Raising the Standard of Care:
A Special Report on Medical Error in Iowa

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Introduction

Medical mistakes represent a significant issue in public health. Identifying a uniform cause for these errors is difficult, and it's equally challenging to develop a consistent and effective solution that reduces the likelihood of repeat incidents. Acknowledging these adverse events, learning from them, and striving to prevent them are key steps towards enhancing patient safety.

In 1999, in its pioneering report *To Err is Human: Building a Safer Health System* (1), the Institute of Medicine (IOM) revealed that as many as 98,000 patients died from preventable errors in U.S. hospitals each year. This report created awareness and launched a national movement to improve patient safety. Almost twenty-five years later, such errors remain a serious concern, with tens of thousands of patients experiencing harm each year. However, today patient harm from medical errors is no longer considered inevitable. The narrative has changed about medicine's ability to avoid safety problems. While much work remains, experts say the patient safety movement has achieved several significant successes:

- Federal focus on Patient Safety.
- Hospital oversight on quality and safety through regulatory agencies such as the Joint Commission for Accreditation of healthcare organizations.
- Industry-wide campaign models such as the Institute for Healthcare Improvement (IHI) 100,000 Lives and 5 million Lives campaigns, and the World Health Organization (WHO) Safe Surgery Saves Lives campaigns.
- National focus on an identified group of high-risk preventable hospital infections.
- Integration of curricula across the Association of American Medical Colleges (AAMC) medical schools and teaching hospitals, including development of a common set of quality improvement and patient safety competencies.
- The Partnership for Patients campaign, an outgrowth of the Affordable Care Act (ACA), focused over two-thirds of American hospitals on the improvement of patient safety and the reduction of hospital- acquired conditions between 2000-2015. This work continues today through several government programs.

But medical error continues. Medical error is a preventable adverse effect of care ("Iatrogenesis"), regardless of if it is evident or harmful to the patient. This might include an inaccurate or incomplete diagnosis, or treatment of a disease, injury, syndrome, behavior, infection, or other ailment. There are many types of medical error, from minor to major, and causality is often poorly determined. There are also many taxonomies for classifying medical errors. In the end, however, medical errors can result in patient harm.

In 2023, House File 161 (2) was enacted to address malpractice awards in Iowa. The bill also directed the Department of Health and Human Services to convene a Medical Error Task Force to examine the topic of medical errors in the physician population in Iowa. Their purpose is to explore if state oversight of patient harm is sufficient. This is a report of their findings.

Background

A System of Care

Health care delivery is enormously complex. There are multiple stakeholders: patients and caregivers, physicians and other clinicians, pharmaceutical and device manufacturers, regulators, and others. Management of the overall enterprise is difficult and equally complex.

The World Health Organization describes that health services are presented as a system of buildings, people, processes, desks, equipment, telephones, etc. Unless the people involved understand the common purpose and aim, the system will not operate in a unified fashion. People are the glue that binds and maintains the system. (3)

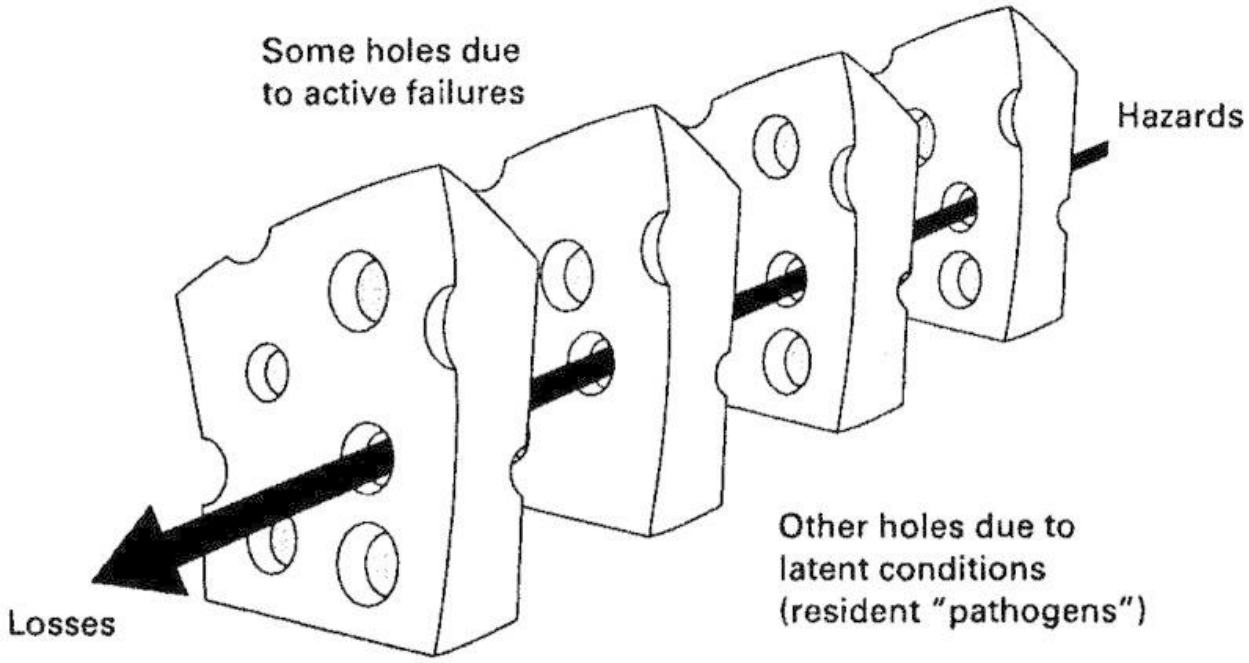
Patients depend on these many individuals doing the right thing at the right time as a system of care. Being a healthcare professional who practices safely requires an understanding of the complex interactions and relationships that occur in health care. Such awareness can help practitioners identify the opportunities for mistakes that can harm patients and take steps to prevent them.

Swiss cheese Model

Most medical errors do not occur because of the practices of one practitioner or a group of practitioners. Most errors are due to systems or process failures that lead to practitioners making mistakes.

Reason developed the "Swiss cheese model" to illustrate how analyses of major accidents and catastrophic systems failures tend to reveal multiple, smaller failures leading up to the actual hazard. (4)

In this analogy, each slice of cheese symbolizes a safety measure or precaution associated with a specific risk. The key aspect is that no individual barrier is completely infallible; they all have vulnerabilities, akin to the holes in Swiss cheese. Normally, a single gap in one layer doesn't lead to adverse consequences; however, when, by coincidence, the holes across all layers align, the risk directly impacts the patient, resulting in harm.



Successive layers of defences, barriers and safeguards

IOM Report and the Birth of the Patient Safety Movement

As health care and the system that delivers it becomes more complex, the opportunities for errors abound. *To Err is Human: Building a Safer Health System* focused its initial attention on the quality concerns that fall into the category of medical errors. They described several reasons for this.

1. Errors are responsible for an immense burden of patient injury, suffering, and death.
2. Errors in the provision of health services, whether they result in injury or expose the patient to the risk of injury, are events that everyone agrees just shouldn't happen.
3. Errors are readily understandable to the American public.
4. There is a sizable body of knowledge and very successful experiences in other industries to draw upon in tackling the safety problems of the health care industry.
5. The health care delivery system is rapidly evolving and undergoing substantial redesign, which may introduce improvement, but also new hazards. Examples include both overuse and underuse.

The World Health Organization (WHO) states, "Investment in reducing patient harm can lead to significant financial savings, and more importantly better patient outcomes (5). The IOM report has been a national call to action on patient safety.

Defining Patient Safety and Medical Error

Patient safety is the process of amelioration, avoidance, and prevention of adverse injuries or outcomes that arise because of the healthcare process. Patient Safety has typically been *outcome-dependent,* and the focus has been on preventing patients from experiencing adverse outcomes when receiving medical care. This may stem from Hippocrates, *primum no nocere*, or “First, do no harm.” (6)

All providers know medical errors create a serious public health problem that poses a substantial threat to patient safety. Yet, one of the most challenging unanswered questions is "What constitutes a medical error?" Broadly stated, medical errors are “failure to complete the intended plan of action or implementing the wrong plan.” Errors of omission and commission are the two major types of medical errors. Examples include:

1. The failure to complete the intended plan of action or implementing the wrong plan to achieve an aim.
2. An unintended act or one that fails to achieve the intended outcome.
3. Deviations from the process of care, which may or may not result in harm.

Medical error is often confused with an adverse event. An adverse event is, “an injury caused by medical management rather than the patient’s underlying disease.” Not all adverse events are the result of a medical error, and identifying something as an adverse event does not imply “negligence” or poor-quality care. (7)

Health care is constantly changing with emerging technologies, changing workforce, and payment reform. Because of this, medical errors are difficult to scientifically measure. A lack of standardized nomenclature and overlapping definitions of medical errors has hindered data analysis, synthesis, and evaluation. What is clear is that when planning or executing a procedure, an act of omission or commission may contribute to an unintended consequence.

While definitions in the literature are unclear, some general concepts can be garnered. Multiple similar definitions are available for each of these terms from various sources; the health practitioner should be aware of the general principles and probable meaning. (6)

Medical Error Task Force

Task Force Charge

House File 161 directed the Department of Health and Human Services to convene a Medical Error Task Force to examine the topic of medical errors in the physician population in Iowa and explore if state oversight of patient harm is sufficient. The bill language specifically identifies the following task force charges:

1. Review medical error rates of licensed physicians in this state.
2. Make recommendations to the general assembly and director of health and human services including recommendations that address options for reducing medical error rates.
3. Make recommendations to the general assembly and director of health and human services including recommendations that address options for improvements in education and training to minimize medical errors.
4. Make recommendations to the general assembly and director of health and human services including recommendations that address whether applicable penalties for medical errors and physician licensure review measures are sufficient.

Task Force Membership

House File 161 identified core membership for the task force. Other members were added as needed by the Director of HHS as needed to accomplish the work:

- Ed Bull- Deputy Attorney General
- Tom Evans, MD- Iowa Healthcare Collaborative (Task Force Chair)
- Kelly Garcia, Director, Department of Health and Human Services
- Bernardo Granwehr- State Ombudsman
- Robert Kruse, MD- State Medical Director, Division Director: Public Health
- Roger Lacoy – Patient Representative
- Jaime Murphy, MD- Designee, Board of Regents representing the University of Iowa
- Sarah Reisetter- Chief of Compliance and Deputy Director of Department of Health and Human Services
- William Schoenenberger- Patient Representative
- Andria Seip- Designee, Commissioner of Insurance
- Dennis Tibben- Executive Director of Iowa Board of Medicine & Director's Designee, Department of Inspections, Appeals & Licensing
- Jessica Zuzga-Reed, DO – President of Iowa Medical Society

Four members of the Iowa General Assembly participated in an ex officio capacity.

- Sen. Nate Boulton- State Senator
- Sen. Mark Lofgren – State Senator
- Rep. Shannon Lundgren- State Representative
- Rep. Beth Wessel-Kroeschell- State Representative

Task Force Process

To accomplish the work by January 8, 2024, the task force was organized into four meetings. All task force meetings were open to the public. The task force soon recognized the enormity of the issue and worked to stay focused on answering the four specific task force charges. Because of the diversity in knowledge and experience among the task force members the first two meetings were dedicated exclusively to establishing a basic level of understanding of the issues. The last two meetings focused on processing the information and construction of this report.

- Meeting 1 (September 5, 2023)
  Orientation, review of the charge of the task force, and worked to establish critical questions to be addressed in following meetings.

- Meeting 2 (September 23, 2023)
  Education was presented by members of the task force on critical questions identified in the first meeting.
  - *Available National Data:* Robert Kruse, MD, MPH, FAAFP (State Medical Director and Division Director of Public Health)
  - *Regulating the Practice of Medicine in Iowa*: Dennis Tibben (Executive Director of the Iowa Board of Medicine)
  - *Medical Errors and Safety:* Jaime Murphy, MD (Chief Quality Officer for UI Health Care)

- Meeting 3 (October 23)
  Additional education was provided on the following topics:
  - *Ombudsman Report: A System Unaccountable*: Bernardo Granwehr (Acting Ombudsman for the State of Iowa)
  - *Iowa Candor Legislation:* Jessica Zuzka-Reed, DO (President of the Iowa Medical Society)
  - *Review of the Heartland Study:* Tom Evans, MD (President/CEO of the Iowa Healthcare Collaborative)

  Also in this meeting, each of the four task force charges were individually considered, discussed, and task force positions established.

- Between meeting 3 and 4, the task force developed a structure and text for the final report. Four drafts were released for comment and discussion to the general task force. The fifth draft was presented at the fourth meeting for detailed discussion and consideration for approval.

- Meeting 4 (December 1, 2023)
  The Task Force met remotely to consider the draft report. Final edits were made, and the final report was approved on December 8, 2023.

Discussion

It was agreed that the presented information was complex and diverse, handled in a balanced manner, and considered multiple viewpoints. There was unanimous agreement on the lack of straightforward solutions. Several members advised the task force to be mindful of potentially creating new, unintended issues through legislative measures. Bearing this in mind, the task force concentrated its discussions on the four mandates outlined in House File 161.

Charge 1. Review medical error rates of licensed physicians in this state.

Individual medical error rates for licensed physicians in Iowa are not available. There are many barriers in getting true comparative data that can be used by the public.

- **Lack of standard definitions**- Due to unclear definitions, "medical errors" are difficult to scientifically measure. A lack of standardized nomenclature and overlapping definitions of medical errors has hindered data analysis, synthesis, and evaluation.

  Many states have implemented state-based reporting systems. Because there are, 1) no federal standards covering state reporting, 2) no uniform list of reportable events or healthcare associated conditions exists, and 3) states are free to designate which events are reportable, the systems are of limited usefulness. (7)

  To date, 26 states and the District of Columbia have enacted reporting systems to help practitioners identify and learn from serious reportable events. Most of those states incorporate at least some portion of the National Quality Forum's (NQF) list of 28 Serious Reportable Events (SREs) to help establish a more uniform set of criteria by which to report and act. Despite the existence of these standardized SREs, there remains incongruity among states in the use, implementation approaches, and perspectives toward reporting a variety of patient safety events, and in turn, efforts for improving adverse outcomes from these events. (8)

- **Detectability**- Surveillance data is often incomplete. Some true medical errors are not detected or become the subject of lawsuits which limit discoverability.
- **Assignment of responsibility**- Responsibility for an error may be misassigned. Because of the integrated nature of healthcare delivery, the person assigned with the error may not be the person who committed it. For example, physicians are held accountable for a care process that has many parties involved.
- **Relevance of data**- Provider-specific medical error data may be misleading or lead to unintended consequences. For example, data may not be identifying a bad physician, but simply one who takes on very difficult cases or operates in a flawed system. In addition, unclear data has the potential to discourage physicians from taking on difficult cases. This leaves patients with few options for care.

Another question to be considered is whether the data is useful. Providers are data driven and committed to transparency. To improve patient care and safety, performance data should be something that can make a meaningful impact on the operation and culture of the system.

- **Culture of reporting**- Several factors within the healthcare culture limit the completeness or quality of the data. Fear of punishment makes healthcare professionals reluctant to report errors. While they fear for patients' safety, they also dread disciplinary action, including the fear of losing their jobs if they report an incident. Unfortunately, failing to report contributes to the likelihood of serious patient harm. Many healthcare institutions have rigid policies regarding patient harm in place that, though well intended, also create an adversarial environment. This can cause staff to hesitate to report an error, minimize the problem, or even fail to document the issue. These actions or lack thereof can contribute to an evolving cycle of medical errors. When these errors come to light, they can tarnish the reputation of the healthcare institution and the workers. (6)

The Board of Medicine (BOM) is the best available resource of comparative physician-specific medical error data in Iowa.

It is important to note that there are already mandatory reporting requirements in Iowa law. With the reorganization of the Department of Inspections, Appeals, and Licensure (DIAL), there is an opportunity to standardize these requirements across the landscape of provider communities.

The Board of Medicine tracks some categorical data related to the complaints it receives about its licensed providers. It is estimated that as many as 72% of the 674 complaints filed with the board in 2022 included some element that the board could categorize as an alleged medical error. This licensing system is not designed to collect and report specific information about complaints investigated by the board and although it is the best resource currently available, it should not be relied upon as an accurate mechanism for tracking all medical errors in Iowa.

DIAL is currently working to procure a new database to centralize data-reporting and tracking across the multiple boards, commissions, and programs that exist in this new department. This new database is expected to have significantly improved functionality over the systems currently utilized by the Board of Medicine and the other bodies licensing and regulating health professions in our state.

Charge 2. Make recommendations to the general assembly and director of health and human services including recommendations to address options for reducing medical error rates.

Errors can be prevented by modifying the healthcare system to make it more difficult for practitioners to perform incorrect actions and easier for them to do correct actions. While individuals need to be held accountable for errors attributable directly to them, the system and culture need to be focused so that reporting errors lead to system improvement and less on individual punishment. The greatest good for the greatest

number of patients is achieved when the system vigilantly focuses on continuous quality improvement and avoiding repetition of the same error.

Embrace and improve the availability and use of systemic data.
Focusing on the function and effectiveness of the health care system directly influences the larger healthcare culture and will bring bigger benefits than individual comparative reporting. Systemic data, like the National Quality Forum (NQF) Never Events or the Centers for Medicare & Medicaid Services (CMS) standard measures, create awareness around common standards of care and challenges providers to meet that.

The ability to generate meaningful data about overall health system performance is changing. Historically the only quality measures available were either measured by hand and not comparable or based on claims submitted for payment. This data, while good for marketing or general directional guidance on performance improvement, is often several months old and does not provide enough detail to truly support care redesign. Over the past ten years with value-based reimbursement the need for real-time and detailed health information has exploded. Health systems are working hard with current legacy systems to enhance the ability of their systems. This new data will significantly enhance performance improvement efforts.

Promote the use of the CANDOR program.
In 2015, the Iowa Medical Society, in conjunction with the Iowa Association for Justice, developed the CANDOR (Communication AND Optimal Resolution) legislation. Modeled after similar programs in Illinois and Michigan, it was built upon earlier statutes enacted in Massachusetts and Oregon. This received strong bipartisan support and was unanimously passed in both chambers.

This program allows health care institutions and practitioners to respond in a timely, thorough, and just way when unexpected events cause patient harm. It seeks to maintain open communication between physicians and their patients in situations where an unanticipated health outcome has occurred. The CANDOR concept also seeks to expand the culture of patient safety through increased disclosure of events causing patient harm. It increases the ability to assess and identify systemic issues that may cause harm.

The program is initiated by the provider following an adverse outcome. Both the provider and patient must voluntarily agree to participate, and discussions are privileged, confidential and not admissible in court. The intended benefits to patients are:

- Patients receive honest and frank answers about the circumstances surrounding the adverse outcome.
- The patient may be invited to assist the facility in implementing procedures to prevent similar adverse incidents from repeating in the future.
- The process is more expeditious than traditional lawsuits, so patients with a legitimate claim receive faster resolution.

- The decision to participate in the discussion is voluntary and does not preclude the patient from using the judicial system if he or she is unsatisfied with the result of the CANDOR discussion.

The intended benefits to providers are:

- The process is more expeditious, allowing the provider to spend more time in the exam room and less time in the courtroom.
- Providers most often see a drop in litigation costs and lawsuits filed.

Results from states who have been using CANDOR like Michigan and Illinois are very encouraging. The University of Michigan found a 55% decrease in the number of claims filed, and a 56% decline in claims resulting in a lawsuit. The University of Illinois-Chicago found an 80% decrease in time to settle a case, a 70% decrease in litigation cost, and decline of malpractice premiums by 55%. The use of the CANDOR program also seems to increase vigilance. A study by the University of Chicago and Medstar showed event reporting more than doubled. There was also a 27-fold increase in event analysis, meaning more root-cause investigations leading to system improvements. (9)

This is a relatively new program in Iowa and provider awareness is developing. Promotion of the program will address the patient more quickly and justly when adverse events occur. It also encourages providers to address adverse events in a positive and proactive manner and promotes system change.

Engage patients and their families as partners in care.

Research shows that when patients are engaged in their health care, it can lead to measurable improvements in safety and quality. (10) After the first task force meeting, two patients were added to the task force. These members were selected because of their experience as national advocates for patient engagement.

Patients and healthcare providers often believe that the quality of care provided or received is high, though there's evidence indicating this isn't consistently the case. Their perceptions of what constitutes quality and safety in healthcare also vary. Providers usually emphasize the clinical aspects of care, whereas patients and their families often prioritize interpersonal aspects. Similarly, views on patient safety differ between patients and providers. Patients generally have a narrower understanding of patient safety, primarily associating it with medical errors, while providers might see errors as largely controllable by individuals, leading them to undervalue the need for systemic changes.

Two recommendations discussed to advance patient engagement are health literacy and use of Patient and Family Advisory Councils in the Iowa hospitals.

- ***Improve Health Literacy***- Patients and providers often do not speak the same language. Health literacy works to promote understanding in emotionally charged, highly technical situations. The definition of health literacy was updated in August 2020 with the release of the U.S. government's Healthy People 2030 initiative. (11) The update further defines health literacy into roles for the patient and the provider:

- **Personal health literacy** is the degree to which individuals (*patients*) can find, understand, and use information and services to inform health-related decisions and actions for themselves and others.
- **Organizational health literacy** is the degree to which organizations (*providers*) equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

- ***Promote Patient and Family Advisory Councils-*** Working with patients and families as advisors at the organizational level is a critical part of patient and family engagement and patient- and family-centered approaches to improving quality and safety. Patient and family advisors are valuable partners in efforts to reduce medical errors and improve the safety and quality of health care. (12) A Patient and Family Advisory Council (PFAC) is an organization of current and former patients, family members and caregivers that works together to advance best practices in a hospital or healthcare organization. PFACs are an excellent way to help health care institutions and providers better understand the perspective of patients and families while also helping caregivers better identify the needs of their patient population and bring patient and clinicians views closer together. (13)

Develop and expand the healthcare workforce.
Health care worker supply has a significant impact on the quality and safety of patient care. Healthcare services are complex, highly integrated, and require coordination and communication. Fewer workers mean work is prioritized to the most urgent needs. Often workers are shifted to other areas where they are not familiar with the established unique quality and safety processes and protocols. This situation is amplified when using temporary nurses and staff to meet capacity needs. The result is a drop in unit performance and the potential for patient harm.

This decline in clinical performance can be dramatic. For example, the Covid 19 public health emergency has put enormous stress on the health care system and disrupted many normal activities in hospitals and other facilities. Despite decades of attention on complications of care, substantial deterioration on multiple patient-safety metrics were observed after the beginning of the pandemic. (14) The fact that the pandemic degraded patient safety so quickly and severely suggests that our health care system lacks a sufficiently resilient safety culture and infrastructure. Efforts that develop and expand the healthcare workforce will reduce medical errors.

Charge 3. Make recommendations to the general assembly and director of health and human services including recommendations that address options for improvements in education and training to minimize medical errors.

Though the task force discussed several possibilities, it was agreed that it is most important to align with current efforts to equip providers.

Providers are committed to reducing medical errors.
The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. The American Medical Association (AMA) and American Osteopathic Association (AOA) each have member statements of ethics. These principles are not laws, but standards of conduct that define the essentials of honorable behavior for the physician. (15) They purport that as a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The Iowa Board of Medicine formally recognizes the AMA and AOA principles as the foundation upon which they do their work through board rule IAC 653-13.20. (16)

Iowa medical professionals have access to a broad array of educational and training activities.
Education in patient safety awareness, training, skill, and execution have improved continuously over the past 20 years.

- Both required and optional Continuing Medical Education (CME) offerings have strongly focused on patient safety and risk reduction since the late 1990s.
- A survey of health system chief medical officers strongly advised not mandating more training for physicians. They report the current amount of required training is already overwhelming to providers and dilutes the importance of the message. (17)
- Health systems, as they transition to value-based reimbursement, are highly incented to focus on safety and effectiveness of care. Elimination of medical errors and improved patient safety are good business.
- The Board of Medicine is appropriately positioned to ensure providers are both adequately prepared and meet the standard of care to serve Iowans.

Focus on the standard of care.
The best way to reduce medical errors is to raise the standard of care. Efforts to align the health care system through common dialogue on system redesign, care coordination, and patient engagement are strong investments in the culture of safety. Health care providers are competitive and commit to a professional standard.

Focus on personal failure though medical error tracking does little to change the operations or effectiveness of the system. It creates a “blame culture” and limits willingness of providers to work together. Focus on quality and safety execution works toward system excellence and creates a race to a higher professional standard.

Statewide focus on quality and patient safety measures works and has already proven successful in Iowa. For example, the Iowa Healthcare Collaborative is working with over 80 hospitals in Iowa to improve patient safety execution in several care conditions of high risk. From March 2022 to October 2023, their collaboration of hospitals has improved anticoagulation and hypoglycemic performance by 15%, opioid adverse drug events by 8%, and the All-Cause Harm measure by 24%. (18)

In another example, Iowa used a campaign model to raise the standard of care. Early Elective Deliveries (EED) are induced deliveries before 39 weeks gestation. These

introduce unnecessary risks to newborns and are recognized as a source of preventable harm. In 2012, in a statewide effort to reduce Iowa early elective deliveries, hospitals were challenged to implement a "hard stop policy" establishing a 39-week standard for delivery unless there were extenuating circumstances. Within 15 months, all hospitals had implemented the policy. Over the course of the campaign, the EED rate dropped from 8% to less than 1%. (19)

Increase patient and provider awareness of how to respond to medical errors.
Patients and providers have a shared responsibility to help reduce medical errors in our state. Providers have mandatory reporting obligations associated with their state license. Regular reminders of these existing reporting obligations will help to ensure reportable events, including medical errors, are reported to the appropriate oversight bodies in a timely manner and improve the body of data available to track medical errors in our state. Greater patient awareness of the institutional and state systems in place to report any concerns with the care they and their loved ones receive, will similarly ensure that more medical errors are being reported and the structural systems in place to help address these issues are made aware as issues arise.

4. Make recommendations to the general assembly and director of health and human services including recommendations to address whether applicable penalties for medical errors and physician licensure review measures are sufficient.

While it is true that individual providers should be held accountable for their decisions, there is a growing realization that most errors are out of the clinician's control. Punishment may, in fact, reduce reporting errors because of the discipline and humiliation that is associated with repeated errors. Nevertheless, not addressing the problem increases the potential for more adverse events, which places more patients at risk. Existing penalties for providers who commit a medical error include public awareness, the tort system, and oversight by the Board of Medicine.

Public perception of effectiveness.
Marketing for physicians is traditionally based on word of mouth. New internet tools and rating systems have increased scrutiny of physician performance. This transparency is good for accountability, clinical effectiveness, and sensitivity to patient needs. Disciplinary actions taken by the Board of Medicine against a licensee due to a medical error or other violation are publicly posted to their website. Disciplinary action taken against other regulated professionals by their respective licensing boards are similarly posted and publicly available online.

Physicians are very sensitive to public perception of their care. They are so sensitive, however, that it has been listed as a key contributor to physician mental health. Physicians are at a higher risk of suicide and suicidal ideation than the general population. Suicidal ideation has been associated with high workload volume and medical errors. (20)

The Tort System Impacts How Clinical Care is Delivered
No physician wants to be sued. Lawsuits take a lot of time and attention, impact reputation, and take a toll on personal self-esteem.

The Iowa Board of Medicine supports a national standard of performance.
The Board of Medicine utilizes multiple national databases to exchange provider information and data with other state regulatory bodies, as well as the facilities and clinics that employ and credential physicians. This includes the National Practitioner Data Bank (NPDB), a federal repository of medical malpractice actions, licensure and credentialing actions, and certain other adverse actions against a practitioner. The board also participates in the Federation of State Medical Board's Physician Data Center and the Interstate Medical Licensure Compact's expedited exchange of state medical board's disciplinary actions.

These systems are designed to allow for the timely exchange of disciplinary action across state lines to ensure that every physician who wishes to practice in Iowa is appropriately screened to identify any potential issues that have occurred in other states. In addition to physicians, the NPDB facilitates the exchange of information regarding physicians, dentists, nurses, and a host of other health practitioners. Across the health professions the DIAL professional licensing boards regulate, there are numerous compact commissions and other data exchange platforms that operate in a similar manner as those utilized by the Board of Medicine.

When a professional licensing board takes disciplinary action against a licensee due to a medical error or any other violation of Iowa law or board rule, these actions are publicly posted to the board's website. This ensures the public has timely access to this information to make decisions about their personal care. Credentialing entities also regularly utilize this information to make determinations about whether to deny, limit, or restrict a practitioner's rights to provide healthcare services in their clinic or facility. This valuable board function serves to protect the public from potentially harmful practitioners and ultimately helps to prevent future medical errors.

Repeat the Ombudsman Licensing Board Report.
In 2017, the State of Iowa Office of Ombudsman issued *A System Unaccountable: A Special Report on Iowa's Professional Licensing Boards*. (21) The report made a series of recommendations to enhance licensing board function and oversight. In 2023, occupational/professional licensing boards underwent realignment with the Department of Inspections and Appeals to form the new Department of Inspections, Appeals, and Licensure (DIAL). Work is being done to standardize processes and measurement in the new department. It is anticipated that this will be a real improvement in alignment and standardization of oversight in Iowa.

There would be value in the Ombudsman's office revisiting the study after DIAL has implemented the new processes.

Conclusions

Continue to improve quality and safety data availability to improve patient safety.

- The provider community is committed to transparency and expansion of the use of data for performance improvement.
- Significant barriers in complexity in definitions, determining the party responsible for the error, and the lack of real time operational data continue to evolve and be addressed.
- Continue to expand the use of data currently available to patients. This information must be packaged and presented in a manner suitable for patients and address issues of health literacy.

Promote the use of CANDOR to address current and real time situations.

- Promote awareness of the CANDOR program.
- Promote early engagement with CANDOR through hospital and provider risk management strategies.
- Monitor CANDOR use and consider future amendments to Iowa's CANDOR statute as needed.

Expand efforts to engage and equip patients as activated partners.

- Promote efforts to improve patient knowledge through health literacy programing.
- Promote use of Patient and Family Advisory Councils in healthcare environments.

Adding more Board of Medicine training mandates is not viewed as helpful by the provider community.

- Training information is readily available. Providers strongly report that education and more training is not the problem and feel overwhelmed with current requirements.
- Focus on systemic performance improvement to raise the standard of care.
- There is an opportunity to harmonize this information and training across the health systems of the state to enhance the culture of safety.

The Board of Medicine is the primary vehicle of state regulation to protect patients from untrained, unprepared, or unscrupulous healthcare providers.

- The Board employs a rigorous system that is connected to other states and meets or exceeds national standards.
- Discussions for reducing medical errors need to encompass all members of the care team and administration. It is not solely the responsibility of the physician.
- All health professional licensing boards have a role to play in protecting and advancing patient safety. The recent realignment of DIAL will raise the standards of all occupational/professional licensing boards to a new level of consistency.
- The Ombudsman Report on the effectiveness of licensing bodies should be revisited after new DIAL processes have been implemented and the provider culture has adjusted.

Summary

One medical error is one too many. Health professionals work hard to save countless lives; however, the incidence of concomitant error is high. All health professions should be focused on the effort to “first do no harm” and work towards decreasing human and system error.

Teamwork, education, and training through structured initiatives are the most effective mechanisms to improve patient safety. Accepting the contributions of team members, reducing barriers to reporting errors, and promoting a work environment where all individuals work together will have the most significant effect on improving patient and staff safety.

The key is to focus on the patient safety of the system. Errors can be prevented by modifying the healthcare system to make it more difficult for practitioners to perform incorrect actions and easier for them to do correct actions. While individuals need to be held accountable for errors attributable directly to them, the system and culture need to be revised so that reporting errors lead to system improvement and not individual punishment. The greatest good for the greatest number of patients is achieved when the system constantly focuses on continuous quality improvement and avoiding repetition of the same error.

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