Duty to Report: Protecting Patients by Improving the Reporting and Sharing of Information about Health Care Practitioners

A Summit Meeting of Health Care Stakeholders, held February 7, 2017, University Club, Washington, D.C.

Introduction

The U.S. health care system has in recent decades experienced rapid growth and increasing complexity. During this time of profound change, the United States has maintained its position as the world's health leader in medical education and many key measures of quality, including the delivery of acute care and specialized care by outstanding physicians, physician assistants, nurses, pharmacists and many other health care professionals, working at world-class hospitals and health systems.

At the same time, studies have shown the need for improvement in various components of the U.S. system, ranging from health spending per capita and outcomes in key benchmark areas such as infant mortality and integration and coordination of the nation's health information-technology infrastructure.

Beyond these measurable and highly visible components are other, less tangible and less quantifiable elements of the U.S. health care system that are in need of improvement – and which may have impacts on patient well-being much greater than is commonly understood. One of these is the way in which information that could improve patient safety and the quality of care overall is reported and shared.

Since the Institute of Medicine (now the National Academy of Medicine) suggested in its groundbreaking 1999 report *To Err is Human: Building a Safer Health System* that preventable adverse events in hospitals were a leading cause of death in the United States, practices and trends in the reporting and sharing of vital information have become an increasing topic of discussion among health leaders and policy makers. In recent years, the discussion has extended beyond the hospital and clinical-care community to more frequently include other stakeholders – from state medical boards to law enforcement agencies – that compile and share non-clinical information and decisions about health care providers that could potentially impact patient safety. Consumers, patients, families and organizations representing them have also become more interested and informed about health care quality and patient safety.

Much of the recent interest in how diverse organizations compile and use information that might impact patient safety – particularly data about adverse events or the behavior or competence of health care practitioners – has been magnified by studies and media-reporting suggesting that gaps exist in how such information is shared and coordinated.

High-visibility instances of negligent activity by physicians or nurses – often with tragic results for patients and their families – who "fell through the cracks" of oversight, and other reporting about the lack of transparency in record-keeping or dissemination of data have fueled calls for health sector stakeholders to share information more often and in new ways in an effort to better protect the public.

The Duty to Report Summit Meeting

Recognizing the importance of this issue, the Federation of State Medical Boards (FSMB), which represents the nation's 70 state and territorial medical licensing boards, adopted a formal position statement on the "Duty to Report" in April 2016, aimed at addressing the reporting and information-sharing and gap in health care by outlining the responsibility of physicians, hospitals and health organizations, insurers and the public to provide reports to state medical boards of information related to patient safety, physician impairment and professional misconduct.

The FSMB continued its advocacy on this topic by convening a diverse group of health-sector stakeholder organizations for a summit meeting on February 7, 2017, titled "Duty to Report: Protecting Patients by Improving the Reporting and Sharing of Information about Health Care Practitioners." During the full-day meeting, held in Washington, D.C., more than 30 representatives of these various organizations gathered to exchange ideas and insights on how information about physicians, nurses and other health care professionals is currently reported and shared between organizations and how the process of reporting and information-sharing might be strengthened in order to better protect the public.

Participants discussed barriers and challenges to reporting and information-sharing during the meeting, focusing on two levels:

- **Individual Behavior:** Participants explored the impediments that can keep physicians, nurses, office staff – and even patients and families – from stepping forward to report unprofessional conduct or share other information that could impact patient safety. Discussions centered on professional cultures and norms, and concepts such as privacy, stigma and societal expectations that may contribute to individuals' decision-making.

- **System Issues:** Participants explored institutional reporting and information-sharing – how key data is currently shared and what is getting in the way of better access to, and usage of, data. Discussions included comparisons of the similarities and differences in system-approaches across the various communities in health care – from physician organizations to hospitals, government agencies and others. Participants also explored cross-sector relationships – between regulators and law enforcement, for example – and the challenges faced by institutions with regard to the cross-sector reporting or sharing of data that could impact patient safety.

Participants discussed potential solutions to these barriers and challenges in a wide-ranging large group session to conclude the summit, identifying steps that could be taken, individually within their respective organizations or in groups or collectively, to address issues in reporting and information sharing. A range of potential action steps were identified for further consideration.

Summit participants agreed that the issues impacting reporting and information-sharing are complex, and may only be effectively addressed through coordinated, sustained action. Honest, open, cross-sector dialogue is an essential first step, followed by the identification and prioritization of elements needed for system change.

This report summarizes those discussions, concluding with a list of potential action steps that could help move the discussion of reporting and information-sharing forward.

Session I: Individual Behavior

What are the challenges and barriers that keep individuals from stepping forward to share information or report issues impacting patient safety?

During the summit meeting's first discussion session, participants identified various factors that currently keep individuals at various levels of the health care system – ranging from physicians, nurses and administrative workers to patients and families – from sharing information that could impact patient safety. Among the factors discussed were:

Cultures of Fear and Secrecy

Summit participants agreed that cultural attitudes – in both the workplace and society, in general – are a key factor to be addressed. Because the reporting of adverse events or issues in health care is usually perceived as an action that leads to punitive results, cultures of fear – rather than openness – have emerged that may encourage suppression of information rather than transparency and a willingness to share. Strongly hierarchical workplaces can exacerbate the problem, impeding the willingness of individuals to come forward to report problems in the behavior or performance of those in more senior positions. "Power differentials" are often perceived in health care teams, in which some participants are viewed as having sway and influence over others – making those in subservient roles less likely to speak up about problems or issues. In an office setting, individuals may fear retribution – including loss of employment – if they report the behavior of a person in authority.

Peers working in health care may be reluctant to report issues of competence or ethics in their colleagues for fear that they will be identified and ostracized by others. For physicians or other professionals who rely on referrals, such ostracization can have economic impacts. Participants noted that in health care workplaces, where physicians, nurses, pharmacists, and others have a high degree of interdependence in a pressure-filled environment, their reliance upon each other may serve as an impediment to "rocking the boat."

There may be practical considerations that inhibit reporting in the workplace, as well: Participants noted that the formal reporting of issues may lead to involvement in time-consuming human resources

processes or costly legal proceedings. Outside the workplace, the same issues are also at play: Patients and families may have the same fears of confronting authority figures, and may be reluctant to engage in time-consuming and stressful formal complaint processes.

Stigmatizing Language and Labeling

Participants noted that the language used to describe the sharing of information has become stigmatizing. Those who "report" may be perceived as being hostile and those who are "reported" are sometimes perceived as being guilty. With these labels – and their psychological impact – strongly entrenched, language itself becomes an impediment to the open sharing of information. Individuals don't want to be put in either category. If reporting is always viewed as a punitive exercise, few will share information. Participants noted that some health care sectors have used language more effectively to reduce stigmatization – for example, the drawing of a distinction between substance-abuse and misconduct when dealing with issues of addiction.

Lack of Knowledge and Understanding

In a complex and bureaucratic health care system, with multiple layers of oversight, regulation and accountability, it is often difficult for individuals to know with whom they should be sharing information, or what steps are required of them. This is particularly problematic for consumers, who may not know the difference between a state medical association and a state medical board, for example. Participants noted that even health care professionals may be confused about where to go with information they want to share. Those who do take steps to report information may find processes confusing and poorly explained.

Participants also noted that while patients have become more empowered in recent years, many still lack a full understanding of the extent of their rights when it comes to reporting problems with their care. This lack of understanding is compounded by variation from state to state in the handling of patient complaints – for example, policies for whether anonymous reporting is allowed or whether complaints can be submitted online – with the result that many credible complaints may never be registered.

Rapid changes in medicine may also have an impact on information reporting. For example, fast-evolving clinical guidelines and best practices, along with use of new methodologies – such as electronic medical records – may create confusion about what should be considered errors in care or violations of standards.

"One size fits all" Environment

Participants noted that the current environment for reporting and sharing information tends to focus on addressing extreme issues and egregious behavior, rather than identifying less-serious – but nonetheless important – problems in health care delivery. The system lacks a sense of spectrum, making it less likely for individuals to come forward with information about early-stage issues that could lead to more serious problems later. Health care providers with moderate performance or behavior issues, for

example, who need to make professional adjustments or improvements, may not be reported by others out of concern that taking such an action would be too extreme a step. Preventive or remedial action is thus less likely to occur. Patients, too, may be reluctant to report some behaviors, fearing that such a step could have more significant repercussions than they intend.

Lack of Incentives

The current system of reporting and sharing information, with its strong emphasis on punitive outcomes, tends to disincentivize individuals from stepping forward. Summit participants noted that many individuals weighing whether to share information may see few advantages, but many disadvantages – ranging from professional retaliation from peers to economic cost and emotional stress. In a system of "carrots and sticks," participants agreed that the sticks far outnumber the carrots in terms of behavioral change. Without clear benefits, the tendency to report is inhibited.

Some participants also noted that institutions often foster non-confrontational cultures, which leads them to build workarounds and systems that can perpetuate an avoidance mentality among employees. Without rewards for transparency and the willingness to take action, problems and issues go unreported.

The lack of incentives inhibits self-reporting, in particular: Individuals who have information about problems related to their own performance or behavior are much less likely to come forward in an environment weighted toward punitive, rather than remedial or rehabilitative, action.

Lack of Accountability

Participants noted that institutions that that do not stress accountability create cultures in which individuals are much less likely to report or share information. When clear expectations of who is responsible for addressing issues in the workplace are lacking, individuals tend to blame the institution, rather than taking the initiative to come forward. Individual leadership often sets the tone for organizational accountability and in the current health care system highly visible leadership and example-setting is needed. Some participants suggested that there is a gap between public and institutional definitions of "accountability" – and that the gap creates an environment of distrust and misunderstanding that inhibits effective reporting and information sharing.

Confidentiality and Anonymity Issues

While accountability is a critical factor in creating cultures of transparency, a need for appropriate confidentiality and anonymity also exists. Participants noted that institutional policies on confidentiality and anonymity, while well-intended, may inhibit individuals from sharing information if they are not well understood. Balancing the rights and responsibilities of individuals who report – as well as those who have been "reported" – requires carefully thought-out policies and sensitivity to sometimes competing or opposing needs. In an environment of heightened concerns about privacy and use of data, and changing standards about what can and should be shared publicly, a lack of clarity about confidentiality and anonymity rules may dampen efforts to improve reporting and information-sharing.

Session II: System Design

What do we know about the current infrastructure and system for reporting of issues impacting patient safety? What resources exist currently but are not being integrated to enhance reporting? What issues keep them from being integrated?

Participants identified various factors that impact the reporting and sharing of information at the systems level during the summit meeting's second discussion session. The multi-layered U.S. health care system has enormous complexity, with numerous private and public sector organizations collecting information about health care practitioners and patients. Insurers, hospital systems, pharmacies, state medical boards, federal, state and local government agencies, health care practitioner organizations, consumer groups and many others are part of this vast network of information. Operating independently, but in a way that often intersects with health care is the nation's law enforcement community, which also collects information that sometimes involves health care practitioners and patients. During this session, participants discussed system issues – hurdles and obstacles that exist within these organizations that may impede the reporting and sharing of information impacting patient safety.

Among the factors discussed were:

Lack of Data Integration and Coordination

One of the most significant issues contributing to issues with information-sharing is a lack of integration and coordination between the vast databases being compiled by various stakeholder organizations in health care. Participants noted that much data exists that could be helpful in targeting issues in patient care, but more effort is needed to make this information more widely shared. Confidentiality and privacy concerns make this discussion complicated and contribute to a lack of greater reporting.

Misaligned incentives are an issue with systems, just as they are with individuals, said participants, noting that some stakeholder institutions in health care may see little upside in the time and effort required to share their data more widely with others. Some may willfully ignore requirements to report information in this environment.

Additionally, there is wide variation in <u>what</u> kind of data is being collected and how it is reported. Standards for how much information can be shared by the boards that license and discipline health care practitioners vary widely from state to state, for example, as do requirements for hospital systems.

Participants noted that the explosion of data-gathering technology in recent years has created a new challenge for system administrators, who must make decisions on how best to process and use the ever-increasing stream of information. The sheer volume of data that is now required to be collected may create an atmosphere in which administrators, focused on managing the process, may miss opportunities to use the data more strategically and collaboratively.

Differing Attitudes on the Role of Data and Reporting

While information about health care practitioners and patients in the U.S. is growing, attitudes about its use in identifying and addressing issues in care delivery may vary by professional or societal culture. For example, participants noted that in the research community, reporting of adverse information may be viewed more positively, as a component of improvement, while in the practitioner community, such reporting – considered punitive – may be viewed more negatively and thus be inhibited.

Public attitudes may also vary about what actions or behaviors rise to the level of being "reportable."

Participants observed that institutional cultures are important in impacting the shape and utility of systems and processes. Senior leaders may set a tone that negatively influences how an institution's systems and processes are developed and used. For example, an aversion to risk and transparency trickles down throughout an organization, impacting the willingness to share information. Long-term cycles of institutional behavior are established in this way and are hard to overcome.

Jurisdictional and Legal Restrictions

Common impediments to the flow of information are widespread statutory and legal restrictions imposed upon institutions. As an example, participants discussed state laws that restrict what kinds of information about disciplined physicians that medical boards can share across state lines. Similarly, federal institutions, such as the Veterans Health Administration, face legal limits to what kinds of information they may share outside the VA system. Similar restrictions apply to large databases, such as the National Practitioner Data Bank, as well as hospitals, insurers and other stakeholders in health care. Participants noted that an institution's contractual agreements – common in hospitals, for example – may also restrict what information can be shared with others.

Procedural and Institutional Hurdles

Participants noted that in addition to legal and jurisdictional restrictions, many long-held institutional procedures may impact the flow and sharing of information. For example, many state medical boards share only what is categorized as public information, and this often does not include minor disciplinary measures, such as letters of reprimand. In Medicare investigations, no report is issued until there is a conviction; meanwhile much potentially important information is gathered. Hospitals may have various levels of "formal" and "informal" reporting of issues, and other institutions don't have access to the results of "informal" reporting – despite the fact that this information, too, could be impactful. Other kinds of potentially useful data are also heavily restricted, including peer-review reports in hospitals and mental health records.

Participants discussed the weakness of many organizations' internal reporting systems – which don't provide adequate tools or easily understood procedures for employees, patients, families and others who wish to step forward to provide information. The information pathway for reporting varies widely from institution to institution and may be starkly different in government vs. non-government settings. The lack of common definitions and standards for reporting information from sector to sector was noted

as a weakness, as well as the lack of enterprise-wide risk management strategies in most organizations. The lack of formal risk-management structures inhibits the likelihood of reporting adverse events, problems and issues in health care.

Lack of Coordination with Law Enforcement

The statutory limitations that impact state regulators, hospitals and others are also a prime cause for a lack of information-flow between law enforcement agencies and health care institutions – an issue that participants noted often causes public tension. Law enforcement investigators work under restrictive procedures that often require withholding information about criminal activities of health care practitioners for periods of time; when the information eventually becomes available publicly, the lack of active coordination and sharing with health care organizations may be criticized as a gap in public protection. Media reports of criminal activity in health care practitioners in recent years have frequently noted these communication gaps as an important issue beyond the crime itself.

Participants noted that in some cases, it isn't statutory restriction that keeps law enforcement agencies from sharing information, but simply a lack of understanding of the role of agencies such as state medical boards – and the usefulness of information they might be able to legally share.

Lack of Coordination with Health Practitioner Organizations

Participants noted that state medical societies and other associations with members who are health care practitioners are underutilized as potential partners in a more effective system of information-sharing and reporting. This is because such organizations have traditionally not played a strong role in disciplinary or regulatory matters, as their primary purpose is to advocate for their members. Still, participants noted that health practitioner associations have infrastructure, data, and other tools and resources that could help in an effort to better share information and encourage reporting at the front lines of patient care.

Limited Resources

Many institutions – especially public agencies, such as state medical boards – are strapped for funding; in the current economic environment, many are being asked to do more with less. Some participants observed that tight budgets lead to a triaging environment in which it is difficult to fully utilize rapidly growing data sources. With understaffed departments, the problem isn't <u>finding</u> the information – it is in building the human and technical capacity to make better <u>use</u> of it. Some participants noted that data gatekeepers in institutional settings – hospitals, regulatory agencies, etc. – are feeling increasingly challenged to keep up with the volume of information they are required to manage.

Regional Health Care Workforce Disparities

Participants noted that in some parts of the United States – particularly rural areas – physician and nurse shortages make it less likely that patients, families or professional peers will report improper conduct or competence issues. There is a perception that underserved areas cannot afford to lose health care workers – fostering a higher level of tolerance for improper behavior or adverse events. In

addition, in smaller communities, health care workers may be reluctant to report the actions of their peers for fear of losing patient referrals or professional ostracization.

Special Presentations

During a presentation before Session III, two speakers offered special perspectives on the issue of reporting and information sharing.

Shauna Slaughter, MBA, *Deputy Director of Delaware's Department of State Division of Professional Regulation*

Ms. Slaughter shared insights about how Delaware made significant changes to its reporting and information-sharing systems following the Earl Bradley case in 2009. Dr. Bradley was a Delaware pediatrician convicted after being accused of more than 500 counts of molesting 103 children in his care – despite warning signs of his behavior that had been noted, but not shared, by members of the health care and law enforcement communities.

Delaware launched a statewide effort in the wake of the case, resulting in major legislation that gave the board more authority to levy fines for failure to report information, to obtain information from peer review panels, to take stronger action against institutions – as well as individuals – for failure to report, and other powers. It also expanded the number of public members serving on the board and made changes to its administrative processes intended to improve the flow of information. The measures have been widely applauded for their scope and impact.

Rachel Rose, JD, *principal at Rachel V. Rose – Attorney at Law, PLLC*

Ms. Rose, a health law attorney and bioethics expert, discussed issues of physician misconduct – including sexual misconduct and substance abuse – that have raised significant questions for professions beyond health care, and which require strong responses from the professional community. These responses include shared, community-wide commitments to ethical standards. Ms. Rose discussed approaches used by the State of Nevada in the wake of national media reporting about physician sexual misconduct, and suggested that existing models for peer-reporting and information-sharing in other professions, such as law, could be translated into similar action in health care.

Session III: Action Steps

What can we do to address the issues in individual behavior and system design to improve the reporting and sharing of information impacting patient safety?

Summit participants considered potential action steps and new ways of thinking that could be applied to the various challenges and hurdles that currently impede the reporting and sharing of information during a final discussion session. Several areas of emphasis were identified that could help begin to steer a national effort toward improvement.

Action areas included:

Cultural Change in the Workplace

A new dialogue is needed about how best to transform workplace cultures of fear and secrecy to openness and transparency. Part of this requires aligning incentives so individuals do not fear the repercussions of reporting or sharing information. It also requires lessening stigmas associated with adverse events, and introducing a wider spectrum of responses when issues or problems in health care are identified. By introducing less punitive, more remedial options when possible, individuals will be more likely to openly share information and use it constructively to effect system change. As the move toward team-based-health care continues to grow, new guidelines are needed to help encourage a process of more effective reporting and information-sharing across disciplines – as well as a new effort to include patients more transparently in this process. Also needed is a strengthened sense of both personal and public accountability for the reporting and sharing of vital information: Health care professionals, patients and families all have the duty to step forward, but so, too, do institutions – and this should be formally acknowledged and communicated.

More Research and Education

More research is needed on the unique cultural factors that impede transparency and the willingness to report or share information in health care workplaces, including study of the practices and system attributes that distinguish cultures of openness versus secrecy. Similarly, more study is needed of factors that may impede patients and families from reporting or sharing information. As a part of this effort, better education is needed – for both health care professionals and the public – to explain the importance of sharing information and the role individuals can play in helping reduce adverse events. Early education of medical students and residents is especially important in helping to change attitudes about reporting, as is education for the public through hospitals and other health care facilities.

Better Tools and Resources

A significant impediment to reporting and information-sharing by individuals is a lack of understanding of how, and with whom, information should be shared. Oversight bodies, such as state medical boards or hospital peer-review committees, can only act if information is made available to them. More resources and better tools are needed for both the public and health care professionals to facilitate their ability to share information, including hotlines, dedicated websites and other tools. Professional associations and organizations, representing health providers, and consumer groups, representing patients and families, could play a leadership role in helping to raise greater awareness and visibility of how to report, and promoting tools to make reporting more effective. The environment for reporting could be improved by changing the way forms and other materials are worded or processes are described – placing an emphasis on confidentiality, ease of use and clarity. Reporting should be “safe, easy, and clear.”

Greater Focus on Prevention and Proactivity

Too often, reporting and information-sharing in health care happens reactively, when serious issues have already occurred. A new emphasis on prevention and proactivity is needed, focusing on identifying smaller issues "upstream" before they become larger issues. A large middle-area exists in health care, in which less harmful – but nonetheless important – adverse events occur each day, and where issues could be ameliorated before they grow to cause more harm later. This should include efforts to better identify and address behavioral or competency issues in health care providers earlier in their medical careers – including at the training level – and stronger, sustained quality-improvement cycles for patient safety processes. In addition, our information-gathering processes for evaluating the performance of both individual health providers and patient-safety systems would benefit from wider sources of input. By using multiple sources of information and perspective, the likelihood of identifying potential issues is increased. As a part of a move toward greater prevention and proactivity, there is a need for health care workplaces to do more to create environments in which information about adverse events or negative outcomes is viewed more constructively – as a way to help drive improvements.

A New Language of Reporting and Information-Sharing

One of the key dynamics that impedes the gathering of information about adverse events or problems in health care is the language that is used to describe the process. The word "reporting," for example, when used in this context, can bring prejudicial connotations of wrongdoing, guilt, surveillance, suspicion and other negatives. Other sectors have made significant progress in achieving goals related to transparency and information-sharing by changing the terminology they use. One example is the recent work of the mental health and law enforcement communities in changing the way they speak about addiction: The use of "person-first" dignity-preserving language and the avoidance of stigmatizing terms have helped create an environment in which addiction can be discussed more openly and vital information is much more likely to be shared. The health care community should engage in a similar assessment of the terminology of reporting and consider new, less stigmatizing ways to describe its processes.

Reassessment of Data Use

The rapid growth of information technology and data collection and processing capability in recent years has created an abundance of information relevant to patient safety and the quality of health care. The problem is that this information is not well coordinated or used strategically to advance the goal of a transparent, proactively oriented system of reporting adverse events or problems in health care. New channels of information-sharing – with appropriate privacy/confidentiality protections – are needed to make it possible for disparate organizations to work together more closely in addressing and preventing adverse events or problems in health care. Included should be a reassessment of statutory requirements that limit data-sharing between state medical boards, federal agencies, the law enforcement community and others. In addition, stakeholders in health care should work together to create more unified, consistent and better aligned systems of reporting and recording adverse events or problems so they can be more efficiently shared. Finally, in the new environment of rapidly growing databases, better data-articulation is needed – that is, systems that can more effectively flag and prioritize issues for

attention. The issue to be addressed isn't as much a lack of information as it is better utilizing the information that already exists.

Broader Partnerships

Organizations with oversight responsibilities related to patient safety and health care quality, including state medical, nursing and pharmacy boards; hospitals; federal agencies, such as the Centers for Medicare & Medicaid Services; large health systems, such as the Veterans Health Administration; and others need to begin to engage more proactively with each other and with new partners to fill gaps in reporting and information-sharing. A key connection in this effort should be engagement with the law enforcement and medical education communities – two vital links for creating a new culture of reporting and information-sharing. Niche organizations, such as Physician Health Programs (PHPs), should also be more actively engaged as partners in this effort, as should organizations such as state, local and national medical, nursing and pharmacy associations – which have resources that can help enlist health care professionals directly. A new dialogue between oversight organizations and patient-safety organizations should similarly seek to involve patients and families as partners. Specialized sectors within health care – chief medical officers and quality assurance managers in hospitals, for example – should be more actively included, as well as the media .

Establishment of Best Practices

Many models of effectiveness in reporting and information-sharing currently exist in the health care system and should be elevated as best practices. Some medical specialty societies, for example, have well-established systems in place for reporting information about physicians who have been disciplined. Clinical data registries and other data-heavy health care enterprises have achieved success in organizing and sharing critical information with stakeholders. Credentialing and certifying organizations in health care also offer excellent models for management of reporting and information-sharing functions. In sectors outside health care, templates also exist that could be built upon to strengthen the environment for reporting and information-sharing. Examples include the adoption of corporate whistle-blower regulations and the well-noted establishment of a sustained culture of safety in the aviation industry – which has required coordination of diverse stakeholders and organizations.

Conclusion

Summit participants agreed during a concluding discussion that continued stakeholder discussion of these issues, along with a process of prioritizing and more clearly defining a set of workable action steps to address them, would benefit the health care community.

To move the discussion forward, the FSMB hosted a special panel discussion on reporting and information-sharing at its 2017 Annual Meeting in April titled "Duty to Report: Sharing Information to Protect Patients." In May, FSMB Chair Arthur Hengerer, MD, gave a presentation titled "Duty to Report or Prevent: The Challenge to Professional Self-regulation in Medicine" as a featured speaker at the 2017 Spring Meeting of the Council of Medical Specialty Societies in Chicago.

In addition to public distribution of this report, other advocacy activities are under discussion.

APPENDIX: SUMMIT PARTICIPANTS

David Benton, RGN, RMN, BSc, M Phil, PhD
National Council of State Boards of Nursing

Brian Betner, JD
Hall, Render, Killian, Heath & Lyman, P.C.

Richard C. Boothman, JD
National Patient Safety Foundation

Jeff Brady, MD, MPH
Agency for Healthcare Research and Quality

Laura Burns
Health Resources and Services Administration

Humayun J. Chaudhry, DO, MS, MACP
Federation of State Medical Boards

Carol Cronin, MSW
Informed Patient Institute

Armando DelToro MHA, FACHE
America's Health Insurance Plans

Mike Dugan, MBA
Federation of State Medical Boards

Andrew L Findley Jr., MD
Department of Defense

Nancy Foster
American Hospital Association

J. Daniel Gifford, MD, FACP
Federation of State Medical Boards Board of Directors

Anna Hayden, DO
American Association of Osteopathic Examiners

Arthur S. Hengerer, MD, FACS

Federation of State Medical Boards Board of Directors

Norman B. Kahn, Jr., MD
Council of Medical Specialty Societies

Patricia A. King, MD, PhD, FACP
Federation of State Medical Boards Board of Directors

Joe Knickrehm
Federation of State Medical Boards

Paul Larson, MS
Federation of State Medical Boards Consultant

Lisa Soleymani Lehmann, MD, PhD
Department of Veterans Affairs

Frank B. Meyers, JD
District of Columbia Board of Medicine

Lawrence H. Mokhiber, MS, RPh
National Association of Boards of Pharmacy

Thomas J. Nasca, MD, MACP
Accreditation Council for Graduate Medical Education

Denise Nguyen
Health Resources and Services Administration

Lois Margaret Nora, MD, JD, MBA
American Board of Medical Specialties

Geraldine T. O'Shea, DO
American Osteopathic Association

Stephanie Radix, JD
American Academy of Physician Assistants

Lisa Robin, MLA
Federation of State Medical Boards

Rachel V. Rose, JD, MBA
Rachel V. Rose – Attorney at Law, PLLC

Ken Simons, MD
Wisconsin Medical Examining Board

Susan E. Skochelak, MD, MPH
American Medical Association

Shauna Slaughter, MBA
Delaware Department of State Division of Professional Regulation

Gregory B. Snyder, MD, DABR
Federation of State Medical Boards Board of Directors

Greg P. Thomas, PA-C Emeritus, MPH
National Commission on Certification of Physician Assistants

David A. Wininger, MD
Alliance for Academic Internal Medicine

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