Self-Regulation Is a Failure

Lucian Leape, David Swankin, and Mark Yessian’s conversation about medical injury in the July/August issue of Public Health Reports is illustrative of the never-ending tension between the differing approaches of health care professionals, regulators, and public advocates to addressing concerns about protecting the public from preventable medical injury.

I have great admiration for Dr. Leape and his pioneering work with systems approaches to reducing medical injuries—especially those that result from medication errors. I can appreciate the logic of his argument that threat of punishment can inhibit the identification, admission, and remediation of errors and error-prone systems. But I do not share Dr. Leape’s optimism that the providers and practitioners of health care are now going to do whatever it takes to optimize patient safety when over the decades they have not policed themselves with notable enthusiasm.

In fact, I would argue that absent a strong, well-supported regulatory system of state and federal oversight that involves at least the possibility of appropriate punishment and that publicly discloses the comparative performance of institutions and practitioners, we cannot sit back and assume that the health care industry is going to get with the program. At least Dr. Leape agrees that some vestige of a regulatory approach is necessary to manage that portion of bad medicine, no matter how small, that results from provider incompetence and impairment. From a public policy perspective, protecting patients from incompetence, whatever the cause, should be our first order of business.

Historically, the professions have not been willing to put patient protection ahead of the self-interest of the guild and neither have hospitals. Professional self-regulation is, I submit, for the most part, a dismal failure. Why is there is so little will on the part of health care professionals and organizations to protect the public from incompetent and impaired practitioners? I am not sure anyone knows the answer. But the defenders of medicine offer up all sorts of reasons to explain away this appalling lack of a professional ethic, including fear of liability, both personal and tort. None of these excuses is likely to offer much solace to the survivors of those whose lives have been ended or those whose well-being has been seriously compromised by the negligence of others. Our current systems of regulatory oversight, with its power to punish and disclose, is in fact a patient safety net, albeit somewhat frayed and a bit too elastic, that cannot be dismantled or neglected until we have evidence that it is not needed. I believe such evidence does not exist, and in fact what we do know about the quality of American medicine suggests that if anything, we urgently need a more effective safety net.

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Dr. Leape replies:

Arthur Levin’s disdain for professional self-regulation is well justified and one that I share. Physicians and hospitals have not lived up to their professional—or, I would say, moral—responsibility to insure professional competence. Why they do not is unclear to me as well, although it probably has a lot to do with glass houses. Both good and bad doctors make mistakes. They are, after all, human beings. In the current system that equates error with negligence, we are all guilty and, understandably, loathe to cast the first stone. Clearly, we need a different way to deal with compromised physicians. Contrary to Mr. Levin’s assertion, I do not think hospitals and doctors are now about to do something about this absent external pressure. They need a push. The question is what kind of push.

Obviously, the current regulatory and legal punitive approach isn’t doing the job. Why? I suggest there are several reasons. First, of course, is its punitive nature. Despite the abundant evidence to the contrary, we are locked into the concept that punishment of individuals deters future errors by others. Punishment of institutions may be another matter. The second reason is the focus on outcomes rather than process, on the accident or injury rather than on the cause. We identify, vilify, and punish the outliers, the ones that get caught, while tolerating unsafe systems in all institutions that allow injuries to happen. Third, we focus on individuals rather than on systems. Finally, much of the regulatory response is reactive, rather than proactively directed toward ensuring safe systems.

I suggest that the objective of governmental oversight should be to prevent errors, not to play “gotcha” with those who fail. If you believe, as I do, that all safety problems are systems problems—for example, what system within a hospital allows a marginally competent doctor to