Op-Ed

# Law, Health Care, and Ethics: Detoxifying the Lethal Mix

## A physician argues that a systems analysis approach to medical errors must be widely used to improve health system safety.

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But there is hope. A systems analysis approach to error in medicine [7] and other similar industries like aviation and nuclear power has made great strides in error reduction and improved safety [8-10]. Unfortunately, this highly successful approach is thwarted by a common theme in current legal and traditional medical perspectives—individual shame and blame. A new medical and legal paradigm must be embraced that allows what works—systems analysis—to be encouraged and widely used in improving health system safety.

## Legal Impediments

The legal system attempts to provide incentives for high quality, safe health care delivery by utilizing tort law, specifically, medical malpractice under the negligence rule [11]. By attaching liability to individuals, it embraces an ethic of individual action causing individual harm, and, hence, individual responsibility.

Such an ethic might have been appropriate when health professionals had unfettered access to tests and treatments and a blank check for reimbursement [12,13]. The vagaries of managed care and cost containment, however, have changed the landscape of practice. Health care delivery is now a complex team enterprise, with physicians, nurses, technicians, administrators, general counsel, managed care organizations, and patients all playing significant decision-making roles. In particular, patients are not mere passive recipients of health care; instead, they are (or wish to be [14]) partners in the endeavor [15].

Unfortunately, although medical care delivery is now a complex system requiring sophisticated analytical tools for improvement, the legal system has not recognized this reality. Malpractice litigation, the ultimate in individual blame, focuses upon the "last person to touch the patient" [16]. This process inhibits error disclosure, and it fails to unearth important information to be gleaned from systems analysis of the error. Important safety tenets—open and honest disclosure, open communications, cooperative blame-free environments, and a systems focus—cannot be engaged [1,17]. The current legal system creates an environment of distrust between the patient, the professional, and the system itself, translating into a deadly situation for the patient: safety information discussion and exchange is stifled by the understandable fear of litigation, allowing system defects to remain and potentially result in harm to patients.

## Medical Issues

The traditional medical ethic for physicians has been aptly described as the "gentlemanly honor" paradigm [18]: physician professionals are to take individual responsibility for any and all patient results. Success is result of individual physician effort, and negative patient outcomes are moral failures [19]; indeed, negative outcomes are unprofessional and should be punished by means that include blame, chastisement, reprimand, and rebuke in a public forum [20].

Hence, like the law, medicine substantially adheres to the traditional, individually oriented shame and blame ethic; this creates substantial barriers to improved health care delivery [21-22]. Predictably, this fallacy of possible perfection in care delivery creates an incentive to hide error to avoid the unpleasantness of public humiliation—an objective all-too-easily accomplished in our complex medical care system [23], but again, deadly for the patient. System failures remain buried, predisposing the system to future failure—an "accident waiting to happen" [23]. This destines providers and patients to multiple encounters with that same faulty system, associated error, and potential negative outcomes [23], a circumstance that could have been avoided had the error been identified, assessed, and corrected the first time it occurred [24].

## A New Paradigm

To reflect the realities of the current health delivery system, law and medicine must embrace a new ethical paradigm. Because systems are the appropriate locus of attention for outcomes improvement and error reduction, systems must be this paradigm's focus. Law and medicine must move to a system accountability ethic, one that creates incentives to communicate about error and system weakness, rather than seeking to attain error-free, individual human action.

Legal policy should establish incentives to collect, analyze, and share error and system information across providers to enhance patient safety but not for unintended uses, such as supporting lawsuits. Some state courts protect information that comes to light during hospital investigations of medical error under state peer review and quality assurance privilege [25]. But national peer review protection must be enacted to address disparities between state laws and uneven application of safety information [26-27]. Protected safety communications that take system analysis into account—like proposed Senate Bill 720 and House Resolution 663 of the current Congress—would help [28-29]. These bills would provide protections for all communications regarding safety data and improvement and would create Patient Safety Organizations to collect and analyze this data across providers and disseminate lessons learned; the data could not be used in lawsuits. But providers must actually engage in systems analysis in order to avail themselves of peer review protections; simply collecting data and storing it in an administrator's office is inadequate. Information collected merely to avoid liability should be discoverable in legal actions, since providers will not have met their legal (or ethical) obligations to use the data in actively promoting system safety.

Medical ethics must also change. The "gentlemanly honor" paradigm based on an individual physician and a passive patient should give way to system accountability and a team model; medical team members, including patients (and families) should be partners in improving patient health and safety.

All participants in this partnership have rights and responsibilities. Medical team members have the right to identify errors and system weaknesses, disclose and discuss errors without fear of sanction, and engage in analysis to improve system processes. Health care professionals have a responsibility to keep up to date on appropriate medical knowledge and experience and actively engage in systems analysis.

Patients (and their families) have the right to identify errors and system weaknesses, receive error information and discuss errors, obtain timely compensation for medical process accidents, and engage in error and system assessment and improvement [30]. Patients (and their families) have the responsibility to keep up to date about their personal medical information and to actively engage in systems analysis [30]. Of course, some patients cannot play a significant role in system assessments. Family members, however, are still invaluable sources of insight into the weaknesses of the health delivery system. Indeed, since patients and their families see the entire health delivery spectrum, they are in a unique position to identify issues and "eyebrow raising events" [26] that may impact safety.

In this paradigm, accountability is broader. Since the system is the target for reduction and quality improvement, all participants must be attentive to and accountable for identifying sources of error and system weakness. This model of accountability necessitates augmenting traditional activities, observing beyond traditional physician turf, and educating everyone about error identification and compensation for system weaknesses. Although system improvements may sometimes focus upon individuals, such corrective action is aimed at system improvement not individual punishment.

Examining the systems nature of medical error can result in true improvements in health care delivery. Medicine and law should reflect this reality, so that no one will suffer the tragedy of harm that could have been avoided through

previous error reporting, discussion, and correction.

## Acknowledgments

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## References

1. UK Department of Health. *An Organisation with a Memory: Report of an Expert Group on Learning from Adverse Events in the NHS*. London, England: National Health Service; 2000.
   Google Scholar
2. Tito F. *Compensation and Professional Indemnity in Health Care. Review of Professional Indemnity Arrangements for Health Care Professionals*. Canberra: Commonwealth Department of Human Services and Health; 1994.
   Google Scholar
3. Wilson LL. Quality management: prevention is better than cure. *Australian Clin Rev*. 1993;13:75-82.
   PubMed   Google Scholar
4. McDonald CJ, Weiner M, Hui SL. Deaths due to medical errors are exaggerated in the Institute of Medicine Report. *JAMA*. 2000;284:93-95.
   View Article   PubMed   Google Scholar
5. Leape LL. Institute of Medicine medical error figures are not exaggerated. *JAMA*. 2000;284:95-97.
   View Article   Google Scholar
6. Hayward RA, Hofer TP. Estimating hospital deaths due to medical errors: preventability is in the eye of the reviewer. *JAMA*. 2001;286:415-420.
   View Article   PubMed   Google Scholar
7. Cooper JB, Gaba D. No myth: anesthesia is a model for addressing patient safety [editorial]. *Anesthesiology*. 2002;97:1325-1337.
   View Article   PubMed   Google Scholar
8. Kinkade RG. *Human Factors Primer for Nuclear Utility Managers*. Pub no NP-5714. Palo Alto: Electric Power Research Institute; 1988.
   Google Scholar
9. Liang BA. Error in medicine: legal impediments to US reform. *J Health Politics Policy Law*. 1999;24:27-58.
   View Article   Google Scholar
10. US Nuclear Regulatory Commission. *Guidelines of Control Room Design Reviews*. Pub no NUREG-0700. Bethesda: US Nuclear Regulatory Commission; 1981.
    Google Scholar
11. Liang BA. The adverse event of unaddressed medical error. *J Law Med Ethics*. 2001;29:346-368.
    View Article   PubMed   Google Scholar
12. Liang BA. Deselection under *Harper v Healthsource*: a blow for maintaining patient-physician relationships in the era of managed care? *Notre Dame L Rev*. 1997;72:799-861.
    Google Scholar
13. Liang BA. Patient injury incentives in law. *Yale Law Policy Rev*. 1998;17:1-93.
    Google Scholar
14. Editors Choice. Informed compliance. *BMJ*. 2002;324:0h.
15. Skelton JR, Wearn AM, Hobbs FD. "I" and "we": a concordancing analysis of how doctors and patients use first person pronouns in primary care consultations. *Fam Prac*. 2002;19:484-488.
    View Article   PubMed   Google Scholar
16. Liang BA. A system of medical error disclosure. *Qual Safety Health Care*. 2002;11:64-68.
    View Article   PubMed   Google Scholar

17. Maurino D, Reason J, Johnston N, Lee R. *Beyond Aviation Human Factors*. Aldershot, UK: Ashgate; 1995.
    Google Scholar
18. Sharpe VA. Behind closed doors: accountability and responsibility in patient care. *J Med Phil*. 2000;25:28-47.
    View Article    PubMed    Google Scholar
19. Hupert N, Lawthers AG, Brennan TA, Petersen LM. Processing the tort deterrent signal: a qualitative study. *Soc Sci Med.* 1996;43:1-11.
    View Article    PubMed    Google Scholar
20. Liang BA. Promoting patient safety through reducing medical error: a paradigm of cooperation between patient, physician, and attorney. *SIU Law J.* 2000;24:541-568.
    Google Scholar
21. Davidoff F. Shame: the elephant in the room; managing shame is important for improving health care. *BMJ*. 2002;324:623-624.
    View Article    Google Scholar
22. Shekelle PG. Why don't physicians enthusiastically support quality improvement programs? *Qual Safety Health Care.* 2002;11:6.
23. Leape LL. Error in medicine. *JAMA*. 1994;272:1851-1857.
    View Article    PubMed    Google Scholar
24. Reason J. *Human Error*. New York: Cambridge University Press; 1990.
    Google Scholar
25. Liang BA. Risk of reporting sentinel events. *Health Affairs.* 2000;19:112-120.
    Google Scholar
26. Liang BA, Small SD. Communicating about care: addressing federal-state issues in peer review and mediation to promote patient safety. *Houston J Health L Policy.* 2003;3:219-64.
    Google Scholar
27. Young A. Case in health law: limits to peer review privilege. *Virtual Mentor*. December 2003. Accessed February 19, 2004.
    View Article    PubMed    Google Scholar
28. Patient Safety and Quality Improvement Act. S 720 IS. March 26, 2003. Accessed February 19, 2004.
29. Patient Safety and Quality Improvement Act. HR 663. February 11, 2003. Accessed February 19, 2004.
30. Liang BA. Error disclosure for quality improvement: authenticating a team of patients and providers to promote patient safety. In: Sharpe VA, ed. *Promoting Patient Safety: An Ethical Basis for Policy Deliberation.* Washington DC: Georgetown University Press; 2004 (in press).
    Google Scholar

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