Controversy

Reporting medical mistakes and misconduct

C. David Naylor, MD

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Error is inevitable in every sphere of human activity. Medicine, unfortunately, is no exception. Every practitioner can recall personal errors in clinical judgement, regrettable lapses in communication with patients or families, or technical mistakes in performing procedures. Although some medical mistakes are relatively harmless, others take a tangible toll. In their classic study of over 30 000 records from 51 acute care hospitals in New York, Brennan and associates found that adverse events leading to disability or death occurred in 3.7% of hospital stays, with more than 1 in 4 events attributable to negligence.

In this issue Eike-Henner Kluge challenges members of the medical profession to share our mistakes more fully with the general public and our patients (page 1321). Some US jurisdictions have enacted legislation that gives the public access to records of not only physicians’ training and honours, but also malpractice suits and disciplinary actions taken by professional self-regulatory bodies. Kluge urges Canadian provinces to do the same.

Kluge does not distinguish among the different types of information that might be shared, indicate how the process could be used to catalyse improvements or place the proposal in the broader context of “report cards” about medical care. These issues warrant discussion.

The names of those convicted of criminal offences, disciplined by the self-governing provincial colleges or sued successfully for malpractice are already in the public domain. In theory, Kluge’s proposal simply increases access to this information. In practice, however, a practitioner who made a serious clinical error 5 years earlier and was reprimanded by the College of Physicians and Surgeons. Rather than staying in her public record for 10 years, as would be the case in Massachusetts, the negative notation might be erased early on the basis of multiple positive practice audits, favourable letters of reference from colleagues and evidence of participation in meaningful continuing education activities. Similarly, some who are sued successfully will either limit their practices or refrain to reduce the chances of another malpractice suit. If it is decided that a negative record will survive for some standard period, perhaps such positive information should also be recorded, so that the system includes incentives for practitioners to redress deficiencies, and gives patients a fuller picture.

Particular thought must be given to framing any Canada-wide registry of malpractice suits. The physician’s specialty has a substantial bearing on the likelihood of malpractice litigation. Record audits confirm that the baseline risk of adverse events varies by specialty, even though relative rates of negligence are similar. As well, many suits are settled out of court. The physicians involved may be innocent of negligence, but settlement is pursued as a risk-management strategy by lawyers and malpractice insurers. In other cases the plaintiff’s suit may be so strong that settlement is viewed as the least expensive option. A reporting system must fairly encompass these variations.

Above all, the tort system in general is neither sensitive nor specific in measuring problems with the quality of care. The New York study found no consistent relation between the initiation of a lawsuit and the occurrence of adverse events or their attribution to negligence. Severity of disability, rather than an objective and independent determination of whether or not care had been negligent, ultimately predicted awards to plaintiffs. Put another way, losing a malpractice suit at most confirms that the practitioner made significant errors that caused one patient serious harm. It does not prove general incompetence. Imagine, for instance, an excellent orthopaedic surgeon who, for whatever reason, makes one major operative error leading to a large malpractice settlement. Thirty other orthopaedic surgeons in the same province
have higher postoperative complication rates on average, but have not been sued successfully. Under Kluge’s proposal, only the first surgeon’s misadventure is a matter of public record.

For these reasons, a system for more visible reporting of malpractice and professional misconduct will do little to foster true accountability for better-quality care. Most adverse events due to negligence never come to the attention of the courts or our self-regulatory bodies. For that matter, notwithstanding the serious toll of overt negligence, the overwhelming majority of quality problems and preventable adverse outcomes are more subtle and systemic.

What we need instead is more systematic assessment of processes and outcomes of care at all levels of the medical system. Outcomes “report cards” for individual practitioners are difficult to generate for most specialties, because of heterogeneous case mix, low volumes with limited statistical power, referral or selection biases, and insensitivity to quality problems. However, more institution-level outcomes reports can and should be published. Various process-of-care assessments are also feasible, are generally more sensitive than outcome assessments and, despite some limitations, can shed useful light on both clinical judgement and technical quality of care down to the individual provider level.

Of course, publishing information about practitioners and practices is not sufficient in itself to create public accountability. For example, early experience in the US with surgeon-specific report cards on the outcomes of coronary artery bypass grafting suggests that they have little bearing on patients’ choice of providers. Easier access to such information may instead be useful primarily for hospitals or clinics that have corporate accountability for the quality of care provided under their aegis. This is true for practice profiles in general, including the limited information that Kluge proposes to disseminate. And no reporting initiatives will have much impact, I suspect, unless we also develop stronger corporate accountability and response mechanisms that will respectively ensure and facilitate quality improvement by providers and administrators.

In short, Kluge’s proposal at best would shine more intense light on the relatively small number of physicians who are guilty of serious professional misconduct or have made conspicuous mistakes that have led to successful malpractice suits. Carefully and constructively implemented, it could indeed offer some patients more information than they have today. However, the real quality and accountability issues in medicine rest with the majority of us who, despite good intentions and hard work, inevitably make many smaller mistakes that never come to the attention of the courts or our professional colleges.

I am grateful for comments from Donald A. Redelmeier and Jack V. Tu but alone am responsible for any opinions expressed in this article.

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References


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