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# Medical Malpractice — A Christian Ethical Perspective

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## Introduction

The profession of medicine in the U.S.A. has undergone dramatic changes since the end of World War II. The revolution in drug therapy, diagnostic and procedural technology, the broadened access to care, and medical specialization have changed the way medicine is practiced. These changes, coupled with major social-political changes characterized by the pendulum swing towards individual autonomy and away from community, have produced major perceptual changes towards the practice of medicine.

The law, too, has undergone revolutionary changes in the past several decades. Unlike the last century when the law protected business interests for the welfare of a developing country and an industrial revolution, this century has seen growth in the recognition, protection, and enforcement of individual rights.<sup>1</sup>

Some of these changed perceptions include the idea of medical care as a basic human right for everyone (which has led to the Federal government's involvement in providing health care),<sup>2</sup> the expectation that medicine can always cure or produce a near perfect result, and an emerging understanding

of the responsibility that individuals have for their own health care.<sup>3</sup> These changes have profoundly affected the basic social relationship found in medicine — that between the patient and his or her doctor. One of the unfortunate resultant consequences of these changes as they have impacted upon the doctor-patient relationship is the rising incidence of medical malpractice litigation.

It will be my intention in this essay to introduce a Christian ethical perspective to the dilemmas inherent in malpractice. By looking at medical malpractice from a Christian ethical perspective, it becomes apparent that something basic is wrong with a society that so easily, and more frequently, can blame its “helping” professions for errors, and receive restitution in unlike kind (money rather than health or life). Either the “helping” medical profession falls short of its professed ethics to heal the sick, or society falls short of its understanding of what healing in modern times is all about. Or as this paper will suggest, both groups fall short of the gospel imperative of charity that becomes the way that the Christian communities display the vision of the Kingdom of God to a modern, pluralistic, and secular society. An underlying thesis is that medical malpractice has resulted from the secularization of the vocation of medicine. In the process of secularization, the basic social unit of the doctor-patient relationship, the spiritual union of God, doctor, and patient has been severely disrupted. The doctor as well as the patient and society have all contributed to this disruption by each taking their own advantage of the changes. A possible solution to medical malpractice for the Christian patients and doctors can be found in a return to gospel imperatives of trust in God, and obedience to God’s commandments.

To develop this thesis, I will first look at medical malpractice from a secular point of view, approaching the problem from the viewpoint of the doctor and medical science, and then from that of the patient and society. I will then discuss the necessity for consideration of a spiritual and a theological perspective to view the problem and describe the actual Christian ethical approach. I will outline some specific solutions that the Christian community might offer, and conclude by contrasting these solutions to the various secular solutions in vogue today. The essay shall conclude by emphasizing that radical nature of change that the gospel message spells for contemporary American society.

### **Medical Scientific Point of View**

In discussing the problem of medical malpractice from a medical or scientific point of view, it is worth emphasizing that medicine is not an absolute science, but an applied science, and that there are inherent limitations to medicine. For this reason medicine is called an art and a practice, as well as a profession. It is to these inherent limitations that I will first turn.

Any treatment option or any illness has inherent in it a set of probabilities

for success or failure. The statistics may be such that not everyone will survive a particular illness or even a particular procedure. Therefore medicine talks about the mortality and morbidity of various diseases. While this is elementary, yet in any illness or a procedure where the mortality or morbidity might be low, as patients we all assume that we will emerge in the majority-with a favorable outcome. Yet each individual patient will finally emerge with only one outcome and that for him or her will be absolute-representing 100%. For the individual patient, there is no way medicine can predict where he or she will fall in the statistics. But for a large number of patients, medicine can predict a mortality rate and a morbidity rate. Psychologically, if we all as patients expect the successful outcome, and trust implicitly in our doctor to achieve this, someone is going to be disappointed. This brings us first to the critical questions of what is medical malpractice and what is error in medicine.

Medical malpractice is under tort law, which governs injuries to persons where crime is not at issue. The operative principle in tort law is the concept of negligence, which is failure to take proper care. The plaintiff attorney acting for the patient in a medical malpractice suit will try to prove that there existed a duty of the defendant physician to the patient that was "breached" by a conduct defined as below the "standard of care". As a result of this breach of duty, the defendant physician was both the direct cause and the immediate cause of the harm that was suffered by the patient. These causes need not be proven beyond all reasonable doubt, but only insofar as the preponderance of the evidence supports them.<sup>4</sup> So the purpose of medical malpractice becomes to demonstrate that the harm or the bad outcome that the patient experiences is culpable to the physician.

There is certainly physician error. As medicine is an art as well as an applied science, there are going to be differences in the practice of the art, and certain physicians (if not all) will fall below the legally defined concept of standard of care. They may do this often or seldom in their careers, but as medicine is an art that has to be learned partly by experience, by erring they will constantly be learning and gaining expertise in the complexity of their profession.

Everyone, of course, makes mistakes, and no one enjoys the consequences. Most people — doctors and patients alike — harbor deep within themselves the expectation that the physician will be perfect. No one seems prepared to accept the simple fact of life that physicians, like anyone else, will make mistakes.<sup>5</sup>

Physicians are human and share in human weaknesses such as fatigue, varying moods and motivations, and the difficulty of balancing professional obligations with other areas of one's life. There are also circumstantial sources of error that can affect physician performance. The Apostle Peter, like the physician, pledges absolute loyalty: "Even though they all fall away, I will not" (Mark 14:29 and Matthew 26:33). Peter would fight with the sword for his master, but he never anticipated the less dramatic circumstances that occurred in the courtyard when a maid

accuses him publicly of being a disciple of Jesus. Occasionally simple circumstances, such as the time of day, creep in and affect the dedication of the physician.

Not all error in medicine, however, is purely physician generated. Medicine today is a team effort involving health care teams and hospitals, and therein also lies the potential for sources of error or circumstantial error that can occur in teamwork, such as misunderstood communications and mistaken expectations.

Science itself, even as an exact or pure discipline, is not free of error. There are always new principles and relationships to be discovered. For example, in the applied science of medicine, a "state of the art" treatment might be discarded over time when it becomes apparent that it is harmful to patients rather than helpful.

In science, it is commonly thought that error can only originate from ignorance (the limitations of the present state of knowledge) or from human ineptitude, the negligence of the scientist.<sup>6</sup> But Gorovitz and MacIntyre in their essay "Toward a Theory of Medical Fallibility," argue a third source of error that deals with the particular. A particular is the object of study to the scientist and includes such examples as salt marshes, hurricanes, animals and people. The scientist looks at particulars and their qualities and from these observations tries to deduce generalities or laws. However, once these generalities or laws are deduced from the study of a grouping of particulars, they are not absolutely accurate in predicting any one particular's behavior. They State:

Many particulars . . . cannot be understood solely as the sum-total of the physical and chemical mechanisms that operate in them. What effects such mechanisms have are affected by the unique history of that specific particular with all its contingent circumstances . . . . One cannot expect therefore in the case of such particulars to be able to move from theoretical knowledge of the relevant laws to a prediction of the particular's behavior.<sup>7</sup>

Particulars are acted upon by differing circumstances in their environmental contexts. Therefore generalizations, although "they may be the best possible instrument of prediction about particulars, . . . lead on occasion to unavoidable predictive failure."<sup>8</sup> They call this source of error the "necessary fallibility in respect to particulars."<sup>9</sup> This source of error has consequences for physician liability for error and to the doctor-patient relationship. They state:

Patients and the public have to learn to recognize, accept, and respond reasonably to the necessary fallibility of the individual physician. The physician-patient relationship has to be redefined as one in which mistakes necessarily will be made, sometimes culpably, sometimes because of the state of development of the particular medical sciences at issue, and sometimes, inevitably, because of the inherent limitations in the predictive powers of an enterprise that is concerned essentially with the flourishing of particulars, of individuals. The patient and the public therefore must also understand that medical science is committed to the patient's prospering and flourishing, and that the treatment of the patient is itself a part of that science and not a mere application of it. The patient thus must learn to

see himself as available for clinical study by methods which aim at his good, but which may do him harm.<sup>10</sup>

In the applied science of medicine, errors therefore can originate from the limitations of scientific medical knowledge (the cutting edge), from the ineptitude of the practicing physician, and from the fallibility of medical principles generalized to individual patients who have their own particular contexts in relation to their disease.

Human error and, therefore physician error, is always potentially present in every healing relationship. With general high expectations present in the minds of the physician and the patient, error from whichever source described above, whether culpable or not to the doctor, might result in the patient initiating a medical malpractice suit. A basic underlying ethical principle for all of us, yet perhaps keenly reinforced in doctors early in medical school is "to do no harm". Now a patient accuses the physician of not only failing to help, but actually having done harm. The consequences of this action to the physician's sense of identity as a "helper" can be devastating, and these consequences have been well described in the literature. Sara Charles, M.D., describes a "malpractice stress syndrome — an adjustment disorder with litigation as the psychosocial stressor."<sup>11</sup> J. Patrick Lavey, M.D. finds that the physician's emotional reaction to litigation is as intense as a reaction to the death of a family member, and describes a psychodynamic model based on Kubler-Ross's five basic reactions to death or loss.<sup>12</sup> Denial, guilt feelings, anger, pre-occupied thinking, and depression all can affect every area of the physician's life, and in that lurks a danger to other patients he or she cares for. "The psychological upheaval precipitated by such anger may overwhelm the physician, affect medical judgement in the management of other patients, and lead to the practice of defensive medicine."<sup>13</sup> A physician can, in fact, become an impaired physician.<sup>14</sup>

### **The Problem From a Patient's and Societal Point of View**

Moving from the anguish that physicians experience when facing a medical malpractice suit, let us now turn to what the patient experiences. There has been an erosion of trust in the professions generally in America, yet individuals continue to trust their own personal professional.<sup>15</sup> The patient comes to the doctor for care with certain preconceived ideas. The patient trusts in his or her doctor to deliver the quality of care called for. The patient also comes to the physician with the expectation of being treated respectfully and courteously. If during the medical care rendered, there results a "bad outcome" of either death or disability, the patient and family has to cope suddenly with this loss or death. Assuming the same reactions described by Dr. Kubler-Ross, the patient and/or family moves from denial to anger,<sup>16</sup> which usually is directed away from the patient, often to the doctor or God. The becomes especially significant if the patient feels his or her trust has been misplaced. And it is misplaced trust, or at least ambivalent

trust, to distrust medicine in general, yet to try and retain trust in one's personal physician, hospital, or nurse.

And since only 2 or 3% of patients injured in hospitals actually sue, something other than the mere fact of injury must be at work. For it's the mistrust that builds up between the patient and physician — perhaps forged by the doctor's indifference or arrogance, perhaps by poor communication . . . We sue because we're angry. Because we no longer trust.<sup>17</sup>

Certain ambiguities in the modern doctor-patient relationship contribute to mistrust and patient dissatisfaction.<sup>18</sup> Lisa Newton describes the ambivalence inherent in the role-differentiation of the doctor-patient relationship. She contrasts the paternalistic role model of the patient's childlike trust in a competent and loving father (doctor) to the relationship of one of contract with both doctor and patient assuming the roles of contracting adults. She points out that most of our other relationships in society have already become based on relationships of contracts, with limited, impersonal obligations on both sides.<sup>19</sup> The problem with ambiguity in role expectations can be illustrated by the example of an ill patient who comes to the physician first for "care" and later experiencing a change in role expectations, may actually expect a "cure".

The patient may initially take the agreement as the granting of his real original request — as an agreement on the physician's part to care for the patient as a father for a child, to do his wise and loving best for the patient's benefit. But the ambivalence of his role is such that, as the transaction progresses, the patient may very well begin to take that agreement as a contractual agreement, not just to care for him, but to heal him, to make him well. And *that* contract is often very hard to satisfy to the extent of the patient's need.<sup>20</sup>

Malpractice might arise in such an ambivalent relationship from failure to perform from either of the role-expectations: failure to lovingly "care" for the patient or failure to contractually "cure" the patient.

Role expectations leads us to a third area of significance as we examine medical malpractice from the patient and society perspective — that of human rights. As already alluded to in the introduction, health care has come to be regarded as a basic human right in America. But there are also other perceived "rights". There is certainly the recognition of legal rights of patients, "including consent to treatment, privacy, confidentiality, and the right to refuse life-sustaining treatment."<sup>21</sup> And, as we alluded to before, there is certainly the high expectation that we as patients will have a good medical outcome. Or has this expectation become a "right"? And do we have a "right" to restitution if something goes wrong? "Our society in the 1980's believes that most wrongs must have a reason, that someone is responsible, and that the wrong must be righted. This results in unattainable expectations in people who treat many bad outcomes as negligent acts."<sup>22</sup> A question becomes apparent in all this talk of "rights" as to whether "rights" are not just high expectations from a very subjective point of view. One person's "rights" can easily intrude upon another person's rights. Human rights as they continue to be advanced can become

a set of subjective high expectations, and are therefore relative to context —time, persons, and place. More will be said concerning this relativization of human rights when the theological perspective is discussed.

Arising from the above discussion, a fourth problematic area concerns compensation. Patients with bad medical outcomes from whatever causes resulting in disability are likely to need financial support from society. And there exists no mechanism for support other than through legal restitution. Patients can sue doctors, and ignoring the complexity and multifactorial nature of illnesses, pile all the blame on physicians' error because they have the malpractice insurance extensive enough to help with compensation. Or patients may even be able to skirt the issue of causation (that the physicians' breach of duty actually caused the harm suffered) entirely. "The problem is that in some cases, some courts, some judges, and some juries have departed from the conceptual foundations of the negligence system and allowed recovery to patients who have suffered undesirable health outcomes not the result of the physician's negligence."<sup>23</sup> Or patients can sue a multitude of people and institutions attempting to spread the blame and broaden the base of reward.

A fifth problematic area from the patient and societal perspective is the wide public recognition of abuses in medicine. While this is a very true and complex problem, there is not space enough here to discuss this topic. The reader is referred to *Medicine On Trial*, a book published in 1988 by The People's Medical Society. It succinctly summarizes the material in its sub-title "Medicine On Trial — The Appalling Story of Ineptitude, Malfeasance, Neglect, and Arrogance."<sup>24</sup> Medicine as a profession does have much work to do to recreate public trust. The medical profession acknowledges abuses and poor physician performance and the malpractice that results. "We must accept that malpractice is occurring and is common. The profession must begin to make inroads to correct this problem, because the rewards will be great for both patients and physicians."<sup>25</sup>

The final area of medical malpractice that we can view from a societal perspective concerns the wider ramifications of medical malpractice to society. The malpractice crisis is causing "attitudinal and positional changes (that) will have far-reaching effects on health care in this country."<sup>26</sup> There is the erosion of trust between the patient and doctor. Malpractice has brought to the physician-patient relationship bitterness, tension, and suspicion and antagonism.<sup>27</sup> Medical services are being cut; there is a refusal on the part of some doctors to treat high risk patients or to enter into treatment in risky situations. This can become an excuse for not seeing poor people or people with AIDS etc. — for not acting responsive to society's needs. Costs are eventually passed on to patients. In 1984 approximately 15% of the total expenditures on physician services represented in cost of professional liability.<sup>28</sup> Interest and enrollment in medical schools are down. The brightest students may not be considering medicine today as much as business and law. The long term consequences of these trends for our health care becomes of concern to all of us in society. Society and our



legislation faces the dilemma, according to Lisa Newton, of balancing the public health and safety on one hand with our sense of justice on the other hand. Justice holds that doctors as a group (an elite, wealthy, privileged and private group of citizens) not be set above the law and allowed to injure others carelessly. She states the

dilemma arises from a conflict between two ethical principles . . . 'utility' . . . (which) judges actions to be right or wrong according to their tendency to produce the greatest good for the greatest number . . . (and) justice or retribution . . . (which) requires that any person who has injured another shall suffer for that injury, and refers the matter to the judicial process to determine the extent of injury and the appropriate retaliatory suffering.<sup>29</sup>

The consequences of malpractice go far beyond the individual doctor and patient and have effects on all of us at various levels of societal organization.

### **The Reasons for a Spiritual and a Theologically Based Perspective**

Basically what has already been said has just been introductory to the larger purpose of this paper — to introduce a Christian ethical perspective. In discussing the complexities of the issues in medical malpractice from the viewpoints of both the patient and society on the one hand, and the doctor and medical science on the other hand, I have covered much of the contemporary medical, legal, and ethical literature. I have found this literature predominantly humanistic, secular and utilitarian in tone, and devoid of any spiritual dimension. Yet it seems essential that a spiritual perspective be brought to bear on the ethical dilemmas inherent in malpractice. For how we act towards one another when our very life and health are at stake must take on a spiritual dimension. Except for our relationship to the living God, and the intimate social relationships in our families, no other social relationship is as deep or as intense to our body, mind and soul as that of a person in need of healing to the person who professes to care or to heal. This section of the essay will look at the reasons establishing this need for a spiritual or theological perspective.

First, we recognize today the importance of our spiritual health to the normal functioning of our minds and our bodies. Holistic health compasses mental, physical and spiritual dimensions. Although we do not always understand, we have always been aware of the interactions between mind and body (psychosomatic illnesses) and the existence of spiritual healing (miracles). Dr. Paul Tournier might be credited with much of the pioneering work in helping the medical profession to understand the importance of our spiritual life to our health. He states that

The body and the mind are only the means of expression of the spirit, which coordinates and directs them both at once.<sup>30</sup>

In medical malpractice when errors occur resulting in harm, the patient and doctor both have intense spiritual needs and questions that cannot be addressed just by a fault-finding repetition of the details of the medical management. There also exists the paradox of errors or misjudgement

having occurred, in a societal atmosphere of denial that mistakes can be made. The spiritual impulse for sharing personal grief, for confessing uncertainties and errors, and for receiving and giving forgiveness cries out in a societal environment that frowns upon such interaction. The legal community would find such communication incriminating. The rules inherent in the doctor patient relationship do not call for the doctor to further add his or her burden of remorse onto a family that is struggling to carry its own questionings and sufferings.<sup>31</sup>

Second, there is also the whole question of fortuitous circumstances that cry out for a theological answer. Scott Peck talks about the miracle of serendipity as circumstances that are life enhancing or growth producing, but also touches on their counterpart — freak accidents.

It is possible that occurrences statistically improbable . . . are as likely to be harmful as they are beneficial.<sup>32</sup>

It is commonly whispered in patient care that when some things seem to go wrong or against the recovery of the patient, everything seems to go wrong. We feel the temptation to absolve ourselves of responsibility by shifting blame — to other people, to fate, to the demonic, or to God. In the beginning of the Book of Job, we hear the interchange between God and Satan:

And the Lord said unto Satan, Behold, he is in thine hands; but save his life. Job 2:6

Jesus speaks to Peter in Luke 22:31-32:

Simon, Simon, behold, Satan demanded to have you that he might sift you like wheat, but I have prayed for you that your faith may not fail.

In medical malpractice, after the horrible circumstances that lead to harm are carefully restated for all to understand the how, there still remains the nagging question of why? Only a theological answer can be given to assert "Sin is against God and the will of God. It is, accordingly, not from God."<sup>33</sup> "Human sin occurs through external temptation, but not through external coercion."<sup>34</sup> "Both Christian witness and human experience bring us to speak of human responsibility for the human predicament."<sup>35</sup> Stanley Hauerwas in *The Peaceable Kingdom* uses the concepts of "narrative" and "agency" to counter the deception that our autonomy relieves us of our responsibility for decisions that were made in the past which were less than fully ours.<sup>36</sup> "Agency encapsulates our sense that we are responsible for what we are."<sup>37</sup> Narrative is our story that fits into the community story of movement toward an eschatological Peaceable Kingdom of God. He states:

To be an agent means I am able to locate my action within an ongoing history and within a community . . . . Even what has happened to me . . . becomes mine to the extent that I am able to make it part of my story. I am not an agent because I can "cause" certain things to happen, whether through the results of my decision or not, can be made mine through my power of attention . . . because I am able to "fit" it into my ongoing story.<sup>38</sup>

Theology gives us a strong emphasis in human responsibility for human suffering in a world constantly trying to shift blame in vain attempts to persevere self-righteousness and pride.

A third area for which a theological perspective is needed in medical malpractice deals with an answer to guilt. Although misjudgements and errors not willed for may not be sins, "they engender similar feelings of guilt."<sup>39</sup> in the medical setting for physicians and for patients. It is always so apparent in retrospect how many different actions, some ever so trivial, may have averted the bad outcome. Guilt may represent neurotic behavior where we accept too much responsibility for past actions.<sup>40</sup> But as stated above under agency, we cannot ever escape the fact that the untoward event did actually happen and may have been averted. This will always be part of our narrative.

Theology helps us to understand our narrative in relation to God's narrative in the story of Israel and in the story of Jesus Christ. Paul Tournier recognizes the importance of the spiritual dimension in the basic functions of psychotherapy and has this to say about "catharsis":

After the patient has spoken of all those things of which he has been the victim, he always turns to those things for which he feels he is to blame. The problem of sin is raised, and at the same time that of grace, which is the only answer. We are no longer in the technical sphere.<sup>41</sup>

When we are trying to assuage guilt, only a spiritual belief can lead us toward God's grace.

A fourth reason a theological perspective becomes important deals with the treatment of human rights begun earlier in the paper. Gustaf Aulen, writing after World War II, teaches us that the mind and will of God (God's love) is revealed to us both in the Law of God and in the Gospel. The Law of God is a dynamic,<sup>42</sup> a force, working everywhere in human life.

The will of God, thus revealed in His Law, is nothing but the will of His Love. The Law no less than the Gospel is an expression of His Love. God's will is that men shall live 'in love' to each other, and not in selfishness . . . . This universal claim is then the fundamental principle of the justice that God erects as regards the human fellowship.<sup>43</sup>

But as we discussed earlier, justice becomes relativized through the secular, humanistic notion of "human rights", predicated in a natural law of universal, human, moral norms. Human rights, however, cannot be a fixed and unshakable foundation of justice because they will always be interpreted in different ways in differing situations and times. And as I pointed out earlier, human rights are always interpreted subjectively, and may actually only represent a subjective set of high expectations. As rights are relative, one person's rights may conflict with another's. In medical malpractice, as the first sections of this paper explored, there exist many areas of conflictual expectations surrounding the harm incurred in the process of medical treatment. The theological perspective however introduces the Law of God to all sides — the claim that people "shall live

'in love' to each other, and not in selfishness."<sup>44</sup> Bishop Aulen concludes:

if the Law of justice is quite simply to be identified with certain, once-for-all-given human rights, that would mean that the principles of justice should be submitted to a continuing process of relativization. The Law as a claim, on the other side, . . . is primary and superior in relation to all human rights. Only such a claim can be elevated over all relativizing tendencies, and owing to that serve as the fundamental principle of justice.<sup>45</sup>

Theology introduces us to the word of God as revealed to us in both His Law and His Gospel, which is God's claim that charity serves as the guiding principle of justice.

### **The Problem from a Theological Point of View**

The reasons why a spiritual or theological perspective is needed have been elucidated. Now let us look at what an evangelical Christian perspective has to offer the problem of medical malpractice for the Christian patient and physician.

First the gospel declares the bad news — "all have sinned and fall short of the glory of God." (Romans 3:23). We live in God's world, a world tainted by human sin and rebellion. Human sin is a broken relationship with God and with our neighbors. It is a failure to love, a breaking of the two great commandments — love of God, and love of neighbor. Sin is failure to trust in God. And human sin has consequences that multiply our suffering. "We are born into a world that is already old with suffering and sin. As Exodus 20 says, the 'sins of the parents are visited unto the third and fourth generations.'"<sup>46</sup>

Yet the doctor responds: "True we all sin, but where is the sin in having made a judgement error or a human mistake? Did you not just dismiss the concept of sin when discussing guilt, by quoting 'mistakes are not usually sins?'"<sup>47</sup> Where is the full consent of the will to do harm in the management of patients?" The answer to the Christian physician is that sin, our selfishness, permeates our nature to its very heart, affecting our actions and our desires and that it permeates our professional community. We inherit the consequences of our colleagues' actions as well as add the burden of our own sins. American doctors have taken full advantage of the strides in medical science and technology, reaping rewards for all the marvelous advances.<sup>48</sup> They have justified their greed with the excuse of long hard years in training. They have reveled in positions of special status in society. Doctors have distanced themselves from their patients by a subtle kind of arrogance that includes their often superior education, their supposed time constraints with any one patient, and their seemingly "puffed up" importance to society. Only the doctor can rush in and deliver the baby at the last few pushes for a woman who has long labored. Only the doctor can quietly leave the dying to their family and go to his comfortable home when the magic technology and medicines have failed. Medicine has become secularized, and the doctor's actions conform more to the dominant secular

values in American society than to a calling from God — a “vocation.” The doctor-patient relationship, formerly close, mutually supportive, directed by a trust and hope in God, has become distanced by an aloofness on the part of the doctor and burdened by higher costs. The Christian doctor need not have to look too long at Jesus to see the contrast, or to be admonished by His words: “But not so with you; rather let the greatest among you become as the youngest, and the leader as one who serves. For which is greater, one who sits at table, or one who serves? Is it not one who sits at table? But I am among you as one who serves.” (Luke 22:26-27) For the Christian physician,

The Christian perspective precludes some of the excessive expressions of self-pity we see today on the part of physicians — the complaints about income, work hours, delayed gratification or the justification for recreation at the expense of commitment to patient needs. It precludes also the attitude of some physicians who feel that having worked so hard and paid so much for a medical education, they are entitled to “get it back” financially, or in prestige, privileges, and prerogatives.<sup>49</sup>

And yet the patient responds, “True we all sin, but look at the wrongs that have happened to me at the willfulness and neglect of the doctors. I am only a victim of their lack of care.” And the answer to the Christian patient is the same as to the doctor. Our sin, our selfishness, permeates our nature to its very heart, affecting our actions and our desires. The patient gives away responsibility for his or her health, blindly trusting in the miracles of modern medicine to come through at the critical time.

Modern man seems to lack responsibility for himself or his actions. This is demonstrated by the chronic smoker who develops lung cancer after forty years of smoking and attempts to receive compensation for his injury from the tobacco industry.<sup>50</sup>

The patient picks and chooses from among the ambiguous roles inherent in the modern doctor-patient relationship, first choosing loving “care” regardless of outcome, then restorative “cure,” and becomes indignant when expectations are not always met in either role. And greed, too, is not foreign to the average American. “Another reason for the litigation explosion relates to the gambling nature of many Americans, ie, the lottery mentality.”<sup>51</sup> And the patient easily falls victim to our legal climate which, in the banner of defense of individual rights, encourages such a “victim” to seek retributive justice through the courts. The Christian patient need not have to look too long at the cross to see the folly in our secular world or to be admonished, if not frightened, by Jesus’s words in the Lord’s Prayer, “Forgive us our trespasses as we forgive those who trespass against us.”

The common denominator for both the doctor and the patient becomes, in the final analysis, that neither trust in God. Both misplace their trust to false gods, trusting instead in science, in other human beings, and in our materialistic culture. And to trust is to give up control to that which we trust in. And as science, fellow human beings and materialism are fallible, so our

faith in them will be repeatedly disappointed. A second common denominator is that both take full advantage of the changes in the system that our secular and technological society has brought to the vocation of medicine. All fall short and are in need of God for spiritual grace and salvation.

To this broken human condition, one of selfishness, lack of trust in God, and lack of love, comes the good news. Paul's next verse says "they are justified by His grace as a gift, through the redemption which is in Christ Jesus, whom God put forward as an expiation by his blood, to be received by faith." (Romans 3:24-25). The evangelical gospel proclaims we are redeemed, reconciled with God by our faith, our belief in Jesus Christ as our Savior. God's word, (His Love), is revealed to us in both His Gospel and His Law. Jesus fulfills the Law; He does not abolish it. In the example of His life, and in His teaching, He helps us to discern the fullness of God's Law. He proclaims the Kingdom of God and calls us to its standards. He calls us to repent, to turn around. (Mark 1:15) We are personally reconciled to God by our faith, *and* we are called to imitate the way of God's Love as it has been revealed to us by both His Law and the life, cross and death of His Son, Jesus Christ.

It is in how we mold our lives, our narratives, on these convictions that determine our character and our virtue. It is this claim from God on all believers that brings forth our ethical response, personally and in community, to manifest the Kingdom of God to a secular, pluralistic, and broken world. This claim becomes our vocation, our calling. The Christian physician and patient alike both follow the same calling, that is to trust in God, and to love God and neighbor.

Edmond D. Pellegrino, M.D. uses this same claim which he labels "charity based justice"<sup>52</sup> as the principle of discernment for us in confronting medical ethical dilemmas. He argues "that the concept of love and justice are inconsistent with the ethics of the marketplace, that all society is diminished when health care becomes a commodity and altruism is submerged by self-interest."<sup>53</sup> Christian physicians are to strive, even though they do in fact fall short, for a perfection of "charity based justice" in their practice of medicine.

### **The Solution to Medical Malpractice from a Christian Ethical Perspective**

The above principles of a "charity based justice" that is the claim of God to all Christians can be directed then to specific human relationships and interactions. Bringing these principles to the doctor-patient-human relationship can do much to mitigate the anguish of medical malpractice. First this section of the paper will offer some thoughts in the application of these claims in general, and then specific recommendations to both the patient and doctor will be made.

The doctor-patient relationship needs to be redefined spiritually with the acknowledgement of the presence of God, to become a tirad relationship.

This would be similar to the inclusion of God into the relationship of Christian marriage. This redefined relationship would not require that both doctor and patient necessarily be Christian. A Christian patient can look at a non-Christian doctor as a tool of God for his or her own welfare, "Thus says the Lord to his anointed, to Cyrus" (Isaiah 45:1). A Christian physician can look at a non-Christian patient in his care as being there for a reason, perhaps to be witnessed to by his care. Both the Christian doctor and the Christian patient can see in the other person the presence of Christ.<sup>54</sup>

Second, the Christian patient and doctor both have to put their trust in God, not solely in each other. They pray and trust in God that His will might be done through the other person as a tool. There has to be a recognition of sin and evil in the world and a recognition that illness and biological death are consequences of sin and inevitable for us all in this world.

Third, the word of God in both Law and Gospel, helps us to discern the paradoxical secret of spiritual life and death. Life is relationship with God and our fellow man and woman; death is the opposite. In the secular world we focus always on life in biological terms, and make biological life the higher value. "The problem . . . comes from the misplaced idolatry of the modern age: Life is not only sacred; life is the ultimate. Death is not part of the human condition; death is a failure."<sup>55</sup>

Fourth, the claims of the word of God, to live in love and not in selfishness, can create the conditions for human fellowship. This makes possible the potential for the patient and doctor together to suffer and support each other in the midst and aftermath of a crisis. This fellowship is almost absent now, for various reasons enumerated above. Both doctor and patient shy away from each other when expectations are shattered.

For most important, is the imperative to love one another, the virtue of charity. It is not the requirement for salvation, as that is by faith alone (the gospel), but it is the ethical imperative that follows the indicative of what God has first done for us. God first loved us, created us, and redeemed us through His Son. Because of what God has done for us, we are reconciled to Him, and we have become His children. We are expected to live like His children, manifesting His Peaceable Kingdom to the secular world.

Before turning to the specific solutions for both patient and doctor, two further comments are in order. First from a Christian ethical perspective, it may not really matter where the source of error originated. As the reader is now more aware, it becomes very difficult to try to separate out human error in care that may be culpable to the doctor, from the natural course of disease processes or other sources of error. There is risk in all of life, whether sitting at home, driving in an automobile, or trusting our bodies to a surgeon. As Christians, we trust in God and believe that we are, after all, in His hands. What does matter is what we can hope and pray for in the future. Yet, this does not imply that whatever happens to us in life is all right with God. God's claim of acting in love and not in selfishness requires of us a

devoted responsibility.

Second, the following specific remarks will not discount those things that would be routinely expected and done by any rational person. On the patient's part, they would include taking some initiative and responsibility for one's own health. On the doctor's part, they would include a sincere attempt to stay knowledgeable and well trained in one's profession. And on everyone's part an open and honest discussion and consent to treatment options with understanding of risks. but ultimately the theological perspectives described above entails more for the Christian than what any rational man might do.

For the patient, if there were circumstances that would suggest medical malpractice, the theological perspective described herein would call for him or her *not* to sue the doctor or the hospital. "Christian justice does not focus on strict interpretations of what is owed in accordance with some calculus of claims and counter-claims."<sup>56</sup> Either through need, or for the enhancement of social justice, the patient could appeal to society or government for a mechanism to help fund injured patients that would not be based on an adversarial relationship between people. The patient can appeal to the doctor or the hospital for help. Some restitution in terms of reduced or remitted charges, reoperations, or even monetary reparation through the insurance industry may well be made available. This might be especially possible if the parties involved feel that there may be some question of improperly rendered care. Honesty and trust become paramount among all parties so that the relationship does not become antagonistic. The patient can, of course, also appeal to the believing Christian community for whatever means of help might become available.

Forgiveness on the part of the patient to the offending individuals becomes a mark of a Christian. Hard as it may be when our human emotions are bitter with anger and disappointment, we need to remember again Christ crucified and His words of forgiveness on that cross.

The patient needs to put his trust in God. Through prayer, the patient seeks God's direction, as in all suffering and life. We do not know the larger meaning, before Jesus cures a man blind from his birth, a very informative discussion ensues with his disciples, pregnant with possibilities for us. "And his disciples asked him, 'Rabbi, who sinned, this man or his parents, that he was born blind?' Jesus answered, 'It was not that this man sinned, or his parents, but that the works of God might be made manifest in him.'" (John 9:2-3). During this or during any time of change, we have to remain aware of divine possibilities. God does act in history. God does act in our own narratives.

The patient needs also to trust in his or her own self-informed good judgement and in his or her doctor as a resource, a tool of God, even a gift from God — part of our daily bread. Stanley Hauerwas summarizes this with a discussion of "forgiven people":

To be a "forgiven people" makes us lose control. To be forgiven means that I must



face the fact that my life actually lies in the hands of others. I must learn to trust them as I have learned to trust God . . . we must be a people who have learned not to fear surprises as a necessary means to sustain our lives."<sup>57</sup>

The patient also would *not* sue, according to this theological perspective offered, because of the further evil consequences to the world. We inherit, live and contribute to a world of sin and evil. Forgiveness breaks the links of evil set up by human sin; blame pointing, excessive retributive justice, and the associative redistribution of wealth only continues to add more bitterness and evil links to our condition of human bondage.

For the doctor, if there were circumstances involving the possibility of medical malpractice, the theological perspective described herein would call for the doctor to be most concerned for the welfare of his or her patient. The doctor would share with the patient and family an honest, open appraisal of what actually happened or went wrong. This would include an acceptance of responsibility for error or oversights made during the course of care. The doctor would ask for forgiveness if there were some actions or inactions on his or her part that contributed to a poorer outcome. The doctor could help with financial reparation by deleting his charges for services rendered, by attempting to correct remedial medical conditions and, if need be, by appealing to his or her malpractice carrier for monetary compensation to abrogate the need to sue. The doctor could also help with restitution in many ways other than financial. Sharing with the family some of the anguish of his or her personal feelings, offering and giving time and services, and supporting the injured over the long haul of their illness or disability would be a means of demonstrating the contriteness of heart, the continuing willingness to help and continued interest in the health and welfare of the patient. These actions have the potential, not found in medical malpractice litigation, for healing the bitterness at its source — the broken relationship between people which, as this paper has addressed, is human sin.

The doctor would have to get off his pedestal of societal status, scientific certainty and subtle arrogance. He or she would have to help the patients, themselves, and society to understand that the high expectations we all have blindly given to our health care system and to our doctors are deceptions and not realistic. Much work always will need to be done to keep our health system "caring;" it will always be fallible in "curing." In fact, the health care system will always fail each individual patient as biological death is inevitable. This is why "caring" is more important than "curing." It can never really cure, but it can always care. The physician needs to contribute his or her part in helping all of us to face the denial of death so prevalent in our technological age.

If the Christian physician is sued, the former friendly trusting relationship with the patient or family has already become adversarial. There are third parties immediately involved, introducing their own agendas. Complexities multiply through antagonisms between splintering defending parties. Former teams might break up; friendships become strained. The doctor faces loss of self-esteem and struggles with self-doubt,

guilt, denial and frustration. Here the Christian physician has to deal with the crisis in his or her vocation on two levels.

Personally, the physician needs to begin the process of freeing him or herself from the antagonisms — the hate and the bitterness generated through the process of an adversarial contest. And the physician needs to deal with personal guilt and its associated self-doubt. The physician needs to seek forgiveness from God and from the other parties, so that he or she can go on, rededicated to the vocation of being a tool of God for healing.

Publicly, the Christian physician needs to remain honest to the facts. The temptation to present the story from only a single point of view can be almost overwhelming at times. If the doctor feels he or she did a good job, and doesn't feel any sense of guilt, he or she should say so, and if necessary, go through the court system to say so publicly. On this road, the Christian physician would have the shining example of Christ — truthful and unyielding to false accusations, yet humbly accepting suffering throughout His trials. If, on the other hand, the physician did less than a good or even adequate job and carries some of the blame, he or she should admit so to the patient and family and make serious efforts to settle with the now plaintiff patient. The physician will need to work to improve any deficient skills, and will need to make one's professional capabilities be in line with one's personal theology so that he or she can again be the tool of God for healing.

Finally, in many cases of medical malpractice litigation, the preponderance of the evidence may be doubtful or nebulous in ascribing the blame to the doctor's actions or inactions. In these cases the claim that men shall live in love and not in selfishness requires that the Christian physician keep the patient's best interests and good in mind, even if this conflicts with the doctor's own best interest. This may require the consideration to the patient to settle the suit, even if the physician feels settlement may be unjust. For our truth might not be God's truth, and our will may not be God's will. Just as it is hard for the layman to understand all the subtle intricacies of patient management, so it is hard for any of us to understand the complexities and the requirements of any human need. We all have our own crosses to bear. To fight in court only further contributes to embittered human relationships and again furthers human sin.

Christian charity . . . calls for wishing and doing good precisely under those circumstances where it might be most difficult to justify doing so on rational grounds alone. Charity is, in some senses 'unreasonable' in that it violates philosophical standards of moderation.<sup>58</sup>

If sued, God's claim requires the Christian physician to be honest, open to the truth, accepting responsibility for his or her part, and not to shift blame — rather to be helpful to those sued in concert. Pride falls hard, but the doctor, if truly Christian, need not shy from the cross. The doctor, as the patient above, has to trust God. This involves the process of giving up control to our adversaries. This involves forgiveness — forgiving both oneself and the plaintiff patient. It involves allowing change to sweep into

our lives. Trust in God allows for the surprise of the God in history bursting into our own historical narrative with new life.

### Conclusion

There are a number of practical secular solutions being entertained today to help alleviate the crisis of medical malpractice in America. They all address some particular aspects more than others and fail to correct the problem in its entirety. The problem itself is complex. It is further complicated by the existence of conflicting ethical principles. For example, a patient compensation fund, or a no fault fund, interferes with our sense of justice that when an individual is injured by others in our society, they should have the right to recover damages.<sup>59</sup> A move toward further government control of medicine, and therefore accountability,<sup>60</sup> has the unfortunate side effect of furthering the trend toward secularizing the doctor-patient relationship into one of contract. It has also been suggested that we continue with the present tort system, but tighten up the legal requirements of proving negligence.<sup>61</sup> Or we can continue to accept the present tort system with the assumption that despite inefficiencies, it represents the least expensive way of achieving justice. Our present system is not very cost effective, even with proposed modifications, if it is just for patient compensation. Yet it might continue to have value as a quality control mechanism to assure us all of good health care. "Our negligence-based system of liability for iatrogenic injury can be justified, if at all, only on grounds of deterrence."<sup>62</sup> But then there are real questions raised whether the tort system does safeguard the quality of care.<sup>63</sup>

The solution that this author would favor involves the separation of culpable physician error from the issue of compensation. Gorovitz and MacIntyre effectively argue that physicians make many mistakes that do not necessarily result in bad outcomes. Therefore physician monitoring should be independent of outcome, and based on criterion established by the profession.<sup>64</sup> Licensing bodies or other mechanisms of quality control need to have the power to reprimand and to monitor progress of impaired physicians, and to remove incompetent physicians. Compensation to persons with bad medical outcomes can then become a larger societal question.

However, all of these proposed solutions deal on a secular level with an attempt to balance our sense of fairness to people who have experienced wrong or feel that their rights have been wronged, with the principle of "utility" — the greatest good for us all. In this essay, I have tried to introduce an alternative method of approaching the problem from an evangelical Christian perspective.

The Christian ethical solution to medical malpractice described herein might seem to be so much foolishness to a pragmatic, secular world. How can we discourage the patient from suing, and encourage the doctor to settle (perhaps even if felt to be unfair), and expect that all litigation will just go

away? It probably will not. But the *real* reason for taking this approach is that we focus on what is the *real* problem, human sin, defined theologically as the broken relationship with God and our neighbor.

The Christian solution becomes radical in that it calls doctor and patient alike to turn around, to repent. It calls on all of us, personally and in community, to change from a faith and reliance on a secular materialistic culture and work towards living in the present reality of God's kingdom of right relationship with God and fellow man. The present pain of medical malpractice to both patient and doctor may represent a spiritual movement of the Holy Spirit for broad change in America. Similar spiritual movements were equally as painful in American history for all parties involved (the freedom of black slaves in the South). Medical malpractice may only represent one small painful beginning among others that American Christians will have to face to repent, to be renewed in the gospel spirit of Jesus Christ. The good life of selfishly controlling much of the world's resources, of boasting of inalienable rights and entitlements, of trusting in arsenals of death for our security shall have to come crashing down as idols in front of the Living God — the Creator.

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