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Medical Error Versus Malpractice

Marshall B. Kapp

MEDICAL ERROR VERSUS MALPRACTICE*

*Marshall B. Kapp, J.D., M.P.H.***

On the January 23, 1997, edition of the popular WNBC medical television series ER, a patient with Type O blood died after a nurse mistakenly transfused him with a bag of Type A platelets. The fictional attending physician advised the nurse not to worry about the matter, since the patient was "bleeding out anyway." The nurse replied, "We've saved worse." Continuing to dismiss any proximate causal link[1] between the nurse's error and the patient's death, the physician told the nurse directly, "If you choose not to file an incident report in this case, we will all support that decision." The nurse accepted this implied but obvious invitation to attempt to avoid legal entanglements stemming from her mistaken action, but observed, "I'll still have to look at myself in the mirror."

Errors have always been a part of real medical practice.[2] Physicians are quick to admit that, "When we touch something, we put it at risk." As one experienced clinician has observed, "Error free patient care is the ideal

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**Professor, Departments of Community Health and Psychiatry and Director, Office of Geriatric Medicine & Gerontology, Wright State University School of Medicine; Member of the Adjunct Faculty, University of Dayton School of Law. B.A., Johns Hopkins, 1971; J.D., George Washington University Law School, 1974; M.P.H., Harvard University, 1978.

[1]Proximate causation is an essential element of proof in any negligence action, including those based on an allegation of medical malpractice. *See* MARCIA MOBILIA BOUMIL & CLIFFORD .E. ELIAS, THE LAW OF MEDICAL LIABILITY IN A NUTSHELL 115-127 (1995).

[2]The classic sociological study of physician errors is CHARLES L. BOSK, FORGIVE AND REMEMBER: MANAGING MEDICAL FAILURE(1979).

standard but in reality unattainable."[3] While the existence of this phenomenon has been acknowledged for some time, error remains a significant, recurring problem in terms of patient safety and welfare.[4]

Physicians' pervasive, and often erroneously or even irrationally based anxiety about medical malpractice litigation and liability[5] -- and their consequent defensive behavior toward patients[6] -- often acts as a barrier to effective individual and collective strategies for preventing and reducing medical errors. This article describes and analyzes the ways in which physician apprehension about potential involuntary involvement with the civil justice system[7] affect professional practices toward patients in a manner that negatively interferes with attempts to make errors in medical practice less common or to keep them from occurring altogether. Additionally, potential educational and public policy strategies are

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[3]Carlo Fonseka, *To Err Was Fatal*, 313 BRIT. MED. J. 1640, 1640 (1996).

[4]*See* MARILYN SUE BOBNER, HUMAN ERROR IN MEDICINE (1994); Lucian L. Leape, *Error in Medicine*, 272 JAMA 1851 (1994); David Hilfiker, *Facing Our Mistakes*, 310 NEW ENG. J. MED. 118 (1984); Alvan R. Feinstein, *System, Supervision, Standards, and the 'Epidemic' of Negligent Medical Errors*, 157 ARCH. INTERN. MED.1285; Timothy S. Lesar et al, *Medication-Prescribing Errors in a Teaching Hospial*, 157 ARCH. INTERN. MED. 1569 (1997).

[5]*See generally* F. Patrick Hubbard, *The Physicians' Point of View Concerning Medical Malpractice: A Sociological Perspective on the Symbolic Importance of 'Tort Reform,'* 23 GA. L REV. 295 (1989). Although physicians' anxieties about the law's intrusion into medical practice is an international phenomenon, *see, e.g.*, HARVEY TEFF, REASONABLE CARE: LEGAL PERSPECTIVES ON THE DOCTOR/PATIENT RELATIONSHIP (1994) (describing these anxieties from a British perspective), this article concentrates on the current situation in the United States.

[6]*See* Nathan Hershey, *The Defensive Practice of Medicine: Myth or Reality?* 50 MILBANK MEM. FUND Q. 96 (1972); Laurence R. Tancredi & Jeremiah A. Barondess, *The Problem of Defensive Medicine*, 200 SCIENCE 879 (1978). For analyses that are skeptical that physicians really alter their conduct in caring for patients specifically because of legal fears, *see, e.g.*, U.S. CONGRESS, OFFICE OF TECHNOLOGY ASSESSMENT, DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE, OTA-H-602 (July 1994).

[7]Physicians also are concerned about potential criminal or regulatory liability exposure. *See, e.g.*, GEORGE D. POZGAR, LEGAL ASPECTS OF HEALTH CARE ADMINISTRATION 84-123 (6th ed. 1996) (chapter on "Criminal Aspects of Health Care"); Alexander McCall Smith, *Criminal or Merely Human? The Prosecution of Negligent Doctors*, 12 J. CONTEMP. HEALTH L. & POL'Y 131 (1995); Einaugler v. Supreme Court, 918 F. Supp. 619 (E.D.N.Y. 1996); Green v. Abrams, 984 F.2d 41 (2d Cir. 1993);People v. Anyakora, 616 N.Y.S.2d 149 (Sup. Ct. 1993); People v. Klvana, 15 Cal. Rptr. 2d 512 (App. Dep't Super. Ct. 1992); State v. Warden, 813 P.2d 1146 (Utah 1991); People v. Protopappas, 246 Cal. Rptr. 915 (App. Dep't Super. Ct. 1988); People v. Coe, 501 N.Y.S.2d 997 (Sup. Ct. 1986), *aff'd* 510 N.Y.S.2d 470 (App. Div. 1987), *aff'd*, 522 N.E.2d 1039 (N.Y. 1988); State v. Brenner, 486 So. 2d 101 (La. 1986); State v. Serebin, 350 N.W.2d 65 (Wis. 1984); Commonwealth v. Youngkin, 427 A.2d 1356 (Pa. 1981); People v. Ketchum, 358 N.Y.S.2d 353 (App. Div. 1974). This article, however, concentrates primarily on anxieties about tort suits based on negligence, i.e., professional liability/medical malpractice claims.

presented toward mitigating or overcoming the various barriers that defensive medicine poses to the kinds of positive, ethical (*i.e.*, benevolent and non-maleficent)[8] medical practice that is associated with a reduction or elimination of medical errors.

The following discussion builds on a project in which the author investigated, in depth, the phenomenon of defensive medicine, concentrating particularly on the influence of physician apprehension about litigation and legal liability on the conduct of ethical medical practice. Qualitative data[9] were derived from a substantial number of personal interviews with academic and practicing physicians who are knowledgeable about, and interested in, the implications of defensive medicine for the ethical practice of medicine. The population of interviewees was diverse in terms of professional specialization, geographical location, and length of experience. A small group of attorneys, ethicists, and risk managers were also interviewed.

In "Definitions" of this article, the term "error" is very briefly examined, showing that the perceptions of different parties to the discussion[10] may establish contrasting -- or at least imprecise -- frames of reference. "Culture of Infallibility" specifically dissects physician perceptions regarding how medicine should be practiced and, especially, what it means to the physician when something goes seriously wrong. Physicians' notions about the adverse legal implications of medical errors are the subject of Legal Fears and Deceptive Behavior, as well as a look at the ways in which those worries influence patient care decisions and actions. The legal beliefs that drive physician behavior in certain directions are compared with the actual state of the law in this area. Finally, "Solutions and Initiatives" will discuss possible initiatives for effectively addressing the medical errors problem are outlined.

DEFINITIONS

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[8]*See generally* EDMUND PELLEGRINO & DAVIE THOMASMA, FOR THE PATIENT'S GOOD: THE RESTORATION OF BENEFICENCE IN HEALTH CARE (1988).

[9]For a good description and example of qualitative research in a related area, *see* Sharon Kaufman, *Decision Making, Responsibility, and Advocacy in Geriatric Medicine: Physician Dilemmas With Elderly in the Community*, 35 GERONT. 481 (1995).

[10]*Cf.* J. Douglas Peters et al., *An Empirical Analysis of the Medical and Legal Professions' Experiences and Perceptions of Medical and Legal Malpractice*, 19 U. MICH. J. L. REFORM. 601 (1986).

"Error" in medicine is a difficult concept to delineate precisely in the context of analyzing the law's role as a contributing, or exacerbating factor. The standard dictionary definition of error is "an act, assertion, or belief that unintentionally deviates from what is correct, right, or true; the act or an instance of deviation from the accepted code of behavior; transgression; wrongdoing; mistake."[11] In the medical arena, we are concerned with error as an act; assertions and beliefs are relevant only to the extent that they lead directly to some action taken toward a patient. The concept also entails actions that are omitted or withheld from a patient improperly. Beyond these general guidelines, though, medicine has no officially sanctioned or exact definition of error, and the working ideas held by individual physicians on this subject vary widely.[12]

In the law, "error" is defined quite technically according to the specific factual context. The 1996 Cumulative Annual Pocket Part of WORDS AND PHRASES[13] provides seven fine print pages of annotations for various types of errors with legal significance. In addition, this standard resource contains cross-references to fifty-five other sections carrying an "Error" label, ranging alphabetically from "Administrative Error" to "Waiver of Such Error." The annotation most directly pertinent to the subject matter of this article states:

> The words "mistake," "error" and "negligence" in policies insuring ... against liability for injuries to hospital patients because of malpractice, error, mistake, or negligence mean more than "malpractice," which is failure of one charged therewith to exercise ordinary diligence, care and skill of members of his profession, as a physician or hospital may err or make mistake without necessarily being guilty of malpractice.[14]

Thus, it appears that in both medicine and law, error and negligence are not synonymous. Beyond this point, however, consensus within and between the two professions about this cloudy concept does not exist.

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[11]THE AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE 445 (W. MORRIS ed. 1976).

[12]*Cf.* A.R. Localio et al., *Identifying Adverse Events Caused by Medical Care: Degree of Physician Agreement in a Retrospective Chart Review*, 125 ANN. INTERN. MED. 457 (1996) (finding substantial disagreement among physicians on the causes of adverse patient outcomes).

[13]15 WORDS AND PHRASES 69-76 (Supp. 1996).

[14]*Id.* at 71 (citing Burns v. American Casualty Co. 269 P.2d 656, 659 3rd Cir. (1954)).

THE "CULTURE OF INFALLIBILITY": HOW PHYSICIANS PERCEIVE ERRORS

Tort standards require that physicians provide reasonable care under the circumstances, as judged against the level of knowledge and skill exercised by their professional peers.[15] A mere "error in judgment" is not the basis for finding liability.[16] By contrast, most physicians impose a considerably higher standard on themselves and their colleagues: namely, perfection.[17] Physicians are professionally socialized into a "culture of infallibility,"[18] in which errors in patient care are not truly result from poor training or technique. Instead, errors are seen as manifestations of unacceptable character flaws, and they include not just discrete misdeeds or "sentinel events," but also the failure to treat a patient according to the ideal state of the art prevailing at the time. This may help explain why many physicians understand risks and benefits -- medical as well as legal -- only in absolute, rather than relative or statistical, terms.[19]

In light of this perfectionist mentality, being accused in a public forum, such as a court, of committing an error by an external scrunitizer cannot be interpreted by the physician in any manner other than as a deeply personal affront.[20] One physician has explained this orientation by stating: "[u]pon being served with a summons, the initial reaction is one of benumbed disbelief followed by self-deprecating analysis, schooled as

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[15]On the tort standard of care for medical negligence, *see, e.g.*, Alan C. Hoffman, *Medical Malpractice, in* LEGAL MEDICINE 129, 132 (American College of Legal Medicine, ed., 3d ed. 1995) ("[m]edical negligence is medical care that falls below the established standard of care expected of physicians."); BOUMIL & ELIAS, *supra* note 1, at 24; DOUGLAS A. HASTINGS ET AL., NAT'L HEALTH LAWYERS ASS'N, FUNDAMENTALS OF HEALTH LAW 136 (1995) ("[n]egligence is generally defined as doing--or failing to do--that which a reasonable physician ... in the same specialty, would have done in the same circumstances.").

[16]BOUMIL & ELIAS, *supra* note 1, at 36.

[17]Louis Snyder, *Disclosure of Errors and the Threat of Malpractice, in* ETHICAL CHOICES: CASE STUDIES FOR MEDICAL PRACTICE 47, 51 (Louis Snyder, ed. 1996). According to one study, in a profession that values perfection, error is virtually forbidden. Marc Newman, *The Emotional Impact of Mistakes on Family Physicians*, 5 ARCH. FAM. MED. 71 (1996). *See* Dennis H. Novack et al., *Calibrating the Physician: Personal Awareness and Effective Patient Care*, 278 JAMA 502, 505 (1997).

[18]Levy, *Code Blue*, 7 HARV. PUB. HEALTH REV. 36, 39 (1995).

[19]*See* Mark A. Davis, M.D., et al., *Admission Decisions in Emergency Department Chest Pain Patients at Low Risk for Myocardial Infarction: Patient Versus Physician Preferences*, 28 ANNALS EMERG. MED. 606, 609 (1996) (referring to "training biases resulting in avoidance of error rather than analysis of net benefit.")

[20]Leape, *supra* note 4, at 1851.

the physician is in the pursuit of excellence, then feelings of inadequacy, and, finally, anger, frustration, and a tremendous sense of isolation."[21]

Physicians also ordinarily do a worse job than juries or judges in distinguishing between honest misjudgments (the currently popular term is "mispractice")[22] and negligent errors (*i.e.*, malpractice). This often blurs blameworthy deviation from acceptable professional standards and blameless misfortune or bad luck.[23] Even in situations in which physicians would not be held to be at fault legally, physicians tend to envision themselves as lifeguards upon whose shift no one should be allowed to drown. The fact that he or she has complied with scientific evidence and reasoning rarely assuages the physician's guilty feelings, induced by a disastrously bad clinical result or the embarrassment ("losing face"), occasioned when such a result is called to the attention of one's professional peers.

Physicians can never be psychologically immunized against their own feelings; professionalism does not mean a suspension of emotions and self-doubt. With or without the added pressures of anticipated legal system intrusion, errors associated with seriously deleterious patient outcomes are "etched indelibly" in the physician's mind.[24] Some physicians make mistakes from which they never fully recover emotionally, and almost all physicians exercise some sense of introspection amounting to psychological torment by rehashing errors multiple times within their own mind.[25] Physicians take undesirable outcomes to heart and crave a reaffirmation of personal competence,[26] seeking the ability to sleep well at night again.

Reflecting on his early experience with a patient who had died from undiagnosed tetanus, a physician stated:

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[21]Lycurgus M. Davey, M.D., *The Hidden Costs of Malpractice*, 54 CONN. MED. 209, 210 (1990).

[22]PETER .H. BERCZELLER, M.D., DOCTORS AND PATIENTS: WHAT WE FEEL ABOUT YOU 213-217 (1994).

[23]BOSK, *supra* note 2, at 24.

[24]*Id.*, at 40.

[25]Albert W. Wu, M.D., et al., *How House Officers Cope With Their Mistakes*, 159 J. GEN. INTERN. MED. 566-67 (1993).

[26]MARY-JO DELVECCHIO, GOOD AMERICAN MEDICINE: THE QUEST FOR COMPETENCE (1995); BERCZELLER, *supra* note 22, at 216-17; Hilfiker, *supra* note 4.

> I think that I never came to terms with [this patient]'s death. I suspect that his death must have been a strong influence that subconsciously drove me out of clinical medicine into a preclinical department like physiology, where in those days [the early 1960s] you killed only frogs.[27]

The fact that the author of this cathartic passage is from Sri Lanka illustrates that the potentially devastating psychological ramifications of error to the physician are inherent in medicine and universal in distribution, and not some artifact of the unique American legal system.

LEGAL FEARS AND DECEPTIVE BEHAVIOR: PERCEPTIONS VERSUS REALITY

Physicians' Legal Perceptions

Physicians and patients alike are harmed when physicians attempt to disguise their errors (whether negligent or blameless) from patients, medical colleagues, and other third parties. Thus, it is essential to tease out the explanation(s) underlying such physician behavior.

Physicians instinctively, and virtually universally believe that the current tort system punishes medical errors, and does so aggressively. Consequently, physicians maintain they are too intimidated by fear of adverse legal repercussions to admit their mistakes out loud; instead, the legal incentives are perceived as pushing physicians strongly in the direction of covering up their errors.[28] According to one commentator,

> Those who are associated with errors are the most likely people to be able to provide information about what contributes to the errors. There is an impediment to their providing information, however, which is fear of malpractice litigation. Most medical care providers in the United States will not provide error-related information because to do so might be construed as admitting

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[27]Fonseka, *supra* note 3, at 1640.

[28]Levy, *supra* note 17; Leonard D. Marks, *Letter, Admitting Mistakes*, 26 ANNALS EMERG. MED. 758, 758 (1995), Leape, *supra* note 4; J.W. Senders, *Medical Devices, Medical Errors, and Medical Accidents*, in HUMAN E ERROR IN MEDICINE 159, 171 (Marilyn Sue Bogner, ed. 1994).

> responsibility for any error under consideration. This could lead to litigation.[29]

Renowned Harvard surgeon emeritus, Dr. Francis D. Moore, has described hospital mortality and morbidity (M & M) conferences as essential to continuing medical education and correcting errors. He laments, however, the fact that physicians now feel that honestly discussing with their colleagues things that have gone wrong in patient care puts them at intolerable risk legally.[30]

Another Harvard medical professor, Dr. Lucian Leape, charges:

> We have difficulty dealing with error. We punish with a malpractice suit instead of solving the problem. By suing doctors, we create a monster. Perfect performance is not possible. But punishment is counter-productive, inappropriate and inefficient.[31]

Ethical Principles and Legal Realities

Hiding or rationalizing, rather than acknowledging, medical errors is ethically harmful at least three reasons. First, it interferes with the desirable process of turning errors into educational "treasures"[32] from which both erring physicians and their colleagues might learn and grow professionally. Second, it hurts patients by depriving them and their physicians of information that could potentially be valuable in correcting errors and otherwise improving treatment of present and future patients.[33]

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[29]Marilyn Sue Bogner, *Human Error in Medicine: A Frontier for Change*, *in* HUMAN ERROR IN MEDICINE 373, 379 (Marilyn Sue Bogner, ed. 1994).

[30]FRANCIS D. MOORE, M.D., A MIRICALE AND A PRIVILEGE: RECOUNTING A HALF CENTURY OF SURGICAL ADVANCE 91 (1995).

[31]*Diverse Groups Agree: Unified, Innovative Approach is Best Way to Minimize or Prevent Health Care Errors*, MED. LIABILITY MONITOR (Nov. 15, 1996) at 1, 2 [hereinafter *Diverse Groups*].

[32]David Blumenthal, *Making Medical Errors into 'Medical Treasures,'* 272 JAMA 1867, 1867 (1994); *see* Charles Vincent, *Risk, Safety, and the Dark Side of Quality*, 314 BRIT. MED. J. 1775 (1997).

[33]Michael D. Fetters, *Letter, Error in Medicine*, 274 JAMA 457, 458(1995); *see also* David Casarett & Lainie F. Ross, *Overriding a Patient's Refusal of Treatment After an Iatrogenic Complication*, 336 NEW ENG. J. MED. 1908, 1909 (1997) ("[i]n seeking to undo complications [caused by physician error], physicians may need to perform additional procedures and provide additional therapies, each of which has its own benefits and risks. The occurrence of an iatrogenic complication does not give physicians the right to perform these interventions without the patient's consent.").

This offends the principles of beneficence (*i.e.*, doing good) and non-maleficence (*i.e.*, preventing harm).[34] Patients' families may also be cheated. For instance, fear of uncovering errors that might lead to litigation probably assists in accounting for a decrease in the number of autopsies performed today,[35] thereby diminishing many opportunities for physicians to learn,[36] to comfort families with explanations of the patient's death, and to alert families of discovered genetic risks.[37] Finally, purposeful deception undercuts and attacks the essential fabric of the fiduciary or trust nature of the physician/patient relationship by directly violating the ethical principle of fidelity or truthfulness.[38]

Like many of the other legal perceptions commonly held by physicians about malpractice exposure,[39] the notion that defensively covering up medical errors must be good risk management is highly questionable. Paradoxically, such a strategy is probably legally counterproductive.[40] There is credible evidence that most patients want their physicians to admit medical errors -- both large and seemingly minor -- to them, and that complying with the patient's preference may reduce

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[34]*See* PELLEGRINO & THOMASMA, *supra* note 8.

[35]"The declining interest in autopsies" may be explained in part by the widespread physician perception that, "For the clinician, the autopsy may produce embarrassment and perhaps a legal liability." Hartmann H. R. Friederici, M.D., *Turning Autopsy Liabilities Into Assets*, 250 JAMA. 1165, 1165 (1983).

[36]On autopsy as a learning opportunity, *see, e.g.*, Marten Boers, M.D., *The Prospects of Autopsy: Mortui Vivos Docuerunt? ("Have the Dead Taught the Living?")*, 86 AM. J. MED. 322 (1989); Stephen A. Geller, *Autopsy*, SCI. AM., Mar. 1983, at 124.

[37]A forensic pathologist has written, "Are physicians, in their paranoia about lawyers and the civil justice system, actually hurting themselves by deliberately refraining from obtaining permission for postmortem examinations when an unanticipated and seemingly inexplicable death of a patient occurs?" Cyril Wecht, *Medical Malpractice Suits and Autopsies*, 266 JAMA 360, 360-61 (1991). Another physician replied, "physicians should not be asked to order autopsies to defend their own interest. While autopsies certainly may be used to justify a physician's actions in a medical malpractice lawsuit, it is a fact that the outcomes of such autopsies are also used to initiate these lawsuits." Adam O. Goldstein, *Medical Malpractice Suits and Autopsies*, 266 JAMA 360, 361 (1991); *see also* Martin J. Valaske, M.D., *Loss Control/Risk Management: A Survey of the Contribution of Autopsy Examination*, 108 ARCH. PATHOL. LAB. MED. 462 (1984) (results support author's bias for increased use of autopsy information for risk management).

[38]*See* Jean H. Ritchie & Sally C. Davies, *Professional Negligence: A Duty of Candid Disclosure?*, 310 BRTI. MED. J. 888 (1995).

[39]*See, e.g.*, A.J. Rosoff, *Commentary: Truce on the Battlefield: A Proposal for a Different Approach to Medical Informed Consent*, 22 J. L., MED. & ETHICS 314 (1994); Alan Meisel, J.D. & Mark Kuczewski, Ph.D., *Legal and Ethical Myths About Informed Consent*, 156 ARCH. INTERN. MED. 2521 (1996).

[40]*See* Ritchie & Davies, *supra* note 38.

rather than multiply the physician's risk of punitive actions. While readily admitting mistakes may inspire some malpractice suits, significantly more legal claims are likely to result because a physician conceals an error that the patient subsequently suspects or discovers through other means.[41] Thus, a patient who is under the impression that the physician has been less than candid about an iatrogenic error will more likely bring a malpractice action based on that suspicion or knowledge in the event of an unfavorable clinical outcome, especially if the bad result was an unpleasant surprise.

Dr. Albert Wu of the Johns Hopkins University School of Hygiene and Public Health contends:

> Physicians have an obligation to disclose clear mistakes that cause significant harm that is remediable, mitigable or compensable ... Disclosure can reduce litigation, if patients appreciate the physician's honesty and can appreciate that physicians are fallible. Serious mistakes may come to light, even if the physician does not disclose them. Any perception that the physician tried to cover up a mistake might make patients angry or more litigious. Furthermore, the risks inherent in disclosing a mistake may be minimized if disclosure is made promptly and openly and in a manner that diffuses patient anger, if sincere apologies are made and if charges for associated care are forgone.[42]

This advice is echoed by a healthcare risk manager and an attorney instructing their colleagues:

> The manner in which physicians and staff deal with unintended outcomes or adverse events ... may precipitate legal action. The best approach is to deal with the situation with caring compassion, explaining to the patient what occurred without placing blame on others and what treatment, if any, is required to address the event.

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[41]Amy B. Witman, M.D. et al., *How Do Patients Want Physicians to Handle Mistakes? A Survey of Internal Medicine Patients in an Academic Setting*, 156 ARCH. INTERN. MED. 2565 (1996).

[42]Quoted in *Diverse Groups*, *supra* note 231 at 2.

> Patients generally appreciate the truth and will only become suspicious if they are avoided or their questions are not answered.[43]

A former president of the American College of Legal Medicine cites as a "typical complaint" of patients who consult with legal counsel about filing malpractice claims:

> I never got a satisfactory explanation about the problem that occurred. (There is a tendency to avoid such discussions. Often, physicians who should discuss a problem with a patient send in a resident who does not want to say the wrong thing and does not have the experience or knowledge to know what is correct to say ...).[44]

He admonishes: "When there is a death or misadventure, the responsible party should provide the explanation. There is no excuse for violation of this mandate."[45]

Stephen Fielding, a sociologist who has studied the etiology of medical malpractice notes:

> Good communications and patient relations help keep patients and their families informed about maloccurrences. Many claimants file suits in order to learn the facts about what actually happened and to make the provider(s) accountable. The claimants I interviewed often spoke of getting inadequate information or of feeling as though there had been a cover-up. Several claimants told me that they might not have sued if their physicians had told

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[43]Deborah Korlinski & Ellen E. McLaughlin, *Employment/Physician Issues*, *in* PROCEEDINGS OF SIXTH ANNUAL SYMPOSIUM OF HEALTHCARE ATTORNEYS AND RISK MANAGERS, 287-309, Feb. 6-7, 1997 (AHA ed. 1997). Unfortunately, legal advice on this point frequently is more ambiguous. One physician describes a discussion within a hospital ethics committee about advising a patient's family that there has been a medical error, "We turned to the lawyers, who shrugged and said that whatever we did, we should be sure to document it well. Truth telling is best, someone said. Not always, another replied. We ended up a hung jury, and told the attending that either option was acceptable." JOHN D. LANTOS, DO WE STILL NEED DOCTORS? 122 (1997).

[44]Lee S. Goldsmith, M.D., LL.B., *A Look at the Relationships of Parties Involved in Medical Malpractice Litigation With a View Toward Helping the Patient*, 14 J. LEGAL MED. 125, 134 (1993).

[45]*Id.*, at 135.

> them exactly what had happened. Knowing how a negative outcome occurred is critical to the process of emotional healing.[46]

Fielding continues:

> Certainly, any adverse events should be explained to patients and their families as soon as possible, and these explanations should be repeated, if necessary, after the patient and his or her family have had time to emotionally absorb what happened. *Although this flies in the face of legal advice,* withholding information can trigger a suit.[47]

Unfortunately, Fielding is correct in the presumption that ethically and psychologically prudent advice flies in the face of generally promulgated risk management wisdom. The irony is compounded by the fact that liability may be imposed on a physician specifically because that professional failed to reveal relevant information -- *i.e.,* the occurrence of the medical error -- to the patient. The cause of action here could be based on the physician's violation of fiduciary responsibilities, which encompass obligations to disclose the nature and scope of negligently caused injuries, to allow the patient to have those iatrogenically caused injuries properly and timely remedied or mitigated.[48] In one notorious case[49], for instance, the court held that a professional football player had been the victim of

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[46]Stephen L. Fielding, *When Patients Feel Ignored: Study Findings about Medical Liability*, 72 ACAD. MED. 6, 6 (1997); *see also* SANDRA M. GILBERT, WRONGFUL DEATH: A MEMOIR (1995) (a wife explaining that she filed a malpractice action based on her husband's death because she felt ignored and/or deceived by the medical professionals).

[47]Fielding, supra note 46, at 7 (emphasis added); *see also* BERNARD LOWN, M.D., THE LOST ART OF HEALING 154 (1996) ("[a]dmitting error and offering a deeply felt apology clears the air. I am not aware of a case where apology led to litigation, and I have often known such forthrightness to bond a doctor and patient in a closer relationship of trust and friendship."). According to a recent report of the Royal College of Physicians, entitled *Improving Communication Between Doctors and Patients*, many patient complaints could be resolved by early, frank, and open discussion, and a physician who says that he or she is sorry that a patient has suffered is not admitting liability and should not fear possible litigation by simply expressing sympathy. *See* Linda Beecham, *Learning to Break Bad News*, 314 BRIT. MED. J. 1502 (1997).

[48]*See, e.g.*, Theodore LeBlang & Jane L. King, *Trot Liability for Nondisclosure: The Physician's legal Obligations to Disclose Patient Illness and Injury*, 89 DICK. L. REV. 1 (1984); Joan Vogel & Richard Delgado, *To Tell the Truth: Physician's Duty to Disclose Medical Mistakes*, 28 UCLA L. REV. 52 (1980).

[49]Krueger v. San Francisco Forty-Niners, 189 Cal. App. 3d 823, 234 Cal. Rptr. 579 (Cal. Ct. App. 1987).

actionable misrepresentation when, after the player suffered a knee injury in a game, the team physician failed to reveal to him that the injury was degenerative and irreversible and that continued professional play would only worsen the condition.[50]

Furthermore, by fraudulently concealing the error, a physician unintentionally may be bolstering the patient's ability to later prove the necessary elements of damage and proximate causation in a negligence claim. As a form of equitable estoppel, the statute of limitations in a given jurisdiction may be tolled if the physician is found to have knowingly and intentionally concealed the negligent act or omission from the patient.[51] If knowing and intentional concealment is found, the statutory time for filing a claim begins to run when the plaintiff discovered or should have discovered the wrong.[52]

In light of the above, in the event of a bad, or especially an unexpected, medical outcome:

> It is therefore highly recommended that a physician explain to the patient's reasonable satisfaction just what occurred and why. If no explanation is given, or an inadequate explanation is given this could act to infuriate the patient further. If the patient is already suspicious of the treatment he received, a poor or nonexistent explanation will only collaborative the suspicion and could possibly be the motivation for promptly commencing a lawsuit. Accordingly, it is not only incumbent upon the physician to provide a meaningful explanation but also a very wise physician-patient relationship move."[53]

For both legal and ethical reasons, the physician should attempt to timely repair or mitigate any patient injury that has been caused by medical error. To intervene in a corrective fashion, though, the physician must first obtain the patient's (or surrogate's, in the case of decisionally

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[50]*Id.*

[51]*See, e.g.*, Detwiler v. Bristol-Myers Squibb Company, 884 F. Supp. 117 (S.D.N.Y. 1995); Simcuski v. Saeli, 44 N.Y.2d 442, 377 N.E.2d 713 (N.Y. 1978).

[52]BOUMIL & ELIAS, *supra* note 1, at 145.

[53]Kenneth Ness, *Common Causes of Malpractice Litigation*, *in* 1 MEDICAL AND HOSP. NEGLIGENCE § 3.21 (Miles J. Zaremski & Louis S. Goldstein eds., 1988).

incapable patients)[54] informed consent to the medical intervention.[55] The communication that comprises a valid informed consent process need not always require the physician to volunteer the fact an error was made, and certainly need not include an admission of fault on the physician's part. Such admissions ordinarily will not change the particular patient's medical situation. In unusual circumstances, in which knowing that an error had occurred might affect the patient's medical well-being, a strong argument can be made for imposing a legal obligation on the physician to disclose that valuable and pertinent information. An even more powerful case may be made for the physician's duty to respond truthfully to direct questions posed by the patient.

Nevertheless, it is true that a physician's admission of error in patient care ordinarily may be introduced in evidence as proof of the facts admitted against the physician if a malpractice complaint subsequently is brought. Thus, the physician's own words may be used to help satisfy the plaintiff's burden of proof. As one law professor warns,

> Because the physician seldom admits either a mistake or malpractice, it makes it more precious for the lawyer to latch on to any statement, where in front of third persons, in court or in his own or hospital records, the doctor confesses he goofed. The situation is a *tabula in naufragio*."[56]

Similarly, in many situations the fact that corrective measures were undertaken by a defendant following an adverse event may be introduced in evidence as proof that negligence had occurred.

When an error associated with patient injury occurs within an institutional or organizational structure, it is probable that a written incident report will be prepared. Incident reports used in daily operation

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[54]Regarding surrogate medical decision making for decisionally incapable patients, *see generally* HASTINGS, *supra* note 15, at 116-118; Steven B, Bisbing, Psy. D., J.D., et al., *Competency, Capacity, and Immunity, in* LEGAL MEDICINE 27 (American College of Legal Medicine ed., 3rd ed. 1995).

[55]Regarding informed consent, *see generally* GEORGE D. POZGAR & NINAS SANTUCCI POZGAR, LEGAL ASPECTS OF HEALTH CARE ADMINISTRATION 393-416 (6th ed. 1996); Barry R. FURROW, *et al.*, HEALTH LAW 265-288 (1995); Emidio A. Bianco & Harold L Hirsh, *Consent to and Refusal of Medical Treatment, in* LEGAL MEDICINE 274-296 (American College of Legal Medicine ed., 3rd ed. 1995).

[56]Ralph Slovenko, *Commentary: "Oops!" Admissions by Physicians*, 15 J. PSYCHIATRY & L. 489, 500 (1987) (emphasis in original)..

and primarily to improve safety conditions for the provider are generally discoverable in civil litigation; that is, reports prepared in the course of ordinary business and/or for internal purposes only are discoverable.[57] However, incident reports prepared by a health care provider for the specific purpose of preparing for and defending against potential future litigation, and communicated to the provider's liability insurance carrier, may be immune from civil discovery under the attorney/client privilege and/or work product doctrine.[58]

SOLUTIONS AND INITIATIVES

When errors occur in the delivery of medical care, everyone concerned is a potential victim, as is the medical care delivery system itself.[59] Prevalent physician apprehensions about exposure to litigation and liability associated with the handling of medical errors sometimes are predicated on an accurate understanding of the legal environment. More frequently than not, though, these anxieties are based on erroneous premises about the law and the operation of the legal system. Nonetheless, legal perceptions are infinitely more important than reality in shaping physician behavior toward patients. Thus, physicians' legal anxieties serve as a powerful barrier to the implementation of a concerted strategy to identify, prevent, mitigate, and correct those errors. We must ask, therefore, what strategies can be devised and productively put into place to address and overcome the current perceived legal environment within which medical errors occur?[60]

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[57]Samaritan Foundation v. Goodfarb, 862 P.2d 870 (Ariz. 1993) (statements taken by hospital's legal counsel where employees were not seeking legal advice regarding their own conduct was not privileged); Kupor v. Solito, 687 S.W.2d 441 (Tex. App. 1985) (incident report discoverable unless made in conncetion with claim or lawsuit); St. Louis Little Rock Hospital, Inc. v. Gaertner, 682 S.W.2d 146 (Mo. Ct. App. 1984) (incident report made in the course of ordinary business is discoverable); *see also* White v. New York City Health & Hosps. Corp., No. 88 Civ. 7536 (LBS), 1990 U.S. Dist. LEXIS 3008 (S.D.N.Y. Mar. 19, 1990) (state confidentiality statutes did not prevent discovery of hospital indicent reports in a civil rights lawsuit).

[58]Enke v. Anderson, 733 S.W.2d 462, 469 (Mo. Ct. App. 1987) (incident report protected from discovery).

[59]*See* David C. Classen et al., *Adverse Drug Events in Hospitalized Patients: Excess Length of Stay, Extra Costs, and Attributable Mortality*, 277 JAMA 301 (1997); David W. Bates et al., *The Costs of Adverse Drug Events in Hospiatlized Patients*, 277 JAMA 307 (1997).

[60]This is not an inquiry presently limited to the Unites States. *See, e.g.*, Peter Richards *et al.*, *Managing Medical Mishaps*, 313 BRIT. MED. J. 243 (1996) (discussing the need for greater openness and partnership in addressing the medical errors problem among physicians, attorneys,

A leading expert in the field of medical errors advocates a system modeled on the system used by the Federal Aviation Administration (FAA) for preventing and remedying safety problems in aircraft. Here, a person who reports medical errors, like one who reports safety problems, would be immune from any legal liability associated with the error reported.[61] Another analyst has stated, "It is imperative that an atmosphere be created in which medical care personnel can freely provide data about errors and near errors they experience."[62] This proposal is ironically based on the theory that talking about mistakes is, ordinarily, excellent long range risk management, because the discussion may lead to important, needed improvements in provider practice.[63] Forgiveness encourages "help-seeking" behavior.[64] Moreover, frank and open communication is more likely to maintain and renew than to harmfully rupture the therapeutic relationship between the physician and patient.[65]

A pathbreaking conference was held in October, 1996, in Rancho Mirage, California, on the subject of errors in health care.[66] Convened jointly by the American Medical Association (AMA), American Association for the Advancement of Science (AAAS), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Annenberg Center for Health Sciences, with financial support from numerous other organizations, this three-day meeting brought together national experts from the fields of medicine, law, bioethics, management, and health services research.[67] The announced goal of the meeting was to give impetus to a process dedicated to fashioning and then implementing

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judges, and patients in the United Kingdom).

[61]Leape, *supra* note 4, at 1857; *see* Robert L. Helmreich, *Interview: Human Error in Aviation: Lessons for Health Care*, 5 QUAL. CONNECTION 4 (Fall, 1996).

[62]BOGNER, *supra* note 4, at 379.

[63]John F. Christensen et al., *The Heart of Darkness: The Impact of Perceived Mistakes on Physicians*, 7 J. GEN. INTERNAL. MED. 424, 430 (1992).

[64]BOSK,*supra* note 2, at 178.

[65]William B. Applegate, *Physician Management of Patients With Adverse Outcomes*, 146 ARCH. INTERN. MED. 2249, 2252 (1986); *see also* Wendy Levinson et al., *Physician-Patient Communication: The Relationship With Malpractice Claims Among Primary Care Physicians and Surgeons*, 277 JAMA 553, 553 (1997) (Routine physician-patient communication differs in primary care physicians with versus those without prior malpractice claims).

[66]Linda O. Prager, *Reducing Medical Errors*, AMER. MED. NEWS, Nov. 4, 1996, at 1; *see* Rebecca Voelker, *'Treat Systems, Not Errors,' Experts Say*, 276 JAMA 1537 (1996).

[67]Prager, *supra* note 66.

a major national agenda on prevention, education, and research regarding errors in patient care.[68]

As noted earlier,[69] the frequent occurrence of errors, sometimes serious in their implications for patient safety and welfare, is a problem that has long been recognized. The origins of medical error are multifactorial, relating both to the individual practitioner and organizational deficiencies.[70] A number of scattered, sporadic initiatives to address these problems has been implimented over the years.[71] More recently, though, well-publicized statistical analyses[72] and individual stories regarding lives jeopardized or diminished by health system errors, such as the death of medical writer Betsy Lehman at the Harvard-affiliated Dana Farber Cancer Institute in Boston in 1995, from a massive overdose of a chemotherapy drug being used to treat her breast cancer,[73] have greatly increased both public and professional acknowledgment and concern about this matter.

Purported prophylactic and/or corrective strategies such as voluntary (*i.e.*, non-governmental) accreditation programs[74] and medical malpractice tort law[75] appear to be largely ineffective, if not outright

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[68]*Id.*

[69]*See supra* text accompanying notes 2 - 4.

[70]Timothey Lesar et al., *Factors related to Errors in Medication Prescribing*, 277 JAMA 312, 312 (1997).

[71]*See, e.g., ASHP Report: ASHP Guidelines on Adverse Drug Reaction Monitoring and Reporting*, 52 AM. J. HEALTH-SYST. PHARM. 417 (1995); *Top-Priority Actions for Preventing Adverse Drug Events in Hospitals: Recommendations of an Expert Panel*, 53 AM. J. HEALTH-SYST. PHARM. 747 (1996); *ASHP Report: ASHP Guidelines on Preventing Medication Errors in Hospitals*, 50 AM. J. HEALTH-SYST. PHARM. 305 (1993); Steven K. Howard et al., *Anesthesia Crisis Resource Management Training: Teaching Anesthesiologists to Handle Critical Incidents*, 63 AVIAT. SPACE ENVIRON. MED. 763 (1992).

[72]*See, e.g.*, PHYSICIAN INSURERS ASSOCIAION OF AMERICA, ACUTE MYOCARDIAL INFARCTION STUDY (May 1996); David W. Bates et al., *Incidence and Preventability of Adverse Events in Hospitalized Patients*, 8 J. GEN. INTERNAL MEDICINE 289 (1993).

[73]*Settlement Reached in Overdose Lawsuit*, N.Y. TIMES, Aug. 25, 1995, at A20.

[74]For critiques of the limitations and shortcomings of the voluntary accreditation process in health care, such as the danger of the accrediting body becoming co-opted by the group(s) purportedly being scrutinized. *See, e.g.*,. PUBLIC CITIZEN HEALTH RESEARCH GROUP, THE FAILURE OF 'PRIVATE' HOSPITAL REGULATION (July 1996); Timothy Jost, *The Joint Commission of Accreditation of Hospitals: Private Regulation of Health Care and the Public Interest*, 24 B. C. L. REV. 835 (1983).

[75]For skeptical analyses of the quality assurance benefits of tort law, *see, e.g.*, Gary T.Schwartz, *Reality in the Economic Analysis of Tort Law: Does Tort Law Really Deter?*, 42 UCLA L. REV. 377 (1994); Daniel W. Shuman, *The Psychology of Compensation in Tort Law*,43 U. KAN. L. REV. 39 (1994); Daniel W. Shuman, *The Psychology of*

counterproductive, in achieving their quality assurance goals. Commenting on quality initiatives at health care institutions, Troyen Brennan and Donald Berwick note,

> The pressure of rules set by the JCAHO, the Peer Review Organizations, and malpractice litigation had little or nothing to do with the push for quality. Indeed, the increasing responsiveness of regulatory agencies probably results from the efforts of the health care organizations to adopt modern quality methods.[76]

The current legal environment may even exacerbate the Quality Assurrance problem in some cases. For instance, the reluctance of key actors to admit, even to their colleagues, and remedy their mistakes in a timely and honest manner is -- so they believe, at least -- "reinforced by the American tort system"[77] and translated into a harmful "Code of Silence". Consequently, substantial consensus among health care leaders that the time has arrived for a more decisive and coordinated plan of action inspired the fall, 1996 gathering on medical error.

Among other tangible products emanating from the conference,[78] the AMA unveiled its National Patient Safety Foundation.[79] The foundation can best be described as:

> embrac[ing] the idea that quality is the result of a continuous process, in which the number of errors can be reduced by understanding and examining the systems in which medical care is delivered. The Foundation's goal is to promote a national patient

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Deterrence in Tort Law, 42 U. KAN. L. REV. 115 (1993); Daniel W. Shuman, *Making the World a Better Place Through Tort Law? Through the Therapeutic Looking Glass,* 10 N.Y.L. SCH. J. HUM. RTS. 739 (1993); Daniel W. Shuman, *Therapeutic Jurisprudence and Tort Law: A Limited Subjective Standard of Care,* 46 SMU. L. REV. 409, 410 (1992) ("The capacity of tort law to shape behavior ... is admittedly problematic.").

[76]TROYEN A. BRENNAN & DONALD M. BERWICK, NEW RULES: REGULATION, MARKETS, AND THE QUALITY OF AMERICAN HEALTH CARE 316 (1996).

[77]Levy, *supra* note 18, at 39.

[78]Regarding the major themes emerging from this conference, *see* Donald M. Berwick, *Taking Action: Leading the Reduction of Error in Health Care,* 5 QUALITY CONNECTION 1 (1996) (summary of keynote address).

[79]Information may be obtained from the American Medical Association, 515 N. State Street, Chicago, IL 60610.

> safety movement in which awareness of potential mistakes is a part of every medical interaction and setting.[80]

Other organizations are similarly involved in this quest.[81] An example is the American Society for Healthcare Risk Management -- the primary membership organization for the risk management professionals from whom physicians derive many of their legal perceptions.[82] In late 1996, they established a working relationship with the National Coordinating Council for Medical Error Reporting and Prevention.[83]

Any successful error admission and correction strategy must directly confront physicians' substantial anxieties associated with the National Practitioner Data Bank (NPDB).[84] Authorized by Congress as part of the Health Care Quality Improvement Act (HCQIA) of 1986,[85] the NPDB is a federal repository to collect and disseminate information concerning adverse actions affecting health care practitioners.[86] The goal is simply to improve the process of medical peer review by providing better information.[87]

More particularly, under HCQIA, hospitals and other health care entities must report any "professional review action" adversely affecting the clinical privileges of a physician or dentist for a period longer than

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[80]Barbara Bolsen, Editorial, *Ending the Blame Game,* AM. MED. NEWS, Nov. 18, 1996 at 17.

[81]*See, e.g.,* Anesthesia Patient Safety Foundation, 1400 Locust Street, Pittsburgh, PA 15219-5166; Institute for Safe Medical Practices, 300 W. Street Road, Warminster, PA 18973-3236; Institute for Healthcare Improvement, 135 Francis Street, Boston, MA 02215; National Council on Patient Information and Education, Suite 810, 666 Eleventh Street, N.W., Washington, DC 20001-4542.

[82]*Cf.,* Marshall B. Kapp, *As Others See Us: Physicians' Perceptions of Risk Managers,* 16 J. HEALTHCARE RISK MGMT. 4 (1996).

[83]*See ASHRM Working to Prevent Med Errors,* ASHRM FORUM 1 (Jan. – Feb. 1997).

[84]*See generally,* Elisabeth Ryzen, *The National Practitioner Data Bank: Problems and Proposed Reforms,* 13 J. LEGAL MED. 409 (1992).

[85]Health Care Quality Improvement Act (HCQIA), Pub. L. No. 99-660, 100 Stat. 3784-94 (1986) (as amended by Pub. L. No. 100-177, 101 Stat. 1007-1008 (1987); codified as amended at 42 U.S.C. §§ 11101-11152 (1989) with implementing regulations at 45 C.F.R. §§ 60.1-60.14 (1989)).

[86]For an international comparison, *see* Gail Daubert, *National Repositories of Information: A Comparison of the National Practitioner Data Bank in the United States and the National Confidential Enquiry into Perioperative Deaths in the United Kingdom,* 5 ANNALS HEALTH L. 227 (1996).

[87]Virginia H. Hackney, *The National Practitioner Data Bank: A Step Toward More Effective Peer Review,* 24 J. HEALTH & HOSP. L. 201 (1991).

thirty days, as well as the relinquishment of clinical privileges by a physician in circumstances in which the physician is under investigation relating to professional competence or conduct, or in return for not conducting such an investigation. Insurers must report payments on settlements or judgments of medical malpractice claims. State medical and dental licensing boards must report disciplinary actions. These federal mandatory reporting obligations surpass any existing reporting requirements under applicable state law.

Health care entities are required to request information from the NPDB at the time a physician applies for a position on the medical staff or for clinical privileges and at least once every two years thereafter, with regard to any physician who is then on the medical staff or has been granted clinical privileges. A health care entity also may request information at other times.[88] Understandably, the majority of physicians are concerned about the possible negative impact that a blemished NPDB dossier may exert on their individual careers,[89] as health care entities attempt to distance themselves from physicians who might expose the institution or organization to an increased risk of vicarious and/or corporate liability.[90] The NPDB, as well as state medical boards' easing of patient access to identifiable data about individual physicians' legal and disciplinary histories,[91] heighten physician incentives to avoid adverse legal entanglements, thereby, preventing the sullying of their own records. Coupled with physician perceptions that dealing straightforwardly with medical errors increases the risk of exactly those sorts of legal

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[88]For descriptions of the NPDB's operation, *see generally* M.P. Demos, *What Every Physician Should Know About the National Practitioner Data Bank*, 151 ARCH. INTERNAL MED. 1708 (1991); Scott C. Pugsley, *Implementing the Health Care Quality Improvement Act*, 23 J. HEALTH & HOSP. LAW 42 (1990); James Robb, *National Practitioner Data Bank*, 92 N.Y. ST. J. MED. 12 (1992); Ila S. Rothschild, *Operation of the National Practitioner Data Bank*, 25 J. HEALTH & HOSP. L. 225 (1992).

[89]*See* Kathleen L. Blaner, *Comment, Physician Heal Thyself: Because the Cure, the Health Care Quality Improvement Act, May Be Worse Than the Disease*, 37 CATH U. L. REV. 1073 (1988).

[90]Regarding the potential tort liability of a health care entity for the negligence of its physicians, *see generally*, FURROW, *supra* note 55, at chs. 7 and 8; Robert L. Wilson, Jr., *Respondeat Superior*, *in* 2 MEDICAL & HOSP. NEGLIGENCE §§ 19:0-19:10 (Miles J. Zaremski & Louis S. Goldstein eds. 1988); Robert L. Wilson, Jr., *Corporate Negligence of Hospital*, *in* 2 MEDICAL & HOSP. NEGLIGENCE §§ 20:01-20:12 (Miles J. Zaremski & Louis S. Goldstein eds. 1988).

[91]*See, e.g.*, *Maryland Board Easing Access to Data on Physicians*, AM. MED NEWS, Jan. 13, 1997.

entanglements that are recorded in the NPDB and publicly accessible state data banks, these apprehensions present a powerful obstacle to salutary systemic change.

A successful effort to improve the medical errors situation must strike an acceptable balance between the rights of patients and society to obtain information about physician performance and the legitimate confidentiality interests of providers. As long as physicians and other providers live in apprehension that the public, and especially plaintiffs' attorneys, enjoy too ready access (including access through the civil pretrial discovery process) to physician-specific NPDB, peer review,[92] licensure board, and JCAHO records, they will resist most error improvement initiatives. At the same time, any restrictions on the valid informational interests of particular patients and the public, generally, can only be justified by demonstrated, significant improvements in the quality of medical care provided to them by providers whose legal fears have been reduced. One commentator made it clear when he stated, "There is continuing strain between the right of doctors to fairness and confidentiality and the right of the public to information that may be essential to the informed choice of a physician."[93]

CONCLUSION

To a certain inevitable extent, chronic unease may be the price of patient safety. The law, as an important source of chronic unease for most physicians and other health care providers, ought to exert a therapeutic impact overall.[94] In the sphere of medical errors, however, it appears that

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[92]For a strong argument in favor of broad access to hospital peer review proceedings, *see* B. Abbott Goldberg, *The Peer Review Privilege: A Law in Search of a Valid Policy*, 10 AM. J. L. & MED. 151 (1984); Geoffery J. Wright, *Comment, Anatomy of the Conflict Between Hospital Medical Staff Peer Review Confidentiality and Medical Malpractice Plaintiff Recovery: A Case for Legislative Amendment*, 24 SANTA CLARA L. REV. 661 (1984). The confidentiality provisions regarding the federally mandated Peer Review Organizations (PROs) are found at 42 U.S.C. § 1320c-9(a) (1994), implemented at 42 C.F.R. § 476.101 (1996).

[93]Norman G. Levinsky, *Social, Institutional, and Economic Barriers to the Exercise of Patients' Rights*, 334 N. ENG. J. MED. 532, 533 (1996).

[94]On the concept that the law ought to exert a therapeutic impact on patient well-being, *see, e.g.*, LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE (David B. Wexler & Bruce J. Winick, eds., 1990); THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT (David B. Wexler & Bruce J. Winick, eds., 1990); DAVID B. WEXLER & BRUCE J. WINICK, ESSAYS IN THERAPEUTIC JURISPRUDENCE (1991).

physicians' chronic unease, bordering on obsession, about their own exposure to legal liability often has threatened, rather than protected, the welfare of their patients. The health care system's longstanding difficulty in effectively identifying, reducing, and mitigating -- let alone eliminating -- errors, illustrates starkly the limitations of negative reinforcement. Fear of blame and finger-pointing at specifically identified culprits has unduly inhibited attention to the sorts of systemic improvements that should decrease harmful medical errors.[95] To the degree that the law itself is at fault for errors in medicine, it is time for honest re-evaluation, reflection, and revision.

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[95] *Cf.* Jerry Avorn, M.D., *Putting Adverse Drug Events Into Perspective*, 277 JAMA 341, 341 (1997) (today's "industrial vision of medicine has brought with it, along with its many adverse effects, a new way of thinking ...: the conceptualization of health care as a collection of processes interacting within a larger system.").