State of California Department of Consumer Affairs

Medical Board of California

January 15, 2008

To: Members

From: Janie Cordray, Research Director

Subject: Medical Errors Task Force Meeting

The following is offered to assist with discussion:

Objective/Problem Statement of Task Force:

The following statement may be useful in initiating the discussion:

> Since the IOM report "To Err is Human" was published, there has been tremendous discussion, as well as legislation, to promote the reduction of medical errors. Traditionally, the Medical Board has played its part in patient protection through its mandated responsibility of disciplining physicians, without great involvement in quality improvement initiatives. The Board would like to examine its role to determine if it could provide greater public protection by becoming involved in initiatives to reduce medical errors, or how it might provide assistance.

Work of the Task Force:

The following elements may be useful to consider:

- Examine the extent of the medical error problem in California, and how the Board's licensees contribute to or remedy the problems;
- Learn from those I the healthcare delivery systems (physicians, hospitals, societies, associations, medical schools, and others) how they are addressing medical errors, and the success of current programs or initiatives;
- Examine how the current Medical Board system of discipline, mandatory reporting, and other programs may inhibit or assist addressing medical errors in various settings;
- Examine how the Board may assist organizations, societies, facilities, or others in their efforts to reduce medical errors.

IOM categories of medical errors:

Diagnostic:
Error or delay in diagnosis
Failure to employ indicated tests
Use of outmoded tests or therapy
Failure to act on results of monitoring or testing

Treatment:

Error in the performance of an operation, procedure or test
Error in administering the treatment
Error in the dose or method of using a drug
Avoidable delay in treatment or in responding to an abnormal test
Inappropriate (not indicated) care

Preventive:

Failure to provide prophylactic treatment
Inadequate monitoring or follow-up of treatment

Other:

Failure of communication
Equipment failure
Other system failure

Possible Major Topics for Discussion at Future Meetings:

- Assessing the Current Environment - Statistical data on errors, literature, current programs, and initiatives;
- Reluctance of physicians to report medical errors - encouraging participation in reporting;
- California reporting laws and the disciplinary process; how it helps or hinders the reporting and addressing of medical errors;
- Potential opportunity for the Medical Board to assist in the reduction of medical errors