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.

Bryan A. Liang, MD, PhD, JD

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

The assistance of Shannon M. Biggs, JD, MA, MEd, is gratefully acknowledged. This work was supported in part by grant number 1 U18 HS11905-01 from the Agency for Healthcare Research and Quality, and is also gratefully acknowledged.

References

5. Leape LL. Institute of Medicine medical error figures are not exaggerated. JAMA. 2000;284:95-97. [View Article Google Scholar]
   Google Scholar
   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. 
22. Shekelle PG. Why don't physicians enthusiastically support quality improvement programs? Qual Safety Health 
26. Liang BA, Small SD. Communicating about care: addressing federal-state issues in peer review and mediation 
30. Liang BA. Error disclosure for quality improvement: authenticating a team of patients and providers to promote 

Bryan A. Liang, MD, PhD, JD, is the director of the Institute of Health Law Studies at the California Western School 
of Law and the University of California, San Diego School of Medicine in San Diego, Calif. Dr. Liang was asked to 
testify at a closed session briefing of the Senate Health Education Labor and Pensions Committee in support of Senate 
Bill 720.

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of 
the AMA.

© 2004 American Medical Association. All Rights Reserved.