State of California
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, Ca 95815
www.mbc.ca.gov

Memorandum

Date: October 20, 2008

To: Members,
Medical Error Task Force

From: Janie Cordray,
Research Director

Subject: Direction of Medical Errors Task Force

At the last meeting of the Task Force on July 24, the members heard from two speakers and discussed the future direction of its work. The following summarizes the recommendations and suggestions from Board members, staff, and speakers:

1. The Board should become more educated about laws and existing programs addressing medical errors:

Members agreed they would like to hear more from groups currently working on improving patient safety. Specifically, members asked to be informed about the Federal Patient Safety Act and malpractice carriers. In addition, a number of groups and individuals have asked to make presentations to our membership.

Staff has contacted the User Liaison Program of the Agency for Healthcare Research & Quality, a division of Health & Human Services and the entity responsible for the Patient Safety Act, to arrange for a speaker at a future meeting. Staff had also hoped to have a speaker from a major malpractice insurer, however, scheduling difficulties prevented it for the November meeting.

Dr. John Keats of The California Patient Safety Action Coalition (CAPSAC) is scheduled to make a presentation at the November 6 meeting of the Task Force.

As discussed at the last meeting, some of the topics for presentations may be of interest to the full Board, or possibly the Education Committee. In the future, staff will schedule speakers for the appropriate meeting.

2. **The Board should assist the public and profession by providing education and information on the subject of medical errors, and about activities and programs.**

As the members are informed of the various programs and initiatives, those that are found to have the greatest potential to assist physicians and patients should be publicized. How best to promote the information will be under the jurisdiction of the Education Committee.

3. **The Board should become aware of existing programs rather than create its own medical error reduction program.**

As discussed, for legal reasons, the Board must be cautious in endorsing private programs, however, it may choose to act as a conduit of information to share useful findings and data from others' activities with the profession and consumers.

4. **The Board should utilize the information contained in its complaint and investigation files.**

Every year, the Board is the recipient of over 6,000 jurisdictional complaints, conducts over 1,000 formal investigations, and refers about 400 cases to the Attorney General for filing of charges. While the Board's newsletter publishes its disciplinary actions, they represent less than ten percent of all complaints and only events that were substantially related to physician conduct, such as gross negligence, incompetence, fraud, or criminal behavior.

The vast majority of complaints received fall under several categories, such as insufficient evidence to pursue action, mistakes made by other professionals or systems, or a single act of simple negligence. These types of cases are perhaps of more value than those that go on to discipline, as they may capture patterns of frequent problems that could have a remedy through education or better systems.

In addition to the non-disciplinable complaints containing information on errors, research of the files could yield insight on the progression of behavior of disciplined physicians. While most licensees may have a single complaint filed against them, staff has noticed a pattern in those disciplined. Most disciplined physicians have a history of prior complaints that were non-disciplinable. Impulsive behavior, arrests for conduct unrelated to the practice of medicine, harassment of fellow staff, failure to timely submit records or answer calls, and other conduct often signals the physician is progressing in a self-destructive manner. An analysis of these complaints may be useful to our enforcement staff to develop a profile to prioritize complaints when a physician has such a history. In addition, sharing information on patterns discovered in the analysis, without disclosing any information on individual physicians, may provide a useful

profile to assist wellness committees to identify those for whom they should intervene.

For that reason, staff would recommend that it conduct two research projects; one to analyze disciplined physicians' complaint history, and another to analyze meritorious, but undisciplinable complaints. The data rendered from these studies can be used to educate the profession and the public, and provide a greater understanding of risk factors that may serve to provide an early warning system to identify at-risk physicians.

In Summary:

As the Task Force concludes its work on this issue, the following suggestions could be submitted to the full board:

- Staff will work with the Information Officer and the Education Committee to develop informational materials to assist and inform the profession and consumers;
- Staff will continue to work with patient safety programs and initiatives to identify avenues of shared benefit, and assist with sharing information about meritorious activities;
- Staff will begin conducting research projects: 1) A retrospective analysis of complaint history of disciplined physicians, and; 2) an analysis of physician of complaints with merit.

I will be at the November meeting of the Task Force and available to answer the members' questions. In the meantime, please feel free to contact me at 916-263-2389 or by e-mail at jcordray@mbc.ca.gov, if you have any questions or suggestions.