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Meeting Report

The Federation of State Medical Boards
February 7, 2017 – Washington, DC

The Federation of State Medical Boards hosted a meeting, "Duty to Report: Sharing Information to Protect Patients" on February 7, 2017 at the University Club, Washington DC. The meeting was attended by representatives from the following organizations:

American Association of Osteopathic Examiners
American Osteopathic Association
American Medical Association
National Council of States Boards of Nursing
American Hospital Association
Department of Defense
Agency for Healthcare Research and Quality
National Patient Safety Foundation
Department of Veteran Affairs
Informed Patient Institute, Accreditation Council for Graduate Medical Education
American Board of Medical Specialties
American Academy of PA
Council of Medical Specialty Societies
American's Health Insurance Plans

A recent Journal of the American Medical Association article reported that 17% of people surveyed had direct knowledge of clinician impairment but did not report. Three prominent cases were discussed in which there was a delay in reporting and disciplining. Christopher Duntsch, MD, a neurosurgeon in Plano, Texas, "maimed up to 15 patients", and Baylor Hospital allowed him to continue with unrestricted hospital privileges. Eleanor Santiago, MD, a California physician, had been overprescribing opioids for years, and was only recently sanctioned. Earl Bradley, MD of Delaware, where 103 children molestations information had been compiled since 1990, still had a medical license until he was convicted in 2015. Informants with suspected child abuse are ready to report, however reporting a colleague creates that negative "labeling of reporting".

During the meeting, representatives attempted to answer the question, "What are the problems and barriers that keep individuals from stepping forward to report issues impacting patient safety?" Obstacles of reporting are many, including the severity of the issue in question, local standards and culture. There is a fear of loss of referral. Also, the limited number of physicians in a particular community and the removal of a physician can impact the balancing act for patient care.

The mechanism of reporting to ensure confidentiality vs. anonymous mechanism remain a factor, as do the loss of reputation by getting involved in legal proceedings, and the impact on patients and families. Potential informants, also question the value for the whistleblower. If a clinician accuses a peer, and there is a no probable cause found, the potential for retaliation of the accused may present barriers. Also, an individual reporting a peer within the same practice/group/system may affect the bottom line and presents the potential for risk avoidance.

A balance must exist between data systems and confidentiality, particularly what is shared in the medical record. Failure in communication costs time. There are also jurisdictional issues with sharing information between insurance plans.

Representatives also discussed how the group can address these issues and improve reporting. First and foremost, best practices can be developed to be non-punitive. Education should be developed for students and residents, specifically informing the learner about processes and behaviors that are recognized as non-professionalism. Education should also provide clarity on who is responsible to report, including boundaries vs. organizational responsibilities that exist.

Finally, tools must be developed to allow for reporting, and guide questions and concerns about where to report bad medicine, process, consequence of reporting, and the vulnerability of patient. These tools should also address complaint barriers, costs, time and fear of outcomes. Future work should focus on how to define peers. Can an operating nurse evaluate an orthopedic surgeon?

Delaware had some reactive legislative changes after Dr. Bradley was convicted. They increased fines for non-reporting, and added an attestation on their application for re-licensure so that the physician had to confirm that they understand the duty to report. They added chaperone provisions for patients <15 years old. The Delaware Board of Medicine also changed its name to The Delaware Department of State Division of Professional Regulation. The licensing board became a criminal justice agency for reporting and enforcement access systems information.

Rachel Rose, JD presented a bioethics perspective on the areas of misconduct. Examples of a Nevada case of texting patient information in an anaesthetized state were presented. Other examples included overprescribing of opioids, monetary kickbacks; performing unnecessary tests and substance abuse by physicians were discussed.

The Hippocratic Oath is an oath stating the obligations and proper conduct of doctors taken by those beginning medical practice. Bioethics Utilitarianism states that "Everyone is obligated do whatever will achieve the greatest good for the greatest number."

The goal of the group is to create a solution that creates a culture that is non-punitive for reporters, and provides openness and sharing within the clinician, payor, government, practice and system settings. An emphasis should be placed on mining data to create a safer public.

Overall the entire meeting was very informative and the solutions to the duty to report will need a change in the culture of reporting.

Respectfully submitted,

Anna Z. Hayden, DO
President