MEDICAL ERRORS: HOW SHOULD MEDICAL BOARDS BE RESPONDING?

The Institute of Medicine Report makes many recommendations to reduce medical errors and enhance patient safety. As the title implies, "To Err Is Human: Building a Safer Health System," published in 1999, the report focuses on “the system” rather than on its individual components. It explores the role of legislative, regulatory, and economic means to improve patient safety. The report asks medical boards to do 2 things: periodically re-examine and relicense physicians, and work with other organizations to develop methods to identify those who are unsafe. What can medical boards do? What should medical boards do?

I. THE PROPER ROLE FOR STATE MEDICAL BOARDS

The Institute of Medicine Report, along with quality management and improvement strategies, generally focuses on systems. Medical boards, historically and intentionally, focus on individuals — not systems. Professor Timothy S. Jost, a leading commentator and former State Medical Board of Ohio member, argued before the report was issued:

“The quality improvement philosophy defines quality in terms of meeting the needs of ‘customers,’ defined broadly to include not only patients, but also others who consume the services of the institution, including physicians themselves. It asserts that organizations can be more effective at improving quality, and thus at serving the customers, if they work at improving production systems, rather than at looking for ‘bad apples.’ One can accomplish more, the philosophy contends, by raising the mean of the performance curve and by narrowing the zone of acceptable variability in performance than by chopping off the tail.

“The emphasis on polishing apples rather than culling leaves the government with a primary responsibility for identifying and disciplining truly incompetent providers. This task, never a pleasant one, has traditionally fallen to licensure boards. In the past, the performance of licensure boards in this area has often been deficient. If the task is going to be undertaken (and it must be), it is likely that licensure boards will have to perform it.

“Professional licensure boards in particular have only a modest role to play in combating profession-wide quality problems. Continuing education requirements—imposed by many state statutes with respect to many health care professions—could play a role in disseminating new knowledge and exposing bad practices, though the value of mandatory continuing education is in dispute. Boards may also contribute by forbidding certain practices (such as the use of controlled substances for treatment of weight loss, steroids for enhancing athletic abilities, liquid silicone injections for breast enlargement, or laetrile for the treatment of cancer), where the dangers of the form of treatment are well understood and rapacity on the party of professionals is likely to cloud medical judgment.

“Second, sub-optimal outcomes may occur because of errors committed by otherwise competent practitioners or because of faulty systems within adequate institutions. By definition, 50% of medical practice is below average. The best hope for dealing with problems caused by below-average practice by medical professionals is to strive continuously to raise the average standard of practice and to reduce the deviation from the mean at the lower end. This is the job of institutional quality improvement programs, which are rapidly becoming standard within the health care industry.

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“Quality improvement programs, however, exist at the institutional or health care-system level. This is appropriate, given the insight on which the programs are based—that quality issues are usually systemic in nature. These programs cannot take the place of licensure boards, which focus on the performance of individual professionals, nor can the licensure programs substitute for their systemic focus.”

Jost is right. Medical boards’ principal role throughout their history has been to ensure that their licensees are of sufficient character and competence. Applicants found deficient in either of these are to be excluded from the profession. Licensees whose conduct or incompetence demands it are to be thrown out. This mission is unlikely to change as a result of the report.

Medical boards’ guiding principle in performing this mission is the protection of the public. As such, reducing errors is central. However, given the mission of medical boards of ridding the profession of incompetent or unscrupulous professionals, reducing errors is secondary.

II. SPECIFIC MEASURES CURRENTLY EMPLOYED BY STATE MEDICAL BOARDS

Medical boards’ licensing and discipline decisions, as mentioned above, are not designed to address medical error specifically. Instead, they are geared toward character, competence, and conduct. A few boards will discipline physicians for a single error or incident of malpractice. However, all boards look at indications of error to glean evidence of bad character, incompetence, or misconduct. Most boards accept information of this sort from any source, and undertake the following systematic searches for error.

Malpractice Reports
The Federation of State Medical Boards (FSMB) recommends, in its Guide to the Essentials of a Modern Medical Practice Act, and most states require, that malpractice payments be reported to medical boards.

Hospital Privilege Reports
The Federation recommends, in its Guide to the Essentials of a Modern Medical Practice Act, and most states require, that hospital privilege changes made during or as a result of an investigation be reported to medical boards.

Data Banks
The Federation maintains a Board Action Data Bank to facilitate the exchange of information among member boards and other parts of government regarding adverse actions taken against physicians’ licenses, participation in Medicare, federal privileges to practice, and similar matters. Medical boards are permitted access to the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank for similar information.

Other Sources
The medical boards of the various states undertake other systematic reviews. For example, some medical boards review autopsies of deaths resulting from medical error or reports of deaths caused by drugs.

Immunity Provisions
The Federation recommends, in its Guide to the Essentials of a Modern Medical Practice Act, and many states provide by statute, that persons making reports to medical boards in good faith are entitled to immunity from suit or criminal prosecution.

III. PROPOSALS FOR MEDICAL BOARDS DESIGNED TO REDUCE ERRORS

A. Continuing Competence
Medical boards are paying increased attention to quality of care and continuing competence. The IOM report recommends, “Health professional licensing bodies should work with certifying and credentialing
organizations to develop more effective methods to identify unsafe providers and take action.” Similarly, the Federation of State Medical Boards recommends that medical boards establish mandatory reporting of adverse outcomes, conduct random audits, require clear and complete patient records, develop a “system of markers (age, health status, number of complaints, practice location, etc.)” to identify licensees warranting evaluation, and take other measures to process all this information.

One of the IOM report’s recommendations is that, “Health professional licensing bodies should implement periodic re-examinations and relicensing of doctors, nurses, and other key providers, based on both competence and knowledge of safety practices.” The report’s comment on this issue, in its entirety is:

“For most health professionals, current methods of licensing and credentialing assess knowledge, but do not assess performance skills after initial licensure. Although the state grants initial licensure, responsibility for documenting continued competence is dispersed. Competence may be considered when a licensing board reacts to a complaint. It may be evaluated when an individual applies to a health care organization for privileges or network contracting or employment. Professional certification is the current process for evaluating clinical knowledge after licensure and some programs are now starting to consider assessment of clinical skill in addition to clinical knowledge. Given the rapid pace of change in health care and the constant development of new technologies and information, existing licensing and accreditation processes should be strengthened to ensure that all health care professionals are assessed periodically on both skills and knowledge for practice.”

This may be a long time coming. The medical profession is just beginning to learn how to make such an assessment. No one who has submitted to a licensing examination can be expected to want to do so again, so licensee resistance to such a plan likely will be high. Other problems include deciding what fund of knowledge and skills is relevant to a particular physician’s unique, sub-specialized practice. Assessments are quite expensive, beginning at around $5,000 each.

FSMB and the National Board of Medical Examiners (NBME) have established the Post-Licensure Assessment System (PLAS). Assessment Techniques used include computer-based clinical case simulations, clinical judgment analysis, standardized multiple-choice examinations, and neuropsychological screening.

B. Increased Licensing Standards
FSMB has a policy that “all applicants for licensure should have satisfactorily completed a minimum of 3 years of progressive postgraduate training in an ACGME- or AOA-approved postgraduate training program.” Most licensing jurisdictions in the United States currently require 1 year of postgraduate training for graduates of accredited medical schools and 3 years for graduates of unaccredited medical schools. Efforts to raise the requirement are generally met with resistance.

IV. A KEY ISSUE FOR MEDICAL BOARDS – ACCESS TO ERROR REPORTS
Key recommendations in the IOM report include reporting adverse events. The report says:

“The committee believes that there is a need for both mandatory and voluntary reporting systems and that they should be operated separately. Mandatory reporting systems should focus on detection of errors that result in serious patient harm or death (i.e., preventable adverse events). Adequate attention and resources must be devoted to analyzing reports and taking appropriate follow-up action to hold health care organizations accountable. The results of analyses of individual reports should be made available to the public.

“The continued development of voluntary reporting efforts should also be encouraged. Reports submitted to voluntary reporting systems should be afforded legal protections from
data discoverability. Health care organizations should be encouraged to participate in voluntary reporting systems as an important component of their patient safety programs.”

Both sets of reports could constitute an important source of investigative information for medical boards if the boards can access it. Regarding such access, the report says:

“The recommendations contained in Chapter 5 and in this chapter reflect the committee’s recognition of the legitimacy of the alternative views. The committee believes that errors that are identified through a mandatory reporting system and are part of a public system of accountability should not be protected from discovery. Other events that are reported inside health care organizations or to voluntary systems should be protected because they often focus on lesser injuries or non-injurious events that have the potential to cause serious harm to patients, but have not produced a serious adverse event that requires reporting to the mandatory system. Protecting such information encourages disclosure of problems and a proactive approach to correcting problems before serious harm occurs.”

The report recommends that, “Congress should pass legislation to extend peer review protections to data related to patient safety and quality improvement that are collected and analyzed by health care organizations for internal use or shared with others solely for purposes of improving safety and quality.” Without saying whether the committee would want medical boards to be able to access voluntary reports, the report notes that, “Some state medical licensing boards have gained access to peer review information for disciplinary purposes.”

V. THE ETHICS OF ERROR

Another theory medical boards can use in addressing error is examining whether physicians act professionally when an error has occurred. Grounds for discipline usually include “departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, or the ethics of the medical profession. Incompetence, possibly revealed by the commission of multiple errors, subjects physicians to discipline, but committing an isolated error by itself, in most states, will not subject a physician to discipline. Failing to act ethically in the face of even a single error is grounds for and may subject a physician to discipline.

A. One’s Own Errors

The American Medical Association’s current opinion, titled “Patient Information,” is as follows:

“It is a fundamental ethical requirement that a physician should at all times deal honestly and openly with patients. Patients have a right to know their past and present medical status and to be free of any mistaken beliefs concerning their conditions. Situations occasionally occur in which a patient suffers significant medical complications that may have resulted from the physician’s mistake or judgment. In these situations, the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred. Only through full disclosure is a patient able to make informed decisions regarding future medical care.

“Ethical responsibility includes informing patients of changes in their diagnoses resulting from retrospective review of test results or any other information. The obligation holds even though the patient’s medical treatment or therapeutic options may not be altered by the new information.

“Concern regarding legal liability which might result following truthful disclosure should not affect the physician’s honesty with a patient.”

The American College of Physicians says similarly, “Physicians should disclose to patients information about procedural or judgment errors made in the course of care if such information is material to the
patient’s well-being. Errors do not necessarily constitute improper, negligent, or unethical behavior, but failure to disclose them may.”

B. Another’s Errors
Some take the position that health care personnel have a duty to report the errors of others, such as Fred Rosner in his article, “Disclosure and Prevention of Medical Errors,” published in The Archives of Internal Medicine.

“How should a physician proceed when another physician’s error in patient care has been observed? For example, a primary care physician learns that a consulting pulmonologist has performed a thoracentesis on the nonaffected hemithorax before repeating the procedure on the correct side. The patient experiences a clinically inapparent pneumothorax, and the pulmonologist does not disclose the error to the patient. The pulmonologist is obligated to disclose to the patient the commission of the error and should be encouraged by the primary care physician to do so. However, if the consultant is unwilling to disclose the information, the primary care physician nevertheless is obligated to keep the patient fully informed. The staff member involved in the error should be identified to the patient at the patient’s request. The physician is also obligated to inform hospital quality-assessment mechanisms so that problems with systems and substandard practitioners are addressed.

“Should a physician commit and not disclose an error, house staff, nurses, and other personnel should inform the appropriate supervisor. These supervisors should approach the physician for clarification of the purported error. Supervisors should report suspected error nondisclosure to the department chief or medical staff office. To encourage and support physician disclosure of error, peer error committees or discussion groups should adopt nonpunitive responses to reporting errors and provide anonymity outside the committee deliberations.”

Whether prosecutions on these theories would lead the profession to deal more openly and effectively with errors or whether it would lead the profession to hide them is an open question.

CONCLUSION
First and foremost, medical boards exist to eliminate incompetent or unscrupulous physicians from practice, or at least to rehabilitate and control their conduct. The IOM “To Err is Human” report should not change this at all. Somebody must identify those physicians whose competence or conduct places them a few standard deviations short of the mean and remove them from practice. No other institution within medicine is constituted to perform this essential role. Medical boards must do this and do it well. Medical boards can lend their support to efforts to reduce errors, but other institutions are better positioned to carry it out. Other institutions can concern themselves with generally raising the mean performance of physicians, narrowing the left side of the bell curve and making human failings less important to patient outcomes. Medical boards can adopt policies to encourage and facilitate these efforts. Most of all, medical boards need to ensure that error-reporting mechanisms give boards the information on individual physicians they need to do their jobs without interfering with the operation of reporting mechanisms used to improve health care systems.