STATE MEDICAL BOARDS AND THE PATIENT SAFETY MOVEMENT: TIME TO MAKE A CONNECTION

Mark R. Yessian, Ph.D.

ABSTRACT

The patient safety movement has great potential to reduce the number of deaths and injuries caused by medical errors. The author argues it is time for state medical boards to become much more closely connected to this movement. He sets forth two basic approaches: One, modeled after that taken by the Massachusetts Board of Registration in Medicine, would be to establish a separate component to receive and respond to confidential incident reports from hospitals (as well as other types of health care facilities). The other would be to integrate into their traditional functions new initiatives to support facilities' own efforts to improve systems to help prevent harm to patients. Both approaches would call for boards to broaden their mission and to develop new ways of relating to facilities and facility regulators.

INTRODUCTION

In recent years, the patient safety movement has drawn public attention to the widespread phenomenon of medical errors and to the many injuries and deaths caused by them. Its call for reform has focused on establishing a systems-oriented, blame-free, preventive approach to reducing the errors.[1,2]

In contrast, state medical boards, in carrying out their patient protection mandates, have continued to focus on the individual physician licensee. In response to complaints, they conduct case investigations and, when they find it necessary, impose disciplinary action against a licensee.

A key question then is: How should medical boards respond to the patient safety movement? One approach is to *tune out* the distractions of the movement and to focus on the boards' core statutory mission. That mission of protecting patients from harm by individual practitioners is still a vital one and one even patient safety advocates say has some value, albeit at the margin. By and large, this is the approach the boards have taken.

The other approach, the one I advocate in this article, is to *tune in* to the movement and to search for ways of connecting more closely to it. This involves some risk. It can divert boards from their core mission and in so doing further jeopardize the already limited public support for them. And it can draw boards into more professional and academic orbits that can heighten the suspicion of patients and patient advocates. But, it is essential, I argue, for boards to take up this challenge if they are to play a vital role in protecting patients in the decades ahead.

THE CASE FOR TUNING IN

Why is the *tune in* approach so important? I offer four considerations.

First, the working environment for physicians has changed dramatically. When boards were first established and for decades thereafter, physicians functioned with a substantial degree of autonomy, working as solo practitioners, largely in their own offices. Now, as we all know, they work with less autonomy and in much more complex environments where they are part of a system of care involving other care givers, insurers, government agencies and health care institutions with which they are affiliated or even employed. Boards, if they are to remain vital, must adapt more fully than they have to date to these changed circumstances. The patient safety movement offers them opportunities to do so.

Second, the patient safety movement has a substantial amount of credibility. It builds on long-established precepts about system change established by the continuous quality improvement movement and on much well documented

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research on the causes of errors and the ways to deal with them most effectively.[3-5] To the degree it succeeds, it offers the potential to reduce infringements calling for disciplinary actions by boards and thereby to avert harm to patients. Boards have a stake in facilitating this development.

Third, as credible as it is, the patient safety movement is itself fragile. Its mantra of calling for practitioners and institutions to identify, report and address adverse events (which may or may not be attributable to errors) in a blame-free environment represents a sea-change in operating environments accustomed to the prerogatives of professionals and the dangers of legal liability. While the movement has yielded some successes thus far, physicians and institutions remain wary of it and have held its potential largely in check. Boards can help here by serving as a valuable ally, reinforcing the legitimacy and importance of efforts to prevent errors.

Fourth, boards have something to offer in support of these efforts. After all, they are in control of an important card: the license of the individual physician. The conditions they associate with licensure and the manner in which they respond to complaints against physicians can have a significant bearing on the progress of patient safety efforts.

HOW BOARDS CAN TUNE IN

So the question becomes: Just how can boards connect more closely with the patient safety movement without compromising its core mission of protecting patients from harm by individual physicians?

This is, of course, a difficult question to answer in any operational way. Patient safety advocates look to blame-free reporting of serious adverse events as a way to identify and address system defects. And in some states they have been instrumental in the establishment of adverse event reporting mechanisms outside the purview of the medical board. Boards, in sharp contrast, look to enforce licensure requirements. They are, after all, regulators, not researchers.

But the divide is not as great as these differences may suggest. Boards can play the balancing act suggested by the above question. But to do so effectively, they must connect with the patient safety movement on the basis of a sound strategic framework.

The starting point for boards seeking to make this connection is to be grounded in what they are. The boards' essential role in protecting patients is to ensure the licensee meets the minimum acceptable standards set forth in the medical practice acts.[6] That is their niche, their rationale for being. But they cannot do this in today's health care system by assuming physicians function in a bubble, free from the multitude of workplace related factors influencing their capacity to meet these standards.

Herein is the opening to join forces with the patient safety movement. Both the boards and patient safety advocates share an interest in *preventive* actions that can be taken in the *workplace* to avoid errors and ensure compliance with minimally acceptable standards of practice. Boards do not have to wait for something bad to happen to act; they can and should take appropriate preventive action. After all, the licensing process is itself a preventive action intended to avoid unnecessary harm.

How, then, to venture into the work place without the impetus of responding to a complaint? I suggest there are two basic approaches boards can take that offer promise. One, which I label the add-to-your-base approach, calls for boards to develop a component separate from its traditional licensure and discipline functions that serves as locus for facilities to report adverse events on a confidential, nonpunitive basis. The other, which I label the build-on-your-base approach, calls for boards to integrate into their traditional functions new initiatives that lend support to facilities' own efforts to improve systems to avert patient harm.

The former approach requires participating boards to take a major leap into the systems' world and to perform a more delicate balancing act with their traditional regulatory functions. The latter approach enables the boards to remain focused on the individual practitioner but seeks ways to support facility efforts to monitor the performance of individual practitioners. Both approaches broaden the patient protection mission of boards. Both lead boards to new ground that over time would call for statutory, organizational and even cultural change. Both require new ways of dealing with health care facilities, facility regulators and facility accreditors. Both enable (indeed, require) much experimentation, whereby boards carry out the classic role of states as laboratories of democracy. Below, I elaborate on both approaches.

THE ADD-TO-YOUR-BASE APPROACH

Adverse event reports are the raw material of the patient safety movement. The guiding rationale is for practitioners and institutions to acknowledge serious adverse events that may be attributable to errors when they happen and for institutions to draw on that information — not as a basis for

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punishment, but as an opportunity to correct the system breakdowns leading to errors.[7]

For medical boards, which are accustomed to receiving complaints — not adverse event reports — the establishment of a separate component focusing on adverse events is a major adjustment, much like one corporations would experience by taking on an entirely new product line. It means for this portion of its operation, boards would serve more as an analyst than an investigator, and would focus more on system change than practitioner accountability.

To date, only one medical board, the Massachusetts Board of Registration in Medicine, has taken this route. In 1986 the Massachusetts legislature passed the Medical Malpractice Reform Act mandating that the board establish a Patient Care Assessment (PCA) program that would function collaboratively with the state's health care facilities. Under this program, all health care facilities in the state are required to establish within their governing body PCA committees to oversee the facility's patient safety activities, to track and analyze medical error incidents within their facilities and to submit to the medical board, on a quarterly basis, major incident reports.[8] These reports are to describe not just the incident itself, but also an analysis of why it happened and what actions were taken to prevent future occurrences. The board then has the authority to work with the facility to determine the adequacy of its responses and the opportunity to draw on such incident reports as a way of providing early-warning alerts to all facilities in the state.[9]

During the course of its history, the board's PCA program has met its share of resistance by the hospital community, on which it has focused its efforts. And to some degree this is still the case as physicians express concerns about the confidentiality and anonymity of physician-specific information associated with incident reports.[10] Just how successfully the Board can carry out both its traditional enforcement function and this add-on educational effort, without one adversely affecting the other, remains a vital matter, one warranting scrutiny by the Massachusetts board and other boards that may consider adapting a similar program.

Yet, although more evaluative information is important, I do not hesitate to describe this pioneering effort as a promising one. I conclude that for numerous reasons. It represents the most concerted operational effort by any board to take a preventive approach in a major health care workplace: the hospital. It has drawn on data from individual hospital incident reports to issue patient care advisories to all hospitals on vital patient safety matters such as oncology drug administration and radiology coverage in emergency rooms. It has cajoled and worked with hospitals to improve their own physician monitoring activities. And, as an indication that its outreach to hospitals has had some effect, in recent years it has received an increased number of incident reports from hospitals and has increased its own capacity to respond to them.

THE BUILD-ON-YOUR-BASE APPROACH

Here I suggest four specific initiatives boards can take to heighten their relevance to the patient safety movement. Although these initiatives involve working within the licensure and enforcement base of the boards, they still represent potentially significant change and call for an openness to different ways of meeting the patient protection mission of boards.

1. Search for System Interventions that can be Linked with Board Orders.

When boards find they have enough evidence against an individual physician to warrant some kind of board action, be it as part of a disciplinary order or a settlement, they then determine what package of responses are most appropriate in light of the individual circumstances. In addition to the revocations, reprimands and the like, this portfolio of possible actions includes additional training, mentoring, periodic reporting back to the board, practice restrictions of various kinds and more. Each of these interventions is geared to the individual licensee.

Here, again, by taking a broader look at their work, boards have an opportunity to link up with the patient safety movement. The key question in this case is: is there some part of the fact pattern in an individual case that goes beyond the individual practitioner and offers an opportunity for intervening in a system of care? If so, what and how?

One can argue any board order that resulted on the basis of inadequate performance in a hospital or any other facility is by definition a system issue. Why is it that the facility's own internal processes were unable to prevent the poor practice from taking place? Does it suggest that a vulnerability exists that might place other patients at unnecessary risk?

For the most egregious cases resulting in disciplinary actions by the boards, the facilities are most likely well aware of the infringement and could well be taking some follow up action whether on their own accord or because of the actions of the regulators or accrediting bodies. But for most others, this is not likely to be the case.

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Boards, of course, do not have the authority as part of their own board orders to mandate facilities or regulators take any particular action. But the boards' patient protection role does serve as a kind of bully pulpit that gives them the opportunity to meet with facilities and/or regulators and to urge their attention to system vulnerabilities revealed by board investigations. As examples, specific physician violations could well serve as a basis for examining a hospital's prescription drug review procedures, or a nursing home's medical review practices, or a physician provider group's patient referral protocols.

2. Identify and Share Systems Safety Information Culled from Complaints

Buried within the large stream of complaints flowing into medical boards may well be signals of system problems that remain undetected.[11] This is an essentially untapped but perhaps important universe for taking preventive action that can prevent patient injury.

The disciplinary actions taken by boards are a small percentage of the complaints they receive. Many of the complaints are not addressed because they are not ones within the jurisdictional authority of the boards. Complaints within their jurisdiction typically must be investigated and result in a finding of facts that may or may not lead to possible disciplinary action.

The key question here is: to what degree is there information in this large universe of complaint-generated data that could be helpful to hospitals and other facilities interested in finding possible defects in their patient safety systems? No one, at this point, really knows.

Here, then, is another area where boards can make an important contribution. But it is a difficult area that will call for a substantial commitment. It will mean broadening the purview of investigators accustomed to searching for narrower sources of evidence warranting disciplinary action. It will mean developing an understanding of just what is meant by systems related information. It will mean determining when such information should be shared with a regulator or accreditor, as well as the facility. And not least of all, it will mean addressing statutory limits now precluding some boards from conducting investigations that go beyond the particular complaint submitted and/or from sharing complaint information with other parties, even other state regulators. This is a formidable array of constraints, to be sure, but they are worth tackling for states and boards ready to make a serious commitment to reducing medical errors.

Some boards have been taking small and largely informal steps in this direction. These, include follow up contacts with facility administrators to alert them to what might appear to be a system issue associated with a complaint; follow up letters to complainants informing them their complaint might be more appropriately handled by the facility or facility regulator; and reports in the board newsletter of system-related errors identified through complaints. But, overall, such efforts have been minimal and appear to represent only a small part of what could be done with a more concerted effort.

3. Establish Early-Intervention Mechanisms for Identifying, Assisting and Monitoring Marginally Competent Physicians

Physicians, like other professionals, can reach a point where their practice skills are not quite what they should be. Most physician readers of this journal have probably known such colleagues, ones to whom they would never refer a loved one.

Medical boards are hard-pressed to intervene in such cases unless they receive a complaint against physicians and find they are in violation of the state medical practice act. In most states, mechanisms have been developed for boards and hospitals to work proactively and sympathetically with physicians who are impaired by their addiction to drugs and alcohol. Yet little is in place to help those who have questionable skills but who have not yet been found to have committed actionable offenses. From a system safety perspective, this kind of situation is a medical error waiting to happen.

One promising pro-active approach to address this void is the Practitioner Remediation and Enhancement Partnership (Prep 4 Patient Safety) program being led by the Citizen Advocacy Center and funded by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. Now in its fourth year of implementation, this demonstration program provides medical boards and hospitals the opportunity to work together to identify, remediate and monitor physicians with deficiencies that cause concern but do not rise to the level warranting reporting to the level calling for reporting to the medical board or to the National Practitioner Data Bank (NPDB).[12]

To date a number of medical boards have committed themselves to develop such a program and have limited operational efforts underway.[13] The progress has been slow because of the hospitals' inherent reservations in working

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with regulatory boards and because of concerns about legal liability. Nursing boards have been somewhat more successful in bridging this divide, with three of the six participating boards already having substantial efforts underway with hospitals. Like any innovative idea, this one can take a while to catch on, but if medical boards seek to make themselves more relevant to the patient safety movement, perseverance here would seem to be warranted. Given the legal concerns hospitals raise, it also would seem to be important for boards to seek statutory changes clearly authorizing board-hospital programs along the line of the Prep 4 Patient Safety program and, in particular, specifying the conditions under which hospital reports to boards are not required.

4. Help Tap the Potential of Hospital Privileging as a Demonstration of Continued Competence

Hospitals and other organizations, such as managed care organizations and physician practice groups, look to the granting of hospital privileges as an important marker of a physician's qualifications. The privileging process has significant potential as a way of drawing on a variety of information sources to determine continued competence and where necessary to attached certain conditions to the granting of hospital privileges. But to date, this potential is far more impressive than actual practice. Too often, it appears, the process is not a very exacting tool for identifying danger signs that could lead to problems. And while there are hospital privileging standards regulatory and accrediting authorities address, neither the standards nor the enforcement run too deep at this point.[14-16]

This domain, to be sure, is quite removed from the day-to-day responsibilities of boards and one for which most have little jurisdiction. Yet, it is a domain to which they have an inherent connection. Hospital privileging, after all, is an assessment of an individual physician's capacity to practice. Boards at this point assess individual capacity only at the point of initial licensure (unless a physician becomes involved in a disciplinary process). But the movement for regular assessments of physicians' continuing capacity is gaining steam, and it is one boards are likely to have to address in some form that goes beyond the development and monitoring of continuing education requirements. As boards go down that road, they could well find hospitals' privileging and reprivileging process represents an important physician-run leverage point to ensure continued competency.

Eventually, boards may find themselves in the business of developing standards for continued competency and of granting deemed status to continuing competency assessment programs meeting those standards.[17] Those programs may be carried out by hospitals, as well as by other facilities and specialty certification boards. More immediately, drawing on their existing authority and the forum they have as a vital patient protection entity, they can draw wider attention to the valuable role hospital privileging can play and then to any shortcomings in the standards and operational practices associated with privileging. More operationally, they can work with hospital associations to identify and share techniques for evaluating continued competency and to examine the extent and kind of standards that should be developed.

The aim here is to focus on the substance of the privileging process. How much and what kind of data does it draw on in assessing whether initial privileges should be granted or existing ones renewed? How do hospitals use this information in making privileging decisions? What kind of measures do they use? For hospital officials concerned that attaching certain conditions to a privilege might call for reporting that physician to the medical board or to the NPDB, the boards can help the hospitals understand the conditions under which they can take remedial actions without having to report. With respect to the NPDB, for example, boards can point out that under NPDB rules, proctoring can be imposed as a privileging restriction as long as it is "routine and mandatory" for all similarly situated physicians, such as all physicians who have not performed a specified number of procedures in a given period of time.[18]

CLOSING

I offer two closing thoughts. First, for those boards that do set forth to make a closer connection with the patient safety movement, it is essential they find ways to retain and even reinforce their accountability as public bodies. They must develop mechanisms for reassuring a skeptical public that a link with a movement that avoids blame and emphasizes confidentiality is not a retreat to the "trust us" mentality that may have worked in the past but certainly does not in the present. Providing such assurance is possible, but is not an easy task.

Second, for those who do the work of the medical boards, the staff and the board members themselves, I recognize the suggestions put forth in this article are likely to come across as more than a little Pollyannaish. These individuals must cope with significant caseloads, limited resources,

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complex processes and often little external respect. How practical, they might reasonably ask, is it to even consider such an expanded agenda?

But at the same time, it is important from time to time, to step back, to examine how effective an organization is in reaching its overall mission, and to think "out of the box" about new approaches. The boards can exert leadership in addressing this challenge. But one way or another, professional associations, patient advocate groups, elected officials, administrators and staff in both the executive and legislative branches must also be part of the process. The message put forth in this article is directed to the constellation of interests that care about and influence board performance, not just the boards narrowly defined. The message, I suggest, is one that can bring new energy and creativity to the boards. More importantly, it can also contribute to safer medical practice.

AFFILIATIONS

Mark R. Yessian, Ph.D., has studied state medical boards for more than 20 years. For most of this period, he served as Regional Inspector General in the U.S. Department of Health and Human Services. In this role, he led numerous reviews of medical boards, as well as of other health care licensure boards, published articles on the boards in the FSMB's *Journal of Medical Licensure and Discipline*, as well as in the *New England Journal of Medicine* and other publications, and spoke at a number of FSMB annual meetings. He retired from the Office of Inspector General in December 2005 and now does some teaching, writing and consulting.

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8. Four types of incident reports must be reported to the board. Three of them involve specific outcomes: (1) maternal death related to delivery, (2) death during or resulting from an elective ambulatory surgery, and (3) a wrong site procedure. The fourth involves "a death or serious injury that was not ordinarily expected, based on the patient's condition upon presentation or admission to the facility." These incident reports, whether or not they are based on errors, are seen as opportunities for improvement. For further information on incident reports and the entire PCA program, see www.massmedboard.org/pca.
9. For further description of the program, see Bovbjerg R, Aliaga P. *State Discipline of Physicians: Assessing state medical boards through case studies*. Washington D.C.: U.S. Department of Health and Human Services; 2006; 52-3.
10. The board does not call for physician-specific information to be included in the incident reports sent to the board. In their outreach to hospitals, board officials have sought to ensure physicians that the state's confidentiality statute specifically protects the confidentiality of any physician-specific information associated with the PCA program.
11. This point was strongly reinforced in a report of the chief medical officer of the United Kingdom. See A report of the chief medical officer, Sir Liam Donaldson. *Good doctors, safer doctors: proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients*. Department of Health; 2006. In the report, in a section on complaints, after noting how the current system of handling complaints to the National Health Service must be addressed "in a more sophisticated manner," he states: "The majority of com-

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plaints relate to several interlinked elements of care and a requirement to define a complaint and allocate it to a specific stream at an early stage is counterproductive." See pp. 181-2.

12. For further information, see www.4patientsafety.net.
13. The initial intent of the Prep4Patient Safety program was that the hospitals would identify practitioners requiring remedial assistance and would take the lead in providing it, with the cooperation of the licensure board. Thus far in practice, this is how it has worked for nursing boards. But for the medical boards that have efforts underway, it has been the boards not the hospitals that have taken the lead in identifying and working with the physicians.
14. Leape LL. Fromson JA. Problem Doctors: Is There a System-Level Solution? *Annals of Internal Medicine* 2006;144(2):107-15.
15. U.S. Department of Health and Human Services, Office of Inspector General (OEI-01-97-00051). *The external review of hospital quality: the role of accreditation*. Washington, D.C.: 1999.
16. It is important to note here that in April 2006, the Joint Commission approved a revised set of credentialing and privileging standards for physicians. These new standards do raise the bar on expectations–for example, on continuous evaluations of practitioner performance and on focused professional practice evaluation — but it remains to be seen how fully the hospitals will respond and how rigorously the JCAHO will enforce the standards.
17. This direction is called for in a recent examination of continuing competency requirements. See Swankin D, LeBuhn A, Morrison, R. *Implementing continuing competency requirements for health care practitioners*. Washington, D.C.: AARP; 2006.
18. See www.npdb-hipdb.hrsa.gov.

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