NEW YORK LAW SCHOOL

NYLS Law Review

Volume 51
Issue 4 *Faculty Presentation Day*

Article 16

January 2006

A Proposal to Use Common Ground that Exists Between the Medical and Legal Professions to Promote a Culture of Safety

Steven E. Pegalis
New York Law School

VOLUME 51 | 2006/07

STEVEN E. PEGALIS

A Proposal to Use Common Ground that Exists Between the Medical and Legal Professions to Promote a Culture of Safety

ABOUT THE AUTHOR: Steven E. Pegalis is Adjunct Professor of Medical Malpractice at the New York Law School and author of the three volume text, THE AMERICAN LAW OF MEDICAL MALPRACTICE (3d ed. 2005). Please address any correspondences to the author at spegalis@pegalisanderickson.com.

INTRODUCTION

There is a common ground that exists between attorneys who represent patients injured by medical error and responsible doctors who strive to avoid such injuries. That common ground is patient safety. Both attorneys and doctors share a common interest in using the tort liability system to promote patient safety. State Boards regulate competence and hospital peer review activities oversee privileges.[1] This article contends that the civil liability tort system is an important third process that can promote patient safety. If responsible doctors and lawyers work together towards the common ground of patient safety, this joint effort will make health care safer.

Liability cases are unpleasant for doctors. Often the doctor views the case as an assault on his or her professional reputation and, as a consequence, there may be a disproportionate response to what has actually occurred.[2] As heretical as it may sound to some physicians, however, by fighting the tort system doctors are actually doing themselves a disservice. Responsible forces in the medical profession should embrace the idea that liability cases, albeit unpleasant, are an alternative to more draconian action (e.g., loss of privileges or license). The individual isolated meritorious liability case, while unpleasant for the physician, is not "punishment," but does create appropriate accountability.[3]

---

1. See N.Y. EDUC. LAW § 6508 (McKinney 2007) for an example of a state board's authority to determine, among other things, if a doctor is grossly negligent or negligent on multiple occasions. In New York, the Office of Professional Medical Conduct ("OPMC") is the board vested with this authority. *See also* N.Y. EDUC. LAW § 6509 (McKinney 2007) (defining of professional misconduct); The Standards of the Joint Commission on Accreditation of Hospital Organizations ("JCAHO") (providing that quality assurance and risk management are defined respectively as a guide for development of programs for education and evaluation to identify and correct problems in health care settings; and prevention and containment of liability by the careful and objective investigation and documentation of critical or unusual patient incidents).

2. *See* William M. Sage, *Reputation, Malpractice Liability, and Medical Error*, *in* COLUMBIA PUBLIC LAW & LEGAL THEORY WORKING PAPERS 159, 159 (2004):

> Doctors hate malpractice suits. They hate them passionately and continuously. Being sued becomes a recurring nightmare for many physicians, and occasionally an obsession. Eliminating malpractice suits takes precedence over every other political objective — whether public-interested or self-serving — for the American Medical Association and state medical societies. No contradictory belief, however well reasoned, empirically based, or sincerely held, succeeds in crowding out antipathy toward malpractice from physicians' minds.

3. For the purpose of this article, the author defines "punishment" as a removal or restriction of a health care provider's hospital privileges and/or license. Though the motive for such action is intended to protect the public and is not intended to be punitive, the net impact on the physician is "punitive" or "draconian." In addition, on certain rare occasions, a health care professional's acts or omissions may be viewed to be so egregious as to warrant criminal action so that if he or she is convicted the law does intend punishment. Whenever a doctor is unfortunate enough to be "accused" in any forum that can produce a "punitive" result, (even if the doctor admits "fault") the defense still can and usually will maintain that civil liability should suffice. If the net practical effect of the law is to give doctors what amounts to immunity from civil liability, there would be a natural tendency to try to hold doctors accountable in other forums, which can produce more dire consequences. Robert J. Blendon et al., *Views of Practicing Physicians and the Public on Medical Errors*, 347 NEW ENG. J. MED. 1933, 1936–38 (2002) (a national survey revealed that when medical error produced harm to a patient, the public favored not only suing the doctor but also fining and suspending the doctor's license). Doctors do not have their own liability system; the only liabil-

The medical profession has focused public attention on tort reform, maintaining that a liability crisis exists.[4] What if no such crisis exists, but instead, as this article maintains, there are only certain insurance problems which are amenable to insurance solutions?[5] What if the medical profession, which has focused the public on tort reform, is asked to explain why it has not focused public attention on the issue of medical error, which produces injury and death at what could be described as an epidemic rate?[6] Appropriately, the medical profession seeks autonomy so that it may set its own standards to achieve its ethically motivated goals.[7] If the public perceives that its attention has been misdirected by the medical profession, will there be an outcry for more regulation and less autonomy?

Good doctors are motivated to reduce the incidence of patient error. If those doctors also embraced the idea that their patients should have access to motivated attorneys, the medical profession would be benefited by promoting the idea that doctors accept accountability even from unpleasant liability cases. This would be consistent with their ethical mandates and would prove that doctors can be trusted to promote patient safety.

II. THE LIABILITY TORT SYSTEM

The civil tort system works in a context of rights and responsibilities.[8] The law related to medical malpractice is simple and well settled. The physician is in the "business" of practicing medicine and must use reasonable care and diligence to accomplish the purpose for which he or she is employed.[9] Additionally, the physician must use his or her best judgment to accomplish the goal of patient safety.[10]

The law generally permits the medical profession to establish its own standard of care which, if complied with, will usually insulate the physician from liability. However, physicians also have a professional duty to take precautions when they become aware of unnecessary dangers to a patient.[11] The physician

---

ity system that exists is as part of the civil justice system. It is naive for anyone to be unaware that there are "forces" within the medical profession that would wish the civil justice tort liability system to disappear (e.g., "no fault") and there is strong sentiment for such among the population of physicians. A "no fault" system is, however, *not* a liability system.

4. TOM BAKER, THE MEDICAL MALPRACTICE MYTH 10–14 (2005).

5. *See, e.g., id.* at 45–67.

6. *See, e.g.*, ROBERT M. WACHTER & KAVEH G. SHOJANIA, INTERNAL BLEEDING: THE TRUTH BEHIND AMERICA'S TERRIFYING EPIDEMIC OF MEDICAL MISTAKES (2005) (using the word "epidemic" to define the issue).

7. Ronald L. Goldman, *The Reliability of Peer Assessments of Quality of Care*, 267 JAMA 958 (1992).

8. *See* Pike v. Honsinger, 155 N.Y. 201 (1898).

9. *Id.* at 209.

10. *See id.*

11. Toth v. Cmty. Hosp. of Glen Cove, 22 N.Y.2d 255, 263 (1968).

will be liable if he or she fails to take precautions that can safely minimize risks.[12]

Liability is the rule; immunity is the exception. It is not too much to expect that those who serve and minister to members of the public be subject to that principle and be obligated not to injure through carelessness. The obligation of the tortfeasor to make payment is rooted in traditional common law and is premised on the moral concept that a negligent party (e.g., doctor and/or hospital) should bear the full financial responsibility for a bad outcome.[13] The law also contemplates that the obligation to pay will act as a warning that the law demands the exercise of due care.[14]

Monetary damages recoverable for medical injury should be in an amount equal to the "harm" done (i.e., compensatory damages). In addition to providing compensatory damages, a successful suit places responsibility where it belongs and discourages similar conduct from affecting others in the future. No members of the public are more invested in a desire to improve patient safety for others than patients (or their family members) who have directly and personally felt the adverse effect of medical error.

A Rand Corporation study supports the use of contingent fees in medical malpractice cases. The study maintains that contingent fees provide lawyers with an incentive to filter out capricious suits and accept clients lacking funds thereby creating a "key to the courthouse door."[15] "Without contingent fees, the deterrent signal to the physician would be reduced."[16]

The main criticism of the contingent fee system is that it tends to discourage the acceptance of meritorious cases involving minor injuries. However, no alternative has been proposed because fee for service also discourages pursuing meritorious low-recovery cases. The liability tort system does address the most serious cases often on behalf of poor clients in which a financial recovery is desperately needed.[17] If plaintiffs' attorneys have been aggressively pursuing the most serious cases and the number of such cases has not increased, that fact would support a conclusion that the liability signal has effectively contributed to limiting the incidence of the most serious avoidable injuries.

12. *See id.*

13. Bing v. Thunig, 2 N.Y.2d 656, 666 (1957).

14. *See id.*

15. William B. Schwartz & Neil K. Komesar, *Doctors Damages and Deterrence: An Economic View of Medical Malpractice*, 298 NEW ENG. J. MED. 1282, 1288 (1978).

16. *Id.*

17. Transmission letter, Dep't of Health, Educ. & Welfare Publ'n No. 7, 73–88 (July 16, 1973) (on file with author). The author maintains that the tort signal can be further strengthened without undue financial pressure on the medical profession. However, a detailed discussion of this important subject is beyond the scope of this article.

Alternatives to civil jury trials such as informal arbitration and a "no fault" system have been raised.[18] The Rand Corporation Report noted that any gains in efficiency from proposed alternatives to a jury trial might be offset by substantial losses. The complete and careful presentation that must be made to a jury provides accuracy in result, and a broad-base rotating jury pool provides protection against bias and influence.[19] The Rand Report also noted that "no fault" did not appear to offer noteworthy advantages over the present system.[20] Absent fault, there is no rationale for compensating on a no-fault basis people harmed from medical care any more than there is a rationale to compensate all people who get sick or injured.

Information from a liability case may lead to hospital inquiry or even state investigation. If so, due process in those forums exists, but if action is taken in either of those forums, it is not for the purpose of retribution or punishment but rather for the purpose of protecting the public.

Multiple independent studies of closed medical malpractice insurance files show that the litigation process does weed out most of the weaker claims and that frivolous cases are not a major problem.[21] The studies found that the existence of negligence is the most important determinant to the outcome of a medical malpractice claim.

The context of the civil justice system clearly imposes a responsibility to use due care to protect the patient from foreseeable injury. Procedurally the civil justice system imposes on the patient (and for all practical purposes the patient's attorney) an obligation to allege and then to prove by a fair preponderance of the credible evidence that such protection was not received.[22] For decades, plaintiffs' attorneys have resisted any tort reform efforts designed to make it more difficult for them to accept and pursue meritorious cases.[23]

One author advocates what may be an expansion of hospital liability as a mechanism to improve patient safety. According to this author, creating explicit judicial recognition that hospital patients have a "right to safety" would motivate hospitals to develop and implement systems for improved patient safety, since failure to improve patient safety which results in injury would create hospital liability.[24] The author proposes that physicians could use the threat of liability to work together with patients and their attorneys to improve safety. The author states: "Effective pressure for a change in safety culture seems most likely to come

18. Schwartz & Komesar, *supra* note 15, at 1288.

19. *Id.*

20. *Id.* at 1289.

21. BAKER, *supra* note 4, at 78–87.

22. N.Y. PATTERN JURY INSTRUCTIONS § 2:150 (2006).

23. *See, e.g.,* Carmel Sileo & David Ratcliff, *Straight Talk about Torts*, TRIAL, July 2006, at 42.

24. George J. Annas, *The Patient's Right to Safety — Improving the Quality of Care Through Litigation against Hospitals*, 354 NEW ENG. J. MED. 2063, 2064–65 (2006).

from an increased risk of liability, which is signaled by an increase in patient-safety lawsuits, one incentive to which hospitals . . . seem to respond."[25]

Whether the creation of a new overt "patient right to safety" doctrine would add up to the creation of a new hospital liability theory or whether it amounts to a liberalization of the law is a moot point. The threat of liability can be effective only if the patient's attorney is motivated and has access to the information. The notion that doctors who up to now have not been forthcoming (in violation of their ethical obligations) will suddenly become forthcoming (and ethical) with immunity from liability is both illogical and disingenuous.

If a medical error has occurred that has caused injury, it follows that one or more individual health providers is responsible for that injury and therefore is a tortfeasor. Ideally each tortfeasor should openly admit fault, and use the experience to make certain that the error will not be repeated. In addition, others can and should learn from the experience by building safer systems. This idealistic scenario, however, does not change the undeniable fact that the threat of liability has in the past and will in the future create a powerful motive to avoid error. Expanding these powerful motives for institutions such as hospitals clearly would add to the culture of safety.

III. THE INSTITUTE OF MEDICINE'S 1999 REPORT

In 1999, the prestigious Institute of Medicine ("IOM") issued a report entitled: *To Err is Human: Building a Safer Health System* (the "Report").[26] The Report estimated that as many as 98,000 hospitalized patients die each year as a result of medical error.[27] These estimates were extrapolated from prior large studies.[28] Using conservative estimates, the Report noted that more people die in a given year as a result of medical errors than from motor vehicle accidents, breast cancer, or AIDS.[29] The Report described a "disconnect" between public perception and the actual health care error rates and complained that "silence surrounds this issue."[30]

The Report concluded that medical errors, that is, events that "everyone agrees shouldn't happen," are responsible for patient injury, suffering, or death. The Report also contends that medical errors are "readily understandable" by the

25. *Id.* at 2066.

26. *See generally* INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Linda Kohn et al. eds., 2000).

27. *Id.* at 1.

28. Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I*, 324 NEW ENG. J. MED. 370, 370–76 (1991); Eric J. Thomas et al., *Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado,* 38(3) MED. CARE 261, 261–71 (2000).

29. *See* INST. OF MED., *supra* note 26, at 26.

30. *Id.* at 1, 3, 42–43.

American public, that a sizeable body of information from other industries exists to draw upon in tackling the "problem" of medical errors, and that healthcare has been rapidly evolving, creating improvements that have brought new hazards.[31]

Notwithstanding a belief that the ground work for improving safety had been laid by the 1999 Report, two members of the IOM committee five years later[32] maintained that "progress is frustratingly slow," and that "building a culture of safety has proven to be an immense task and barriers are formidable."[33] The fact that respected members of the IOM Committee complain five years after the Report that progress is "frustratingly slow" implies a continued intolerance to preventable injury.

The Report did not determine a statistical way to measure avoidable patient injuries or deaths for that year because the studies used to extrapolate statistical estimates had been performed years earlier. And, although the Report set as a goal a fifty percent reduction over five years, a comparison study five years later was never conducted.

While the Report has unequivocally identified an important problem (injury due to medical error) and urged focused action (a culture of safety), the Report does not directly address the role of the liability tort system with respect to achieving this goal. The Report does imply that liability cases do have a positive impact when it states "[l]iability is part of the system of accountability and serves a legitimate role in holding people responsible for their actions."[34]

IV. WHAT HAS BEEN THE ROLE OF THE LIABILITY TORT SYSTEM IN ACHIEVING PATIENT SAFETY?

The studies used by the Report to help define the incidence of avoidable medical error were undertaken only because of the medical malpractice "crisis."[35] The model system cited by the Report to respond to patient error was first utilized by anesthesiologists because of the high number of medical malpractice cases in this specialty.[36]

Anesthesia is known to be an intrinsically hazardous undertaking, yet the administration of anesthesia has been made "safer" through the adoption of safety

31. *Id.* at ix–x. The Federal Government agreed with the IOM's conclusions noting that the number of errors was at an "unacceptably high level," and endorsed the IOM goal of reducing the number of medical errors by at least fifty percent over a five-year period of time. *See* QUALITY INTERAGENCY COORDINATION TASK FORCE, DOING WHAT COUNTS FOR PATIENT SAFETY: FEDERAL ACTIONS TO REDUCE MEDICAL ERRORS AND THEIR IMPACT (2000).

32. Lucian L. Leape & Donald M. Berwick, *Five Years After* To Err Is Human*: What Have We Learned?*, 293 JAMA 2384, 2384–90 (2005).

33. *Id.* at 2385.

34. INST. OF MED., *supra* note 26, at 110.

35. *See* Brennan et al., *supra* note 28, at 370–76; Thomas et al., *supra* note 28, at 261–71.

36. INST. OF MED., *supra* note 26, at 32, 144–45.

standards. Anesthesiologists use retrospective studies of closed medical malpractice cases to identify avoidable injury and death and then respond by adopting and implementing safety standards.[37] These patient safety efforts have worked to reduce the incidence of avoidable injuries and deaths.[38] In addition, these efforts have also reduced cost. That patient safety efforts have worked[39] is demonstrated by the fact that the malpractice insurance premiums have "dropped dramatically."[40]

"The malpractice crisis galvanized the profession at all levels, including grass roots clinicians, to address seriously issues of patient safety."[41] As a result, "strong leaders emerged who were willing to admit that patient safety was imperfect and that, like any other medical problem, patient safety could be studied and interventions planned to achieve better outcomes."[42]

The liability "crisis" has extended the monetary incentive for risk management into the doctor's office. For example, the Professional Insurance Association of America ("PIAA") has engaged in its own risk management. Using information from closed cases, particularly those in which payment has been made, all doctors (not just those who are sued) are encouraged to avoid similar events and circumstances.[43]

Since the liability tort system creates a body of information that can identify avoidable medical injury, it would be irresponsible not to use that information to promote patient safety. Additionally, it would be irresponsible to weaken or dilute a system that creates that body of information. Both the patient/plaintiff

37. John H. Eichhorn et al., *Standards for Patient Monitoring During Anesthesia at Harvard Medical School*, 256 JAMA 1017, 1017–20 (1986).

38. *Cf. id.*; AM. SOC. OF ANESTHESIOLOGISTS STANDARDS, GUIDELINES, & STATEMENTS, STANDARDS FOR BASIC ANESTHETIC MONITORING (2006), *available at* http://www.asahq.org/publicationsAndServices/standards/02.pdf.

39. *Cf.* Eichhorn et al., *supra* note 37.

40. *Cf. id.*

41. David M Gaba, *Anaesthesiology as a Model for Patient Safety in Health Care*, 320 BRIT. MED. J. 785, 785 (2000). *See generally* Jeffrey B. Cooper & David Gaba, *No Myth: Anesthesia is a Model for Addressing Patient Safety,* 97 ANETHESIOLOGY 1335, 1335–37 (2002).

42. Gaba, *supra* note 41, at 785.

43. In 1998, the Physician Insurers Association of America ("PIAA") published a study, with regard to medical malpractice claims, of neurological impairment in newborns. This study contained a list of "risk management recommendations." These "suggestions" were provided with the intention of "improving patient care and minimizing malpractice losses." *See* E.S. Draper et al., *A Confidential Enquiry into Cases of Neonatal Encephalopathy*, 87 ARCHIEVES OF DISEASE IN CHILDHOOD FETAL NEONATAL EDUC. F176, F176–80 (2002) (identifying areas of "suboptimal care" associated with children who develop neurological injury). The list of what has been identified as suboptimal care by this independent medical study to a large extent overlaps with the PIAA Risk Management Recommendation List. Other examples of PIAA Risk Management Guidelines and Quality Care "suggestions" derive from malpractice claims involving breast cancer, neurology claims, medication errors, claims involving delay in diagnosing lung cancer, claims alleging a delay in diagnosing and properly treating meningitis, and claims involving allegations of radiology error.

alleging medical error and the institution and/or health care providers have legal advocates, and the case itself acts as a "forum." This unique situation creates the potential to discover a "gold mine" of information that can promote patient safety.

V. DEFINING QUALITY OF HEALTHCARE AND MEDICAL ERROR

The quality of care was defined by an IOM consensus statement as the degree to which health services for individuals and for populations, consistent with current professional knowledge, "[i]ncrease the likelihood of desired health outcomes" such as avoiding or limiting injury, disability, or death.[44] The consensus statement maintains that "[t]he quality of health care can be precisely defined and measured with a degree of scientific accuracy . . . ."[45]

If good quality care can be precisely defined and established by objective medical evidence, that standard should apply whether the forum is a state medical board, hospital peer review, or a civil liability case. Because doctors cannot know what will happen in the future for a patient, they must *always* use due care to anticipate complications. Doctors are never required to guarantee a good outcome, but are *always* required to use a medically rational approach. These absolutes help to precisely define and measure the quality of healthcare in any forum.

The Report defined a medical error as the failure of a planned action to be completed as intended (an error of execution), or the use of a wrong plan to achieve an aim (an error of planning).[46] An adverse event is an injury caused by medical management rather than the underlying condition of the patient.[47] An adverse event attributable to error is a "preventable adverse event."[48]

VI. MEDICAL COMPLEXITY AND ADVANCES

Medicine has been making profound advances in delivering unprecedented cures to millions of Americans. These advances, however, also create an expanding complexity not faced by any other industry.[49] "The more complex any

44. Mark R. Chassin et al., *The Urgent Need to Improve Health Care Quality: Institute of Medicine National Roundtable on Healthcare Quality*, 280 JAMA 1000, 1001 (1998), *available at* http://jama.ama-assn.org/cgi/reprint/280/11/1000.pdf (citing MEDICARE: A STRATEGY FOR QUALITY ASSURANCE (K.N. Lohr ed., 1990)).

45. Chassin et al., *supra* note 44, at 1000.

46. *See generally* INST. OF MED., *supra* note 26, at 8, 36 (containing a list of errors, e.g., error or delay in diagnosis; error in the performance of an operation, procedure or test; failure of communication or other system failure). These kinds of errors form the basis for most meritorious liability cases.

47. *See generally id.* at 8.

48. *See generally id.*

49. The medical profession, unlike, for example, the airline industry, is constantly making exponential changes and improvements in its ability to achieve good patient outcome. In terms of safety, the airline industry "simply" must avoid airplane crashes. What exists today for the airline industry in this regard is not

system is, the more chance it has to fail."[50] So because the knowledge base and the technical ability to produce favorable medical outcomes is constantly expanding and improving, this fact must be reflected in efforts to statistically measure improvements. Consistent with applicable tort law, the IOM consensus statement notes that healthcare professionals must stay abreast of advancements in the medical community.[51] The legal standard of reasonable care is clear and unchanging.[52]

A complex medical diagnostic and treatment protocol that can affect "cures" unavailable five years earlier would create opportunities for avoidable harm due to errors in diagnosis and treatment that did not exist five years earlier. Hence the challenge is to be aware of and continue to use that which has been effective, to identify and fix that which has not been effective, to continually incorporate new diagnostic treatment options into a proactive system, and to devise a rational measuring rod to help keep track of whether the efforts to improve patient safety are effective. Although the opportunity for avoidable medical outcomes has been exponentially increasing, the number of medical liability cases has been decreasing.[53]

VII. HUMAN ERROR AND MOTIVATION

The Report has appropriately noted that humans in the medical profession do make injury-producing errors and many of these errors can be prevented by creating systems that make it hard to do the wrong thing and easy to do the right thing.[54] It is also normal and human not to want to admit fault, not to want to be sued, and not to want to disclose errors made by colleagues. It has been noted that physicians often hesitate to be too critical of one another because they fear it will get them in trouble with their colleagues and they will lose referral work.[55]

terribly different from what existed five, ten, fifteen, or even twenty years ago. However, what exists now for the medical profession in terms of their ability to identify medical problems and to effect good outcomes is much different today then it was five, ten, or fifteen years ago and importantly will be much different in the future.

50. Chassin et al., *supra* note 44, at 1005 (noting for example, using randomized control studies as a "gold standard" to measure the efficacy of healthcare interventions in the year 1998, more of such contributions had been made in the previous five years than in the previous twenty-five years combined); Leape & Berwick, *supra* note 32, at 2387.

51. Chassin et al., *supra* note 44, at 1001.

52. *See id.*; *see also* N.Y PATTERN JURY INSTRUCTIONS § 2:150 (2006) (defining in pertinent part the negligence of a doctor as a deviation or departure from accepted practice and requiring a doctor to "keep reasonably informed of new developments").

53. *See, e.g.*, BAKER, *supra* note 4, at 37–38.

54. INST. OF MED., *supra* note 26, at 1–16.

55. *Are Doctors Doing Their Job? Interview with Malcolm C. Todd, M.D., President of the AMA*, U.S. NEWS & WORLD REP., Jul. 1, 1974, at 31.

One study noted that hospital personnel are likely to be reluctant to report or take action with regard to colleagues they work with regularly and see socially.[56]

However, physician-owned insurance companies and their member physicians have a powerful financial incentive to identify those colleagues who may be prone to negligence. It follows that they therefore have an incentive to create practice restrictions that are likely to improve physician performance and to create financial benefits for those who are able to maintain a favorable claim record.[57] One of the goals urged by the Report is to create "sufficient pressure to make errors costly" so health care providers are compelled to take action to improve safety.[58] Liability cases are an important part of that "pressure."

It is normal for doctors to want to believe that suits are frivolous and to want suits to "go away." It is the overreaction to this human motive that works against better achieving the common goal of patient safety. How can we best understand and "use" the positive and offset the negatives of human motivation to make the healthcare system safer? We already have in place ethical mandates and legal forums (disciplinary boards, hospital peer review process, and the civil tort justice system). While an end point of a meritorious civil case is financial compensation and an end point of hospital peer review and state board action may be to restrict or remove the right to practice, the common overlapping end point is that each pathway "uses" human motivation to discourage substandard care.

VIII. "BLAME" AND INDIVIDUAL ACCOUNTABILITY

The Report emphasizes that its primary focus is not on "getting rid of bad apples"; according to the Report the problem is not about bad people. Rather, the focus of the Report is to urge the design of better systems to provide more lasting and broad-based safety improvement.[59] While the Report urges a shift in focus from blame of past errors to a focus on preventing future errors, the Report also states that designing a better system does not mean that individuals can be careless and that "people still must be vigilant and held responsible for their actions."[60] Further, the Report states "unsafe care is one of the prices we pay for not having organized systems of care with clear lines of accountability."[61] The concept of accountability and responsibility lies at the heart of the liability system. The Report, which seems to endorse these basic concepts, seeks to tone down the

56. William B. Schwartz & Daniel N. Mendelson, *The Role of Physician-Owned Insurance Companies in the Detection and Deterrence of Negligence*, 262 JAMA 1342, 1346.

57. *Id.* at 1341.

58. INST. OF MED., *supra* note 26, at 4.

59. *Id.* at 49.

60. *Id.* at 5.

61. *Id.* at 3–5.

rhetoric by deemphasizing the word "blame." Any proposal that reduces hostility and promotes progress on common ground, without sacrificing safety or any of patients' legal rights can only be positive.

The Report refers to the issue of injury and death from medical errors as a "problem" and not as a "crisis."[62] Shouldn't those who advocate change from the traditional legal system allege that their issue is a "problem" rather than a "crisis"? Once a problem is identified, isn't it logical to define the problem and propose solutions specifically related to solving it?[63]

Two distinguished physicians wrote a book entitled *Internal Bleeding: The Truth Behind America's Terrifying Epidemic of Medical Mistakes*, in which they emphasize that "critical safety rules simply must be enforced."[64] In their book, the physicians use a hypothetical example of a typical medical liability case to illustrate their point about the medical liability system. A child runs into the street after a ball and is tragically struck and killed by a car. The driver is then sued, yet "no one is to blame . . . ."[65] These physicians describe the liability process as "an unfair match . . ." where, even when no one is at fault, liability is established because the "ordinary citizens . . ." who sit on a jury assume that somebody must have messed up.[66]

Without citing any factual basis to support their hypothesis, their quantum leap is that these "ordinary citizens" must function without thinking and are in violation of their oath since no thoughtful juror following the law would presume without substantiating evidence that somebody must have messed up. Hence, according to these authors, the liability system is characterized as one in which doctors are made the victims of a "blame and shame game."[67] The punishment these allegedly blameless doctors receive is likened to the sex offenders obligated to register with the local police.[68]

The analysis made by these physicians is an example of a disproportionate overreaction cited earlier in this article. If the actual medical liability case was the factual equivalent, not of a child darting in front of a driver with no warning, but rather a child struck at a school cross-walk because the driver wasn't paying attention, then clearly we would have a different factual scenario. It is inappropriate to assume that grief-stricken parents could not distinguish between the two factual scenarios or even wish to pursue a no-liability situation. Fur-

62. *Id.* at ix–x, 2.

63. For example, if allegedly there are too many frivolous cases then placing monetary caps on meritorious cases is not a solution connected to the alleged problem.

64. WACHTER & SHOJANIA, *supra* note 6, at 325.

65. *Id.* at 303.

66. *Id.* at 302, 308–09.

67. *Id.* at 312.

68. *Id.* at 309.

ther, it is inappropriate to assume without a shred of substantiating proof that juries cannot and are not making decisions based on the evidence in medical cases.

There is no legal or moral rationale to pursue a no-liability case, but there does exist a legal and moral rationale to pursue a liability case which, in addition to creating appropriate compensation, also creates an opportunity to use that information to discourage a repeat event.

Physician authors Wachter and Shojania cite a study where risk managers at two hospitals allegedly discussed only twelve of eighty-two medical liability claims (fifteen percent) as part of quality assurance meetings.[69] According to these physicians, this "fact" proves that the liability system does not improve patient safety.[70] They propose that a "no-fault" system should be used to compensate all those harmed by the medical system.[71] These physicians maintain that the only downside to their no-fault proposal is that perhaps a few bad apples will go unpunished, but they maintain that the upside will be the removal of suits for tens of thousands of doctors who are being unjustly penalized.[72]

These physician authors candidly concede that physician self-policing is "inept and ineffectual."[73] They note a tendency for doctors to "protect their own, sometimes at the expense of patients," and they explain that this circumstance occurs because physicians are reluctant to sanction their peers and do not like confrontation.[74] These tendencies are neither an excuse nor an explanation for inept or ineffectual self-policing, but rather a product of intrinsic human nature that is central to the issue.

Liability cases are what created the impetus for the Joint Commission on Accreditation of Health Care Organizations ("JCAHO") to mandate effective quality assurance.[75] Hospital liability would exist if a hospital failed to comply

69. *Id.* at 313.

70. *Id.*

71. *Id*. at 344.

72. *Id.*

73. *Id.* at 323.

74. *Id.* at 322–23.

75. *See* James B. Cohoon, Comment, *Piercing the Corporate Hospital Liability*, 17 SAN DIEGO L. REV. 383, 383–84 (1980); *see also* AM. SOC. FOR HEALTHCARE RISK MGMT, RISK MANAGEMENT HANDBOOK FOR HEALTH CARE ORGANIZATIONS (Roberta Carroll ed., 4th ed. 2004). Though labeled a "Handbook," it is an extensive textbook containing forty-eight chapters with more than 1300 pages. The chapters include, among many other things, a review of the liability law and an in depth analysis of how to deal with liability cases. The text adopts a comprehensive approach to evaluate *all* risk exposures and requires an "ongoing commitment" to be "proactive," as well as "reactive." *Id.* at xxxvii. "At the heart of every effective risk management program are systems for identifying . . . [among other things] actual loss-producing events that can lead to future losses." *Id.* at 157. The purpose of such risk identification includes utilizing the opportunity for improvement. *Id.* "A meaningful organization-wide reporting system that identifies and prompts response . . . is the backbone of an effective risk program." *Id.* at 176. However, the text also notes that it is important to "keep in mind that any reporting system relies heavily on the human element to make it successful." *Id.* "The basic ethical principles that are most relevant to clinical [care] . . . [include] beneficence, which creates an obligation to benefit patients." *Id.*

with the mandate to engage in effective quality assurance.[76] As such, a motivated doctor serving on a hospital peer review committee can take the stance that regardless of any reluctance to impose sanctions or any desire to avoid confrontation, that action must be taken to protect patients. The motivation for such action should be related to the fact that it is morally and ethically required for doctors to protect their patients. The fact that failure to so act may create hospital liability provides an additional motivation.

The liability system makes it easier to protect patients and harder for doctors to "protect their own" at patient expense. If any hospital actually does engage in only a superficial review of the liability cases (e.g., 15% of cases instead of 100% of cases) that would itself be negligence on the part of the hospital.[77] Therefore it appears that a solution to the issue would be less confidentiality and less secrecy, not immunity.

IX. DISCLOSURE

The Report maintains that the "threat" of liability discourages disclosure and encourages silence.[78] The Report does not, however, document any substantiation for this statement. The Report does urge mandatory reporting of adverse events associated with serious injuries or death and voluntary reporting of errors that resulted in no harm ("near misses").[79] The Report maintains that errors identified through a mandatory reporting system are part of a public system of accountability and should not be protected from discovery in liability cases, whereas voluntary reporting should be non-discoverable.[80]

Any step to promote reporting is positive, but it is important to note that full disclosure is and always has been part of the physician's ethical obligation. The American College of Surgeons, as part of its Code of Professional Conduct, requires that each physician "fully disclose adverse events and medical errors."[81] The American Medical Association Code of Medical Ethics ("AMA Code of Ethics") requires (regardless of any fear or concern about a legal liability case) disclosure to the patient of "all the facts necessary to ensure understanding of what has occurred."[82]

76. *See* Fiorentino v. Wenger, 19 N.Y.2d 407 (1967); *see also* 41 C.J.S. *Hospitals* § 40 (2006).

77. *See Fiorentino*, 19 N.Y.2d 407; *see also* 41 C.J.S. *Hospitals* § 40

78. INST. OF MED., *supra* note 26, at 43.

79. *Id.* at 86–90.

80. *Id.* at 110; Robert J. Blendon et al., *Views of Practicing Physicians and the Public on Medical Errors*, 347 NEW ENG. J. MED. 1933, 1938 (2002) (table showing that in a National Survey, 86% of physicians believed that hospital error reports should be kept confidential, whereas 62% of the public believed that reports should be made public).

81. AM. COLLEGE OF SURGEONS, STATEMENTS ON PRINCIPLES, CODE OF PROF'L CONDUCT (2004).

82. AM. MED. ASS'N COUNCIL ON ETHICS & JUDICIAL AFFAIRS, CODE OF MED. ETHICS: PATIENT INFORMATION, at E-8.12 (1994).

In addition, the AMA Code of Ethics specifically imposes on all physicians the ethical responsibility to play a central role in identifying, reducing, and preventing health care errors.[83] It is a fundamental ethical obligation for each physician to be open with patients and disclose "all the facts."[84] Since physicians must strive to ensure patient safety, fear and/or concern about a lawsuit should not be an excuse for non-disclosure.[85]

Even if a doctor honestly believes that an unfavorable outcome was not due to error, the doctor must honestly document in the record all relevant facts and also must disclose to the patient all of the facts necessary to ensure an understanding of what has occurred. Failure to do so can invite professional sanction and, from a liability point of view, doctors must be made to understand that nondisclosure erodes credibility and can ruin an otherwise meritorious defense. The underlying medical facts must be part of the record and the health care providers must be open and honest with their patients.[86] On this point, doctors and hospitals have no choice. Errors are there to be found if knowledgeable, motivated professionals look for them.

Anesthesiology adopted the position that documentation of the record is a factor in the provision of quality care, which is part of the anesthesiologist's professional responsibility. A leading spokesman in this specialty stated the old adage, "[I]f you didn't write it down, it didn't happen . . . . If the record hardly exists . . . it is tantamount to an outright confession, in the eyes of the law, to careless practice."[87] To the extent nondisclosure and/or inadequate documentation exists, that only makes it worse for defendants in lawsuits (something their attorneys and insurance companies have been aware of for years).

A recent study revealed that "U.S. and Canadian physicians' error disclosure attitudes and experiences are similar despite different malpractice environments," thereby refuting the notion that the malpractice environment was a significant

83. *Id*.

84. *Id.*

85. *Id.*

86. *Id.*

87. John H. Eichhorn, *Risk Management, Quality Assurance, and Patient Safety*, *in* COMPLICATIONS IN ANESTHESIOLOGY 1, 8 (Nikolaus Gravenstein & Robert R. Kirby eds., 2d ed. 1996). The medical record is important as a tool for effective communication. It facilitates, among other things, quality of care evaluations. The medical record is a data source for assessment activities and a tool to plan and evaluate the patient's treatment. The medical record is the single-most important means by which a provider plans and coordinates the patient's care during an episode of illness. Documentation can be defined as the recording of pertinent facts and observations about an individual's health history. *See* Sandra K. Johnson et al., *Documentation and the Medical Record, in* RISK MANAGEMENT HANDBOOK FOR HEALTH CARE ORGANIZATIONS 265, 265, 267 (4th ed. 2004). The purposes of documentation include, among other things, providing evidence of care and treatment in legal actions, as well as providing data reflecting that the physician or health care provider (was or was not) appropriately planning and evaluating the patient's treatment and meeting the standard of care. The medical record can be the strongest ally in proving that quality care was (or was not) given.

determinant concerning error disclosure.[88] Another study disclosed that when mistakes were perceived by the doctor and those mistakes were less likely to be noticed by the patient, the doctor was more likely not to make the disclosure to the patient.[89]

The issue of full and open disclosure should not be a matter of debate influenced by whether such would or would not produce more lawsuits.[90] The only acid test for a lawsuit should be whether the case has merit and the patient wishes to pursue it. The threat of a lawsuit should promote, not hinder, disclosure of the event. Honesty has consistently been shown to be the best policy to defend and sometimes avoid lawsuits.[91] Independent objective review of the records should reveal if error occurred, whether or not a doctor who might be sued concedes error. As Dr. Leape stated:

> Too often, patients do not receive a full and complete explanation of what happened, and too often they do not receive an apology when errors and system failures occur . . . .
>
> The ethical case for full disclosure is straightforward: The patient has a right to know what happened. Hospitals, physicians, or nurses have no moral or legal rights to with-hold information from patients. Full disclosure is not an option; it is an ethical imperative . . . .
>
> A serious preventable injury causes severe emotional trauma; the first step in healing this emotional wound is to explain what happened and take responsibility for it . . . .
>
> The practical aspects of full disclosure and apology are first, that it works; that is, it really does help patients and caregivers recover; and second, that it is less likely to lead to litigation than the "silent treatment" alternative . . . .[92]

Disclosing medical errors and all that should go with it actually reduces the risk of malpractice suits. This may seem counter-intuitive to physicians, administrators, health care risks managers, attorneys and others.

88. Thomas H. Gallager et al., *U.S. and Canadian Physicians' Attitudes and Experiences Regarding Disclosing Errors to Patients*, 166 ARCHIVES INTERNAL MED. 1605, 1605 (2006).

89. Thomas H. Gallager et al., *Choosing your Words Carefully: How Physicians Would Disclose Harmful Medical Errors to Patients*, 166 ARCHIVES INTERNAL MED. 1585, 1585 (2006).

90. *See generally* Allen Kachalia et al., *Does Full Disclosure of Medical Errors Affect Malpractice Liability?: The Jury is Still Out*, 29 JOINT COMMISSION J. ON QUALITY & SAFETY 503, 503–11 (2003).

91. *See* Steve S. Kraman & Ginny Hamm, *Risk Management: Extreme Honesty May Be the Best Policy*, 131 ARCHIVES INTERNAL MED. 963, 966 (1999) ("We conclude that an honest and forthright risk management policy that puts the patient's interests first may be relatively inexpensive because it allows avoidance of lawsuit preparation, litigation, court judgments, and settlements at trial.").

92. Lucian Leape, *Forward* to JOINT COMMISSION RES., DISCLOSING MEDICAL ERRORS: A GUIDE TO AN EFFECTIVE EXPLANATION AND APOLOGY, at v–vi (2007).

Although health risk managers and attorneys whisper their ambiguous advice in one ear, the American Medical Association unambiguously pours its code of ethical conduct in the other, loud and clear:

> The practice of medicine, and its embodiment in a clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering . . . . The relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups, and to advocate for their patients' welfare . . . . Within the patient-physician relationship, a physician is ethically required to use sound medical judgment, holding the best interests of the patient paramount. As one Vermont physician notes, "Nondisclosure is not an ethical or even legal option for a physician."[93]

X. FRIVOLOUS DEFENSES

In the most recent study of liability cases independent physician reviewers found that one out of six meritorious cases did not receive payment.[94] Were frivolous defenses being wrongfully urged? Were the best expert witnesses unavailable for those plaintiffs? If frivolous defenses were actually raised to the disadvantage of patients, then the injury to those patients may be compounded and the cause for patient safety received a setback.

Limitations on attorneys who represent plaintiffs and on expert witnesses available for plaintiffs, along with capping damages on meritorious and serious cases, makes the system more inaccessible to those who truly have meritorious cases. In addition, it undermines the confidence in the medical profession that motivated physicians and health care providers work so hard to achieve.

The Report has its priorities in order when it urges a "culture of safety." If we break a cycle of nonproductive hostile rhetoric so that the legal and medical professions could at least agree that frivolous claims and frivolous defenses exist and are to be discouraged, this would be a positive step towards meeting the shared goal of patient safety. While frivolous cases are wasteful, frivolous defenses are even worse because they encourage substandard care that can harm people.

93. *Id.* at 75 (citation omitted).

94. David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024, 2024–33 (2006) (defining a frivolous claim as a claim that has "no rational argument based on the evidence or law in support of the claim . . . . A frivolous defense would presumably have the same definition") (citing BLACK'S LAW DICTIONARY (6th ed. 1990)).

XI. CONCLUSION

Since medical errors have been producing for many years an immense amount of patient injury, suffering, and death, then why is this "problem" surrounded by "silence" with the public "disconnected" from the true magnitude of the issue? If the public erroneously believes "they are being protected," and if in 1999, the Report urged action in the face of a "cycle of inaction," what has the medical profession done to alert the public about an "epidemic" threat? What has the medical profession done to produce the kind of safety anesthesiologists have demonstrated can work? If the medical specialty of anesthesiology found motivated leaders and grass roots members who responded by producing safer results, it seems that other high risk specialties, motivated at least in part by a wish to reduce liability risk, can move closer to the goal of patient safety.

One of the goals of physicians is to engage in effective peer review activities to avoid oppressive regulation and to allow physicians to maintain control over the standards of their profession.[95] But if the public believes that their attention has been misdirected by an erroneous and irrational preoccupation with punishment and retribution, an issue that never existed, while an "epidemic" of harm to patients did exist, a likely outcry may be a call for the very kind of over regulation that good doctors fear.[96]

The Report urges the creation of a center for patient safety and emphasizes that no single action or single group can offer a "complete fix to the problem."[97] Why not include the data from filed and closed medical malpractice cases for analysis at the patient safety center? Why not include plaintiffs' attorneys in a cooperative joint effort as part of that analysis? The challenge to the plaintiffs' attorney when representing a client is to digest and understand the technical medical information and then to overcome a health care provider's efforts to make a true error appear to be unavoidably due to the underlying disease. Since plaintiffs' attorneys have demonstrated skills necessary to successfully meet the challenge of identifying true medical error, they would represent a potential asset in promoting a culture of safety if they are included in the process.

The Report maintains that while it is part of human nature to err, it is also part of human nature to create solutions and that intrinsic forces in the healthcare profession motivated by ethics can improve safety.[98] Those ethically motivated intrinsic forces in the health care profession have remained too silent on the

95. Ronald L. Goldman, *The Reliability of Peer Assessments of Quality of Care*, 267 JAMA 958, 958–60 (1992).

96. David Blumenthal, *Making Medical Errors Into 'Medical Treasures'*, 272 JAMA 1867, 1867–68 & n. 23 ("Concerning medical error and its prevention, the profession has, with rare exceptions, adopted an ostrichlike attitude . . . . "). Hence twelve years later the public remains disconnected from an awareness of a medical error "epidemic."

97. INST. OF MED., *supra* note 26, at 5–6.

98. *Id.* at 6–15.

benefit of liability cases. When good doctors are diligent, focused, and use rational therapeutic methods, good outcomes for patients can be achieved. The legal profession does not tell doctors how to do this. Attorneys try to identify for their clients those instances when their client did not get that kind of care. If doctors would reach out to ethically motivated intrinsic forces in the legal profession they will find that even more can be accomplished to promote common goals.