MEDICAL BOARD OF CALIFORNIA

Executive Office

AGENDA ITEM 2

Medical Errors Task Force
The Westin Los Angeles Airport
Concourse B Room
5400 West Century Boulevard
Los Angeles, CA 90045

January 31, 2008

MINUTES

Members Present:
Cesar Aristeiguieta, M.D., Chair
Steve Alexander
Reginald Low, M.D.
Mary Lynn Moran, M.D.
Gerri Schipske, R.N.P., J.D.

Staff Present:
Kim Kirchmeyer, Deputy Director
Janie Cordray, Research Director
Renee Threadgill, Chief of Enforcement
Kurt Heppler, Legal Counsel, DCA
Anita Scuri, Senior Legal Counsel, DCA

Members of the Audience:
Tara Kittle, General Public
Sarah Huchel, Senate Office of Research
Wendy Conner, General Public
Janet Mitchell, General Public
Tina Minasian, General Public
Gaby Rodriguez, General Public
James Hay, M.D., California Medical Association
Julie D'Angelo Fellmeth, Center for Public Interest Law
Zennie Coughlin, Kaiser Permanente

Agenda Item 1 Call to Order

The Medical Errors Task Force was called to order by Chair Cesar Aristeiguieta, M.D., on January 31, 2008 at 2:00 p.m. A quorum was present, and due notice had been sent to interested parties.

Dr. Aristeiguieta began by announcing this was the inaugural meeting of the group. The committee is seeking input into the appropriateness of the Medical Board involvement into medical errors prevention.

Dr. Aristeiguieta stated while it is the Board's role to license and discipline physicians, the Board is seeking a means to address medical errors that might save lives before a disciplinable offence occurs. He added it is particularly troubling to the members when they have a disciplinary case on an error but are unable to determine if there was any information shared with the institution on the error in the system that might prevent future injury. In some cases, errors are not disciplinable, but there should be some way in which to address them to prevent future problems. He stated the Board is seeking input on how it might address these types of issues in order to provide greater public protection.

Dr. Aristeiguieta stated there are systems for other professions, such as the Federal Aviation Administration (FAA) program for pilots, involving error reports that are used to prevent future mistakes. Dr. Aristeiguieta hopes the members will hear from interested groups and consumers on how the Board can provide assistance in the prevention of medical errors and more importantly, how can the Board integrate into reporting systems or error reduction initiatives to enhance public protection and encourage better medical quality?

Agenda Item 2 Discussion and Approval of "Problem Statement", Goals and Purpose of Task Force

Dr. Aristeiguieta directed the panel members' attention to the prepared outline, including the drafted problem statement, and asked the members for their comments.

Mr. Alexander stated he wasn't sure the draft statement was appropriate as the Board now spends 90% of its time in enforcement and 10% in prevention, and he would like the board to be able to reverse those numbers. He reported the Board can help physicians and systems to prevent errors by identifying causes and remedies to prevent harm, that would provide greater public protection than disciplining physicians after harm has occurred.

Mr. Alexander said he would like to draft a problem statement that would be conducive to creating a culture where providers are inspired to participate to increase patient safety and the goal should be to find ways to prevent errors.

Dr. Moran said she had attended the Public Education Committee, and from the discussion, it appears that physicians have misconceptions about the Board. She stated she would like to see a system of accountability and responsibility, working with physicians to improve patient care. She added both the public and physicians should be better informed of the Board's existence, as well as its function and purpose. In her opinion, it should be the physicians' responsibility to let patients know about the Board. She stated physicians should know the Board is there to assist them as well, and is not entirely about punishment.

Dr. Low stated the subject of medical errors is so broad, the Board should focus on what it can

realistically do within its jurisdiction and resources. He stated to be effective, the members should identify and focus on an area where the Board can be most useful. He added the Board cannot deal with all types of medical errors; however, it can probably be very effective in dealing with medication mistakes, preventing wrong-site surgery, and others. In his opinion, the Board should focus its efforts on where it can have the most positive impact. As an example, the development of cards for patients to carry in their wallets, containing their medical conditions and prescribed medications. Dr. Low stated the Board would be more effective if it limited it focus to its mission.

Dr. Aristeiguieta explained he had many discussions with Janie Cordray, the staff person working with the committee, trying to determine what type of approach to take that would be consistent with the Board's mission and jurisdiction. He stated it is the Board's mission to discipline physicians, there is a difference between a physician that is having a bad day and makes a mistake and someone that does something disciplinable that requires monitoring and other punitive measures to protect the public. He stated there needs to be some method to determine when the Board can use the information to take preventative steps to prevent the type of error occurring in the future.

Ms. Schipske said she agreed, and perhaps the panel should reframe the words used. She said that on the Federal level, the government is now primarily using "patient safety," which is essentially what all of the programs are trying to improve. She further noted that according to the Institute of Medicine, medication errors are the most serious and numerous of the errors, and should be the major focus of efforts. She would like to see an emphasis on patient safety.

Dr. Moran stated she would like to see some focus on a national centralized database. Knowing it is controversial and costly; she believes that it could be an important tool in preventing medical errors.

Dr. Low stated that the Board has limited jurisdiction and resources, and the panel should decide what it can effectively do within its limits. Dr. Aristeiguieta agreed. He said the Board faces a number of challenges this year, and the panel should look for a means of prevention within its resources.

Dr. Aristeiguieta said the Board should probably examine the nature of the complaints reported, and identify some components to address. He explained the first step should probably be to identify what the members consider an error.

Dr. Low stated he appreciated Mr. Alexander's comments about the FAA system for pilots, but he thinks there is not a strong comparison between pilots and physicians. He said he thinks it is more difficult to be a physician, as pilots have a more focused task with less variables to consider. Mr. Alexander said he would suspect pilots would disagree. Mr. Alexander said it is up to the members to identify practical ways to solve problems within its purview.

Ms. Schipske asked Mr. Alexander what appealed to him about the FAA program. Mr. Alexander said the reporting system is not punitive and pilots and others all work together when

something goes wrong and the system promotes collaboration and problem solving. Mr. Alexander reminded the members that about two years ago the Board heard a speaker from "Sorry Works," which has a similar system, and that been very successful. He reported the challenge is how to take physicians, hospitals, lawyers, and others out of a litigation mentality and encourage them to cooperate to solve problems.

Dr. Aristeiguieta stated one of the challenges to be faced will be cultural. He noted physicians now fear their errors being discovered, are afraid that their discovery will bring disgrace, insurance increases, or punishment.

Dr. Moran said it happens all of the time in department quality assurance programs within hospitals. She said that she is also a pilot, and it is difficult to compare physicians with pilots. She pointed out when pilots make severe mistakes, the accident usually takes care of the problem pilot, and no disciplinary action is necessary. She added medical and FAA systems are difficult to compare.

Mr. Alexander said he would suggest the purpose of the group could be defined as "to identify the role of the Medical Board of California in increasing patient safety within the delivery of healthcare by California licensed physicians and surgeons."

Mr. Alexander suggested the Board could engage in a small pilot program where one category of discipline that did not involve patient harm would be granted immunity if reported and made public for study purposes.

Dr. Aristeiguieta said he thought there would have to be some kind of data on the types of errors and what could be done to prevent them within the boundaries of the Board. He said the agenda was probably too ambitious to ask the members to decide on a problems statement, as the group needs more information before deciding on what it should seek to solve.

Dr. Aristiguita said he thought the panel should hear from some speakers and see some presentations before actually deciding on a statement. He'd like to hear what the academic world thinks of the problem of medical errors, and how the Board might fit into what others are doing. He added there may be programs being performed by other Boards as well and the goal of the first meeting was simply to get the discussion started before beginning anything concrete.

Dr. Moran said she also would like to see models from other boards. Dr. Aristeiguieta said Ms. Cordray could identify some persons involved in quality initiatives and pilot projects that are currently being used. He said he liked Mr. Alexander's statement, and Ms. Schipske's focus on patient care, understanding the Board does have a mandated disciplinary process.

Dr. Moran said the Board should also utilize the Federation, as well as participate in any of their initiatives. Dr. Aristeiguieta asked Ms. Cordray if the Federation had a taskforce on medical errors. She responded she did not think it had a current taskforce, but it had issued a formal statement on medical errors. She said California had already initiated a medication errors taskforce, and Lori Rice, a former Medical Board member, had served on that taskforce and

indicated she would be willing to share her experiences with the Board. She added there are a number of groups that are grappling with the Federal legislation, and have developed some initiatives to meet the Federal requirements; unfortunately, the HHS has not yet completed the regulations.

Dr. Aristeiguieta said he also thought it would be helpful to hear from the CMA and DHS's Licensing and Certification. Ms. Schipske said the CMA published "Translating Patient Safety Research Into Clinical Practice" and it includes references to the Harvard Practice Study.

Agenda Item 3 **Discussion of Types of medical Errors and Identification of Those for Future Discussion/Presentation**

Dr. Aristeiguieta directed the members to page 183 of their meeting binder. He asked them to review the IOM categories of medical errors. He said he thinks the IOM list is very good, as he's seen most of them in the Medical Board's disciplinary cases.

Dr. Moran noted where there are systems failures, those cases are generally the responsibility of the institution. Dr. Aristeiguieta said while systems are certainly the hospital's responsibility, the Board should have some kind of role in passing information to the hospital, DHS, Licensing and Certification, or Joint Commission so that others using the same flawed system might also address deficiencies found in the Board's investigation. He'd like the Board to become part of a larger system to provide information to improve patient safety.

Dr. Aristeiguieta said the IOM list of errors appears to address the types of errors he saw in his practice, as well as the cases seen by the Board -- issues of surgeries being performed on the wrong side, medication errors, missing test results, misinterpreted tests, among others. He thinks the list carries a framework the members can address and expand on as they progress in their discussions.

Dr. Aristeiguieta stated he would work with staff to identify some potential speakers for the next meeting. He would like to seek guidance from the medical community on the appropriate role of the Board in this arena. He'd like to hear the views of the academic, private, public, governmental, and societal sectors represented. He stated the subject is so large the Board needs to be appropriately specific to be effective. He stated the speakers can help identify the best role for the Board. Dr. Moran added she would encourage the Board to attend all sessions of the Federation meetings, especially on this subject.

Mr. Alexander said most importantly, the members need to address the purpose of the task force and decide what the members want to accomplish. He would ask the members not leave the meeting without making a clear statement of purpose. Dr. Aristeiguieta asked if the statement "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 to such" would be acceptable. Mr. Alexander thought the statement should be more positive and should focus on patient safety.

Ms. Schipske agreed the focus should be positive. Dr. Aristeiguieta said he agreed, but was concerned the focus of the panel should specifically address medical errors as a means to improve patient safety. Dr. Moran said she thought it would be more practical, reflecting the environment, to be specific to medical errors.

Dr. Low said the Board and the medical community should be identifying simple solutions for major problems. He asked the audience if there was anyone in attendance that did not own a cell phone. He suggested that cell phones could be used to store medical information, such as conditions and medications. He stated for the few that do not own cell phones, an inexpensive phone that isn't used for calling could be used for the storage of information. He noted by doing that one simple thing, encouraging the phone service providers to store emergency medical information, it would be a simple solution that would have the potential to prevent a number of medication or treatment errors.

Dr. Aristeiguieta asked the members return to the discussion on the statement, and asked if "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 to such," was acceptable. Mr. Alexander stated he would like to see the statement come back to them, but made the motion that it be currently used as the working statement. The motion was seconded and passed.

Agenda Item 6 Public Comment

Dr. James Hay, representing the California Medical Association (CMA), said he had furnished copies of their "Project Safe Care" report. He stated patient safety is of the highest priority to the CMA and organized medicine. The CMA meets quarterly, and has published and distributed four pamphlets, including management of lab tests, hand-off of patients for hospital care and to consultants, and dealing with language barriers. He stated in the short term, the Medical Board could help by disseminating these pamphlets – not only the pamphlets of the CMA, but other groups with similarly fine publications, through printing them in the Board's newsletter and linking to them on their website. He noted another way the Board could help would be to encourage the establishment of some kind of no-fault, confidential reporting of errors and incidents. The CMA has worked in the past to sponsor legislation that would have created that kind of system. He likened medical errors to the tip of the iceberg, and said some kind of reporting system is needed to discover the depth of the problems and possible remedies. He noted there is literature on the subject, and he would encourage the Board to look at what is already produced before initiating any of its own actions. The CMA would like to work with the Board in the future on legislation to establish some kind of confidential reporting system.

Ms. Wendy Connor, public, stated she was blinded by a doctor eight years ago and from a patient's point of view, it seems like the profession is putting the responsibility on the patient. She added the doctor who blinded her had dozens of malpractice suits, none of which were made public by the Board. She noted when looking at the classifications of errors, there is some

information that patients need for informed consent; patients need to know a physician's track record, including malpractice cases. She stated there needs to be some kind of patients' rights system. She understands that doctors are human and will make mistakes, but the doctor that blinded her had lists of malpractice cases and she should have had that information before allowing him to treat her. She added doctors should have to report these errors, and patients should be informed. She stated doctor's history is crucial to patients so they can make informed decisions about their care.

Ms. Tara Kittle, public, stated she is a health care consumer, and one way the Board can help is to go directly to the physicians and ask what kinds of pressures are being put on them that are causing errors. She added the Board then would have a list on which they could take action; Things like sleep-deprivation or battling with insurance companies. She noted there are things that tie physicians' hands that cause stress and probably lead to errors. It is her opinion that dealing with medical errors will probably save money. Any initiative that may seem expensive most probably will eventually save money.

Ms. Gabby Rodriguez, public, stated she has been on crutches since 1998 as a result of a medical error. In her case, it was much easier for the doctor to cover his mistakes, rather than admit what he had done. She stated the doctor was probably afraid of a loss of reputation, litigation, and other problems if he had been honest about his failings. She said she agreed with the panel on embracing mistakes so that physicians can feel comfortable in admitting errors so they can be fixed. She thinks now it is just easier for physicians to say nothing because the law actually protects them. That is what she found in going through her civil lawsuit and with her dealings with the Medical Board complaint process. She noted it is a lot harder for patients to try to hold the doctor responsible than for doctors to make mistakes, say nothing and coast through the system. She stated it would benefit the public if the Board could sponsor legislation to eliminate or lengthen the statute of limitations, as now physicians only need to stonewall and cover up long enough until they can't be held responsible. In her situation, it is the statute of limitations that is preventing her from moving forward with her complaint; the other problem is fraud and concealment. She stated every other doctor that has treated her has immediately identified the problem, but the offending doctor is allowed to conceal information so as not to be held responsible. While no legislation can help her case, there are those who could benefit from an extension of the statute, as well as a requirement for doctors to tell patients about the Medical Board.

Agenda Item 7 Adjournment

The meeting adjourned at 3:00 p.m.