

---

## LETTERS

---

### 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 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.

Arthur A. Levin, MPH  
Director  
Center for Medical Consumers  
New York, NY

### 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

practice?—then the public policy question is how to use the instruments of government to get institutions to develop and enforce safe systems.

Like Mr. Levin, I favor more regulation, not less. But I support a different kind of regulation. I would like to see boards, departments of public health, the Health Care Financing Administration, and others set and enforce standards that would ensure patient safety rather than just react to egregious episodes. We know many of the causes of errors and do nothing about them: long hours, excessive workloads, inadequate training, sloppy procedures, poor supervision, and so on. Why aren't boards of medicine and nursing more concerned about these causes of patient injury? Why are residents allowed to work 24 hours a day? Nurses to work double shifts? Why aren't all hospitals required to adopt safe medication practices, such as unit dosing, pharmacy mixture of intravenous medications, and computerized ordering? Why aren't hospitals required to establish standards of professional conduct and competence and enforce them?

It is not just the doctors and hospitals that have failed to take responsibility to protect the public; so have our instruments of public policy. There's enough blame to go around, but the time has come to go beyond blame to change our systems both inside the hospitals and out.

*Lucian L. Leape, MD*  
*Harvard School of Public Health*  
*Boston, MA ■*

## Hearing Impairment Data

I am writing to comment on the article "Deafness and Mortality: Analyses of Linked Data from the National Health Interview Survey

and National Death Index" (Public Health Rep 1999;114:330-6). The national data reported were based in part on the 1990-91 Hearing Supplement to the National Health Interview Survey, which was co-sponsored by the National Institute on Deafness and Other Communication Disorders (NIDCD). A previous National Center for Health Statistics (NCHS) report compared the 1990-91 findings to those from two earlier Hearing Supplements conducted in 1971 and 1977.<sup>1</sup> One important result from the 1990-91 Hearing Supplement was that the prevalence of reported hearing impairment for US adults had increased 14% since the first Hearing Supplement in 1971, after allowing for the "aging" of the population. This increasing prevalence of deafness and other hearing trouble in the US underscores our need to better understand the relationships between hearing impairment, other conditions, and activity limitations, health care access, and risk of mortality.

The article by Barnett and Franks contributes important information to this discussion. After adjustment for sociodemographic variables and self-reported health status, they found that subjects with postlingual deafness (per their definition) did not differ in mortality risk from control subjects. The one caveat was that the adjustment for health status included restrictions in daily living, some of which may have been affected by deafness. Because of this and other limitations to the available data, the authors concluded that in future national surveys special consideration should be given to increasing the sample of deaf individuals and improving the description of hearing loss categories, which will permit more informative analysis of the deaf population.

The NIDCD is continuing to work with NCHS in co-sponsoring

more detailed studies of hearing impairment in the US population. One result of this interagency collaboration is that the Fourth National Health and Nutrition Examination Survey (NHANES IV), 1999-2004, has begun conducting hearing examinations on a nationally representative sample of the US adult population ages 20 to 69 years. This is the first nationally representative hearing examination survey of US adults since NHANES I, 1971-75. Many other health conditions of participants in NHANES are assessed simultaneously. We expect that these data will provide more detailed information on hearing loss categories and other associated health conditions for the US population. Also, in 1997 the National Health Interview Survey (NHIS) was revised. Each year this survey provides new estimates of the number of hearing impaired in the population. By continuing to strengthen national surveys, we will increase our knowledge of health conditions associated with hearing loss and the implications for improving the years of healthy life for deaf individuals. NIDCD is committed to achieving this goal.

*James F. Battey, Jr., MD PhD*  
*Director*  
*National Institute on Deafness and Other*  
*Communication Disorders*  
*National Institutes of Health*  
*Bethesda, MD*

## Reference

1. Ries PW. Prevalence and characteristics of persons with hearing trouble: United States, 1990-91. *Vital Health Stat* 10 1994:188. ■

### PHR Readers:

Due to server requirements, our e-mail address has been changed to <phr@hrsa.gov>. Please send your letters electronically to this new address.

—The Editors