On Patient Safety

On Patient Safety: How Well Do We Police Ourselves?

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Outlier surgeons—those surgeons who violate universally accepted standards of care—are few and far between, but they are out there. You may have crossed paths with them in the course of patient care. They may work at your hospital, or you may have read about them in your local paper, or even encountered them in legal proceedings. But if you have been in practice long enough, chances are you may know

who some of these outliers are. The question is, what can we do about them? What are our responsibilities to police our own?

Just An Aggressive Surgeon?

I remember a dinner I had with several other surgeons in the community early in my practice. We discussed another one of our surgical colleagues in the community who, by reputation, employed loose indications for surgery. This surgeon's practice patterns, from our perspective, seemed to be financially driven. In one egregious example, the surgeon had allegedly intentionally displaced a nondisplaced fracture to justify going to the operating room, presumably to bill more than he would have with nonoperative treatment. By the end of the evening, after having shared numerous galling anecdotes, the more it seemed like this surgeon was an outlier. If these alleged events were true, we certainly hoped that someone with direct knowledge of

the transgressions would address them. But at the end of the day, these were all unsubstantiated events and none of us had any direct knowledge. And none of us took any action.

Several years later, this surgeon's hospital investigated his practice patterns, and in the end, the surgeon and hospital parted ways. I had to wonder, "How many patients would have been affected, if this action had been taken sooner?" The fact that corrective action took several years from when I first became peripherally aware of this surgeon represents a failure of the system.

I also wondered what I personally would have, should have, and could have done differently. The reality is we, as a healthcare community, should have done better. However, as I recently learned, the mechanisms available to physicians who want to clean up their practice communities are few, difficult to engage, and not always effective.

Mechanisms In Place

Fortunately, outlier physician behavior is relatively rare. If we examine medical malpractice, since 1990, the vast majority (82%) of physicians have

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never had a malpractice payment made on their behalf [2]. Conversely, since 1991, the majority (57.8%) of medical malpractice payments were made on behalf of only 5.9% of physicians [2].

How can one deal with outlier surgeon behavior? Shepard R. Hurwitz MD, executive director of the American Board of Orthopaedic Surgery (ABOS), shared with me a number of mechanisms in place for dealing with rogue physicians. First, a full disclosure and confidential morbidity and mortality conference, where complications are discussed, represents as Dr. Hurwitz noted, “a shame-based mechanism” to identify and address outlier behavior. This, in conjunction with a pre and postoperative conference where indications for surgery are examined, can go a long way to identifying variations in practice and potential outliers in a practice group. These mechanisms certainly can work well, but only within each respective medical center.

What about encountering outlier behavior from outside one’s medical center? In those cases, state regulations may play a role. Imagine Surgeon A treated a patient and a medical error occurred, but Surgeon A did not disclose the error to the patient. If another surgeon sees that patient and becomes aware that Surgeon A did not report the error, that surgeon is obligated to report Surgeon A in select states [1].

With such regulations in place, Surgeon A is more likely to self-report adverse events. Finally, and perhaps most effectively, direct communication between Surgeon A and Surgeon B regarding the situation, though perhaps awkward initially, can be a powerful tool in impacting behavioral changes. In an interview, Dr. Hurwitz noted that an “everybody’s eyes and ears” approach can certainly act as a strong deterrent to outlier behavior. If enough people are watching and you do not think you can get away with something, you are probably not going to try.

Should We Discipline Ourselves?

However, there currently is no formal mechanism for orthopaedic surgeons to discipline themselves. ABOS certifies, but does not license physicians. One can be licensed and practice orthopaedic surgery in the United States, but not be ABOS certified. Thus, the burden of discipline falls largely on state medical boards—the last resort for surgeons policing themselves.

So how effective are state medical boards in disciplining outlier physicians? According to Chris Stombough, president of the Wisconsin Trial Lawyers (Wisconsin Association for Justice), the answer is not at all. “Medical boards are

incredibly weak in handing out discipline to physicians,” Stombough said in a phone interview. “They are unwilling to act unless the cases are egregious, and that’s not good enough.”

According to an analysis of National Practitioner Data Bank (NPDB) files, only 8.61% of physicians with two medical malpractice payments were disciplined by their state medical boards [2]. While two medical malpractice payments may not necessarily raise a red flag, consider physicians who have made 10 or more medical malpractice payments. Of these, only 33.26% were disciplined by their respective state boards. In other words, two-thirds of physicians who have made 10 or more medical malpractice payments saw zero disciplinary action from their state medical boards [2].

Peer-Policing and Stewards of Safety

According to Mr. Stombough, the problem is that no one wants to speak up. “Doctors know [who the outliers are]. Nurses know. They will know before anyone else knows. You know who you would and would not send your loved one to. But physicians do not want to point fingers. Clearly anyone can make a mistake, but typically these are not just mistakes, these are violations of standards of care.”

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There are many truths in his statements. Physicians do know and instead of gossiping about the individuals in question, we need to call them out. For starters, we should adopt Dr. Hurwitz's "everybody's eyes and ears" approach. When we see patients who report physician behaviors that do not quite sound right, instead of shaking our heads in disgust and moving on, we should call the physician in question and find out exactly what happened. Although our natural instinct is to avoid that awkwardness, direct communication can only improve patient safety. If the physician in question was indeed acting with ill intent, such a call would let him or her know that the community is watching and taking note. That, in itself, is a strong deterrent to outlier behavior. Most of the time, we are likely to learn that there was no outlier behavior, but rather simply some difficult clinical circumstances. Offering the provider in question the chance to explain may

generate a conversation in which good ideas can be exchanged, so that the next time such a situation arises, a safer and more-effective plan of care can be in place. And if an "everybody's eyes and ears" approach proves to be insufficient, then perhaps state medical boards protocols need to be revised so as to further deter outlier behavior. Or perhaps governing specialty organizations like the ABOS can develop a due process to peer review alleged outlier behavior before it reaches the state medical board level. Ideally, specialty organizations should be proactive in advising state medical boards in their decisions regarding disciplinary action. Perhaps it is time for specialty organizations to take the lead in policing those they certify.

We are the stewards of patient safety. An "everybody's eyes and ears" approach only works if everyone participates. In addition, if we do not police ourselves, then we surrender ourselves to third-party regulation

through the legal system. The trial lawyers, many of whom regard themselves as the stewards of patient safety, are more than eager to tackle this issue.

"The legal system can help to clean up the medical system where the medical system refuses to act," Stombaugh said.

We should be able to manage this without their help.

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