committee on Quality of Health Care in America; and Bruce E. Bradley, director of managed care plans, General Motors. The transcript released by the Office of the Press Secretary also included the remarks of Mr. Davidson.

Memorandum on Improving Health Care Quality and Ensuring Patient Safety

December 7, 1999

Memorandum for the Secretary of Defense, the Secretary of Labor, the Secretary of Health and Human Services, the Secretary of Veterans Affairs, the Director of the Office of Personnel Management

Subject: Improving Health Care Quality and Ensuring Patient Safety: Directive to the Quality Interagency Coordination Task Force (QuIC)

Assuring quality through patient protections is a long-standing priority for my Administration. Over the past 2 years, with the leadership of the Vice President, Secretary Shalala, and Secretary Herman, my Advisory Commission on Consumer Protection and Quality in the Health Care Industry (Quality Commission) produced a landmark report on health care quality. Through executive action, I extended the patient protection provisions outlined in this report to the 85 million Americans enrolled in Federal health plans, setting the stage for the Congress

to pass a strong, enforceable Patients' Bill of Rights. As important as putting patient protections in place, however, is improving the quality of the services available to these patients.

The United States has some of the finest medical institutions and best trained health care professionals in the world. However, as the Quality Commission reported last year, millions of Americans are harmed or even killed each year as a result of inappropriate or erroneous medical treatment. These health care quality problems include the underutilization of needed services, the overutilization of unnecessary services, and medical errors in the delivery of care. In addition, there is a continuing pattern of wide variation in health care practice.

As a recent Institute of Medicine study confirms, preventable medical errors present an example of the critical importance of improving the quality of health care in our Nation. Over half of the adverse medical events that occur

each year are preventable, causing the deaths of as many as 98,000 Americans annually and adding as much as \$29 billion to our Nation's health care spending. These errors also deeply affect the lives of many individuals and families and the trust of the American people in the quality of the care they receive.

To build on the initial efforts of the Quality Commission and the leadership of the Departments of Health and Human Services, Labor, Veterans Affairs, and Defense, the Office of Personnel Management, and other agencies in implementing a range of quality improvement initiatives, I directed the establishment of the Quality Interagency Coordination Task Force to help coordinate Administration efforts in this area. I also asked the Vice President to help launch the National Forum for Health Care Quality Measurement and Reporting (Quality Forum). This broad-based, widely representative private advisory body, which includes senior government participants, is developing standard quality measurement tools to help all purchasers, providers, and consumers of health care better evaluate and ensure the delivery of quality services.

In addition to the work and significant potential of the QuIC and Quality Forum, the Departments of Veterans Affairs and Defense have been leaders in employing information technology to enhance their ability to provide a higher quality of care to patients. Moreover, the Food and Drug Administration is working to implement new reporting systems that allow for a rapid response to medical errors causing patient injury. However, despite all the progress that has been made, it is clear that more must be done.

Recent advances in technology and information systems can help eliminate dangerous medical errors, lower costs by improving communications between doctors, eliminate redundant tests and procedures, and build automatic safeguards against harmful drug interactions and other adverse side effects into the treatment

process. Despite this fact, very few public and private health plans, hospitals, and employers appropriately use these new techniques.

Therefore, I hereby direct the Quality Interagency Coordination Task Force, to report to me a set of recommendations on specific actions to improve health care outcomes and prevent medical errors in both the public and private sectors in a manner that is consistent with the strong privacy protections we have proposed. This report shall:

- Identify prevalent threats to patient safety and medical errors that can be prevented through the use of decision support systems, such as patient monitoring and reminder systems;
- Evaluate the feasibility and advisability of the recommendations of the Institute of Medicine's Quality of Health Care in America Committee on patient safety;
- Identify additional strategies to reduce medical errors and ensure patient safety in Federal health care programs;
- Evaluate the extent to which medical errors are caused by misuse of medications and medical devices and consider steps to strengthen the Food and Drug Administration's surveillance and response system to reduce their incidence; and
- Identify opportunities for the Federal Government to take specific action to improve patient safety and health care quality nationwide through collaboration with the private sector, including the National Forum for Health Care Quality Measurement and Reporting.

I direct the Department of Health and Human Services and the Department of Labor to serve as the coordinating agencies to assist in the development and integration of recommendations and to report back to me within 60 days. The recommended actions should lay the foundation for a national system that prevents adverse medical events before they occur.

WILLIAM J. CLINTON