



Ethical Health Partnerships

Co-creating a better healthcare system for all of us

Patient Injury: An Ethical Partnership Approach

by Dawn J. Liphrott, LCSW

As stated in the article on tort reform, legal medical liability reform is needed to stabilize the system and prevent additional injury to both patients and physicians, but it is not enough. I believe we need to stabilize the system as much as possible, yet at the same time, focus on designing a more fundamental and encompassing framework. How could we create an approach within the framework of ethical health relationships that would include values of responsibility, justice, care and valuing of all partners, compassion, collaboration, respect and integrity?

Relationship is that physical, emotional, and spiritual space between us (Martin Buber). We constantly create the climate of that space by what we say or do, fail to say or do, and the way we speak and act -- individuals and as groups. How do we create a more just and ethical space of relationship for all involved when we are faced with serious injuries caused by the system?

Patient well-being is the purpose of healthcare, and physicians are the primary givers of that care. Nurses are also essential for both the patient and the physician. That core 'relationship space' must be valued and it must be continually supported and strengthened by all that impact that relationship. The health and well-being of physicians and nurses are also essential for quality healthcare to be sustained. Creating more ethical health partnership in this area would involve protection and care of that core. Physical and emotional safety for all is fundamental.

The Medical Liability Tort System:

The initial goals of creating a medical malpractice liability claims process through the judicial system were to compensate victims of injury resulting from negligence or substandard practice, to hold person(s) accountable for damaging actions (or failure to take action), and to deter physicians, nurses and others from committing negligence in the future. However, the current system fails to do all of those things in a fair and efficient way. In fact, in spite of its initial positive intents, it has created additional damage at many levels for both patients and physicians. It is time to create a more ethical approach.

Stages of Addressing Patient Injury:

To me, there are 4 basic phases to address regarding injury to patients:

- 1. Prevent Injury**
- 2. Communicate in an honest, empathic, and open manner**
- 3. Repair, compensate (when appropriate) and support patient and physician through the process**
- 4. Improve the system of care based on what is learned from the injury**

Meaningful reform must include focus on patient safety, acknowledgement of injury to patient with explanation and empathic communication, and prompt compensation limited to medical expense and economic loss not covered by other sources. Both patient and physician should be supported throughout the process of addressing the injury. Through analysis of the factors leading to the injury, changes should be made in the system in order to prevent future injury. This acknowledgement and plan for action should be communicated to the patient.

1. Prevent Injury:

First, each and every partner in healthcare must commit to creating and improving patient safety, each day, in all elements of patient care. By 'partner' I mean individuals and groups; physicians, nurses, technicians, therapists, pharmacists, administrative staff, hospital administration, pharmaceutical companies, government, insurance and health plans, patients and their families.

For several years, extensive data has been collected on medical errors. Most of the focus has been directed toward inpatient hospital care. However, several national associations of medical specialties, national associations of nurses, and other groups have created committees, collected data and some of implemented improvement plans. Patient safety has become a priority at both national and local levels.

System and individual error:

Through the current medical malpractice system, when injury occurs, the focus has been and continues to be on finding the individual doctor(s) and/or nurse(s) to blame and hold responsible for the injury. By the very nature of the legal system, the assumption is that injury occurs because someone was incompetent or uncaring. The attorney for

the patient must work to prove negligence in some way, shape or form. Unfortunately, the accusation, shaming and blaming approach is especially damaging to physicians who are competent and caring.

Are physicians and nurses incompetent, uncaring, and negligent? A few are. In most cities, there are a small percentage of physicians that consistently provide substandard care. Hospital administration and professional regulatory boards need to do a better job of identifying and intervening with those individuals. Intervention may include a range of actions--supervision, additional training/mentoring, or removal from patient care.

While it is easy to blame an individual for an injury, evidence continues to mount that more often than not, errors are caused by breakdowns in the system, not the individual. These same conclusions have been found in other high performance and complex systems like aviation, nuclear power and others. The IOM report, *To Err is Human*, pointed out the obvious -- people will make mistakes, not because they are incompetent, but because they are human. But those other industries have focused on creating and modifying systems to catch the error before it becomes critical and causes significant damage.

Anesthesiologists lead the way in improving safety:

Human performance research shows that factors like prolonged stress, extended work hours, fatigue, reliance on memory lead to error in even the most competent individuals. The American Society of Anesthesiologists have become leaders in the medical field of using a systems approach to improve patient safety. In 1984 they voted to create the Anesthesia Patient Safety Foundation with the goal that no person shall be harmed by the effects of anesthesia. Their purposes were listed as:

- * "to foster investigations that will provide a better understanding of preventable anesthetic injuries;
- * to encourage programs that will reduce the number of anesthetic injuries; and
- * to promote national and international communication of information and ideas about the causes and prevention of anesthetic morbidity and mortality."

They have looked beyond the individual to human performance factors, equipment improvements, standardized procedures and checks, recovery room monitoring, using mental maps and more. They have also focused on the "chain of accident evolution", looking at the linking actions or failures in action that can lead to accidents. As a result, they have dramatically reduced the risk of injury in general anesthesia. It does not mean that errors cannot happen, but the rate of adverse events and serious injury have dropped significantly. Raymond Ownby, MD, professor and director of the Center for Evidence-Based Clinical Practice (CEBCP) University of Miami School of Medicine gives the following example:

"The problem with the individual responsibility approach to understanding medical errors is that it doesn't work. Substantial evidence shows that errors arise in the context of systems that coordinate the behavior of several individuals. Assigning blame to one member of the system is not only unfair, it's dangerous. It ignores the larger context of the error that may be causative, leaving the dangerous system in place so that the same error is likely to occur again to another unlucky clinician.

This problem may be illustrated by an example. In one study of quality improvement in the ICU, investigators found that a substantial number of dosing errors occurred in the context of code situations when tensions were high and lines of responsibility sometimes blurred [15] . The simple intervention of having nurses repeat verbal orders for medications reduced errors significantly, with a consequent reduction in poor medical outcomes. In the individual responsibility approach, the nurse who administered the wrong dose of the medication might have been viewed as the responsible person; in the systems approach, he or she is viewed as one part of the system, comprising physician, other professionals, and the code situation. While it may be gratifying to be able to blame an incorrect dose on one individual, the blaming process wouldn't have addressed the real problem (communication during a stressful event in the ICU).

Similar problems arise when medications are named or packaged in similar ways. Here again, it may be simpler to blame the pharmacist for dispensing the wrong medication, but changing the packaging or name of the easily confused medications may have greater overall impact on errors. Wrong site surgeries can occur when standard procedures to clarify the correct site of surgery aren't in place or aren't followed. Here again, it may be simple to blame the surgeon or nurse for the error, but a consideration of its broader context is more likely to lead to changes in procedures that is more likely to prevent additional errors.

In the systems approach, errors are accepted as inevitable and are used to improve the system rather than punish the individual; they are seen as evidence of a problem with the way care is organized and delivered, rather than as a problem with an individual's character."

(Source: [Medical Error Prevention](#) by Raymond Ownby, MD)

[The High Costs of Wrong-Site Surgery](#) by Karol DeVito, RN, Risk Management Consultant with MagMutual, identifies risk factors and common system causes of error such as absence of checklists, communication errors, incomplete pre-op assessment, etc. that have been shown to be causes that can be addressed system-wide to prevent the

problem.

The good news about system error is that when the patterns and breakdowns are identified, corrections can be developed that can be easily adapted in similar systems. Every hospital does not have to re-invent the wheel. Each may need to adapt, but all do not need to start from scratch. Essentials of corrective programs can be standard procedures in similar environments. For example, medication errors are the leading cause of error in hospitals. Patients sometimes receive medication intended for another patient, or the wrong amount of medication. Medications given in hospitals sometimes interact with medications that the patient is taking prior to admission. Here is the way one hospital identified the breakdown in the system and developed procedures to help reduce errors. [Reducing Adverse Drug Events by Improving Reliability: A Newsmaker Interview With Roger Resar, MD](#)

The bad news with system errors, is that because it is NOT connected to one individual, it is easy in the pressure environment of hospitals for no one to take responsibility for creating and implementing procedures that would correct it. Physicians, nurses and hospital administration need to provide leadership in developing and insisting on specific, immediate and consistent implementation of procedures to correct those common systemic errors that they and others have identified.

Another difficulty with system errors, is that often they are not identified outside of larger systems like hospitals. A competent, caring physician's office may have breakdowns in procedure that create a greater risk for error, yet no one identifies it. Each physician needs to challenge themselves and their staff to look at their systems and procedures, identify and change those areas that contribute to failures in follow-up, notification, and other areas. Again, though time is a major factor, as is thinking systemically, there is an ethical obligation to protect patients in every way possible. However, while it takes time to change, ultimately those changes can save time AND protect both patients and physicians.

National physician and nurse associations need to identify those common sources of system error and develop standard procedures for addressing those common problems. Again, because system errors are often common across a group of systems, common difficulties are more easily identified and more standardized corrections can be developed. Another part of the commitment to creating a safe environment for patients, requires that hospital administrators, physicians, nurses and other healthcare professionals implement standards that can negatively impact human performance, including, but not limited to, number of consecutive work hours, working conditions, using checklists instead of relying on memory, etc.

Ethical health partnership requires action to make the healthcare space of relationship a safe one. Errors will happen, but many patterns of errors can be prevented.

Patients and their families as ethical health partners in patient safety:

In ethical health partnership, patients and their families also have responsibilities, including the responsibility for their role in creating patient safety. Here are ways to do that:

- Provide accurate and complete information at all times to physicians, nurses, technicians and administrative personnel.
- We also must assume OUR part of the responsibility to be informed about medications, procedures and to monitor those things whenever possible. We need to ask questions, and make sure we and our loved ones are getting what they need in the amount they need. (Download suggestions on Medication Safety.)
- Patients also must assume more responsibility for being adult partners with their physicians and nurses as a health care team. Part of that adult relationship means that we need to take more responsibility for true informed consent. This means we need to educate ourselves and ask questions about risks, benefits, common complications or injuries, what will be done to prevent that, and what reasonable expectations of possible benefit . . . knowing that there are always risks . . . and developing reasonable expectations of the degree of benefit. Patients also need to know inform themselves about risks and benefits of NOT having the procedure or treatment before they make their decision.
- Follow-up on test results instead of assuming no news is good news. Some offices will still tell you that they will call you if there is any problem. Don't accept that. Follow-up is also YOUR responsibility as a patient.
- Get copies of your tests and keep a file at home.
- Following treatment and working with our health care team is essential. If you have concerns, or question the value of the treatment, it is your responsibility to discuss that with our healthcare team and if necessary, to get a second opinion, before you stop or change treatment. If you read something on the Internet or in a magazine that causes us to question our diagnosis or treatment, you have a responsibility to ourselves to discuss it with our physician.

- Every day patients put themselves at risk when they decide to stop medication/treatment or decide to take a reduced amount because of expense. When there is hardship to pay for a prescribed medication or treatment, we must assume our responsibility for informing our physician and exploring possible options. Silence or pride can have very serious consequences.

Part 2: When injury occurs -- honest, open and empathic communication--the beginning of repair:

Repair starts with the conversation with the patient about what happened. The current system of adversarial litigation does not promote that human connection and openness about weaknesses in the system. It does not promote a climate where error can be readily acknowledged without fear of potential litigation. And because of that, it does not do anything to promote patient safety or human connection.

When an error with any degree of injury occurs, ethical health partnership requires that physicians inform the patient as soon as possible. Now, many states require it. Communication about the error needs to include the nature of the error or injury, what happened, and what the impact is expected to be. When necessary, a plan of repair or taking care of the injury should also be presented. Physicians need to stay open and non-defensive to patient and family questions, listen without interrupting, and compassionately address their concerns.

Physicians feel regret when injury occurs for any reason, but often find it difficult to communicate both the fact of the injury and their regret. Why? A big reason is that the current medical liability system creates an ever present threat of lawsuit, instructions to not admit anything that could possibly be used against them, even if an injury was not due to error or an error was systemic. Many physicians want to talk to the patient about it, but are afraid to. The physician will play over in his or her head what happened trying to find if there was any way they could have prevented it. Even when they know they did everything possible, they often feel embarrassed. But it is essential for the well-being of both to address the issue directly. Caring, honest communication is actually part of the repair process.

In spite of the understandable fear of a malpractice claim, research has actually shown that having the conversation about error can actually reduce the likelihood of a lawsuit. One of the reasons patients sue is that they are angry that someone has hidden something from them, has not been truthful, or has not expressed care or concern. Failures in communication about the injury and often, even before injury, were determined to be factors in over 70% of one study of medical malpractice claims. (Sources: The doctor-patient relationship and malpractice. Lessons from plaintiff depositions Beckman, H. B. et al, Archives of Internal Medicine, Vol. 154 No. 12, June 27, 1994; Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries, Gerald B. Hickson et al., 267 JAMA 1359 (1992) ; Development of an Early Identification and Response Model of Malpractice Prevention, Hickson, G. B., et al, 60 Law & Contemp. Probs. 7 (Winter 1997).

Help for having the conversation can be found in [A Mediation Skills Model to Manage Disclosure of Errors and Adverse Events to Patients](#) Carol B. Liebman; Chris Stern Hyman Health Affairs 23(4):23-32, 2004. © 2004 Project HOPE. Also, [Communicating Adverse Events: The Art of Apologizing without Admitting Liability](#)--how to express regret that an injury has occurred even when physician is not at fault.) Some states require disclosure of the error to the patient and that is a good thing.

More and more states are passing 'apology laws' that protect a physician or healthcare providers expression of sympathy, compassion, and apology from being used against them in court. In fact 11 states passed such laws in 2005 alone. Some, like Colorado, Georgia and others have passed full apology laws which include protection of statements of responsibility at the time of disclosure and apology. (I will be including a link here to an article on the need for full apology protection.) Research and healthcare systems that have used that approach report better physician-patient relationships after an adverse event, openness about reporting medical error which can improve patient safety, reduced litigation, increased settlements and contribute to a less adversarial nature of proceedings. Some systems, like the VA Hospital system in Lexington, Kentucky combined apology with offer of compensation where appropriate. They also encourage the patient to consult an attorney to discuss the settlement offer to make sure it is fair. They compensate more patients, yet have significantly reduced costs.

Patients want to be treated with dignity, respect and care. Honesty in communication about what happened and in expressing the physician's natural sense of care and concern for their patients is part of the healing process for all involved. At some point, the patient should also be informed about the steps that will be taken to try to prevent injuries in similar situations in the future. Patients want to know that it will be addressed and that the physician, nurses, staff, administration are taking what happened seriously and will work to protect other patients from similar injuries.

Part 3: Repair — compensate and support patient and physician through the process

Compensation, Deterrence and the Current Medical Malpractice Litigation System:

One of the alleged purposes of litigation is to deter the 'responsible party' from committing the 'offense' again. Because most injuries are not the result of negligence or malpractice, even the majority of those actually filed in claims, physicians feel like they, too, are victims of the system. Unfortunately, as often happens in relationship, the positive INTENT of something can have a negative EFFECT. When that happens, instead of insisting on how right we are in intention and sticking stubbornly to our position, we have to take in the reality of the other . . . what happens to the person on the receiving end of our behavior. That is the nature of relationship. It is not just about one person or group. It considers the wellbeing of both. The current medical malpractice litigation system, while having very positive intents, has had disastrous effects on injured patients, non-injured patients, and on physicians, nurses and other healthcare professionals.

Instead of deterring error, the current system has deterred physicians from providing needed and highly skilled services because of fear of risk, or because of the increase in cost of malpractice premiums if they perform those services. (See [Patient Safety - Just Compensation and Medical Liability Reform](#), by Randall R. Bovbjerg, principal research associate in the Health Policy Center of the Urban Institute, and Brian Raymond, a senior policy consultant with the Kaiser Permanente Institute for Health Policy. Sections IV and V discuss patient safety and shortcomings in deterrence, January 2003)

I, one middle-class ordinary person, know one OB-GYN who retired early because he was fed up with excessive paperwork, decreasing reimbursement, and mostly the threat of litigation. I know another OB-GYN who closed her practice because she could not afford to keep it open with the enormous yearly increases in malpractice premiums here in Florida, combined with steadily decreasing reimbursement from insurance. I know an orthopedic surgeon who stopped doing surgery because of the malpractice system combined with decreasing reimbursement. Taking the risk on a daily basis wasn't worth it, emotionally or economically. I know a cardiologist who has stopped doing any surgical procedures for the same reason. So the intent of deterrence has increasingly become the deterrence of good physicians and the restriction of vital care.

Patients are damaged by the fact that many who have been injured and should be compensated for medical expenses that are not covered and for economic loss when indicated, do not have their cases accepted because they are not determined to be strong enough or lucrative enough. They feel betrayed by the system, and by their physicians. Other patients are damaged when they simply want help for hardship that occurs as a direct result of the injury, but do not want to sue their physician because they believe the physician is competent and the injury was not due to negligence. They find themselves having to step into an adversarial position when they just want help. Injured patients who do file are damaged by the lengthy, contentious nature of the process, and the fact that any award is delayed for years from the time of the injury. Patients are damaged by the reactive and blaming emotional climate fostered by the process. Everyone is damaged when the fear of litigation prevents open, honest evaluation of errors and their causes. Everyone is damaged when physicians order tests and procedures based simply on the fear that if they cannot document that they ordered it, it will be used against them. (See the [Fear of Litigation Study](#)) Everyone is damaged when the costs of malpractice threats and litigation cause good physicians to re-locate, close their practices or stop performing procedures that carry more risk. One need only look at the number of obstetricians in their own community who have stopped delivering babies. Patients are damaged even in those few instances where there are physicians who repeatedly perform at substandard levels, have been found guilty of malpractice several times, and yet do not receive helpful intervention or needed discipline by state regulatory boards.

Physicians are damaged when they are unjustly accused. They are damaged when an error, or even a negative outcome or adverse even beyond their control, is turned into an attempt to prove they are incompetent. They are damaged by the fact that to receive compensation, patients must allege that they provided substandard care, when most physicians pride themselves on their care and their competence. Physicians are damaged by a sense of betrayal and extreme stress during litigation that drags on for years. Physicians are damaged when they work with the threat of litigation hanging over their heads at every moment. They are damaged when malpractice premiums increase at rates that are impossible to cover and the practices are jeopardized. They and patients are damaged when they stop providing important procedures to help patients because of the high risk and potential for claims. They are damaged when they cannot obtain insurance because they practice in a high risk specialty or simply have been named in a suit, even if they are later dropped from the case.

Compensation:

As stated above, many injured patients do not and cannot receive compensation under the current system of adversarial litigation. Others are over-compensated for less serious injuries. The administrative costs of the tort system can cost up to 60% instead of the 5%-30% of other compensation programs like Workman's Compensation or Social Security Disability. (Sources: Lawthers AG, Brennan TA, Laird NM, Hebert LE, Peterson LM, et al. *Relation between malpractice claims and adverse events due to negligence. Results of the Harvard Medical Practice Study III.* N Engl J Med. 1991; 325:245-51. [PMID: 2057025]; Weiler PC, Hiatt HH, Newhouse JP, Johnson WG, Brennan TA, Leape LL. *A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation.* Cambridge, MA: Harvard Univ Pr; 1993.)

All of us pay for a very inefficient system.

An Ethical Approach to Repair in Medical Injuries:

When I attempted to find alternatives to litigation for medical injury, I found several proposals.

1. One is for medical courts which would take decisions out of the hands of juries and create a kind of administrative hearing with a panel of medical experts and specially trained judges to better determine whether negligence has occurred. While that may be fairer in some instances to physicians, it does not solve the problem for patients who are injured and cannot obtain compensation. It also does not guarantee fairness to physicians. Physicians are often more judgmental about a colleague's decisions than a jury would be. This is especially true when they know the outcome of the treating physician's care has resulted in an injury. It seems to replace one form of second-guessing with another without solving some of the core issues already mentioned.

Another variation would be a court of specially healthcare trained judges who could hire neutral experts instead of the current 'expert-for-hire' approach. This would be a modification of the current system.

2. Another option presented is arbitration / mediation. While this is better than going straight to trial, can be quicker and less contentious, it still does not address some of the core defects of the tort system. It is still based on individual blame and focused on negligence. I do think it does offer more opportunity for patients and physicians to communicate more effectively about what happened . . . if you have a skilled mediator. Variations of this are early-offer approaches and statewide administrative resolution.

3. A third way is some variation of an administrative compensation system. When I read brief descriptions, I did not think this would address concerns either, but as I've read more, this one makes the most sense to me. One approach to a modified 'no fault' involves 'early offers' by the physician or other person(s) involved. An administrative board system would allow institutional healthcare providers to offer reasonable compensation to injured patients. A good example of a detailed "Early Offer" approach can be found in *A Proposed Remedy for Medical Malpractice Miseries* by Jeffrey O'Connell and Samuel H. McCoy, II, Professors of Law at the University of Virginia. This also seems to be what the VA system uses, as mentioned above.

The second administrative compensation system is what is often referred to as 'no fault'.

No Fault Approach:

In summary no-fault systems have the following benefits:

- * Injured patients have only to show that their disability was caused by the way they were treated, rather than by the actual disease process for which they were being treated. In Sweden, one of the requirements is that the injury was 'avoidable'. Therefore, it improves access of injured patients to economic help for medical and other loss related to the injury. In one study it was estimated that it make 67% more injuries available for compensation in Utah and 95% more in Colorado and yet could be compensated within budgets that are similar to or less than the costs of the current tort system. (Studdert and Brennan, *No Fault Compensation & Error Prevention*)

- * Removes any need to prove negligence.

- * Removes the contentious adversarial climate of attempts at compensation.

- * Creates a climate of openness to identify, discuss and change errors, including near misses, and ways to improve systems for patient safety without fear of litigation for anything said. Provides more transparency on patient safety issues. Studdert and Brennan also point out that the number of claims brought would be larger than incidents reported currently and would lead to root cause analysis of more errors. The responsibility for that investigation would belong to the institution where injury occurred. The results would be forwarded to a central state based agency that would monitor patterns and provide data for patient safety programs.

- * Reduces the frequency of overpayment for less serious injuries.

- * Significantly reduces administrative costs of running the system and obtaining relief.

There is precedent for no-fault approaches in auto accidents, worker injury. Limited no-fault approaches have been used in medicine related to birth injury. There are also no-fault systems in Sweden and New Zealand.

How It Might Work:

In Sweden one of the key elements is that the injury resulted from treatment (not the disease itself) and it was avoidable. There is no need to prove negligence or substandard care. When the injury is determined to meet the criteria, claims are paid in a uniform way by using a fixed compensation schedule which includes both economic and noneconomic damage components. In Sweden, the injury has to be serious enough to have either resulted in 10 or more days of hospitalization or more than 30 sick days. This helps eliminate the minor injuries that would make no-fault approaches cost prohibitive if all were paid.

In trial projects in the United States, they have channeled providers and hospital into one larger entity which created more 'enterprise liability' and also provided a more consistent experience rating (which puts some financial pressure on employers to pursue safety in the whole system). Those with higher experience ratings, pay higher premiums.

According to Studdert and Brennan that would mean that a hospital would pay more in a given year if there was a higher occurrence of injuries and less if quality improvement programs reduced the incidence of injuries. Since most errors are system based, that would be a more sensible approach than the current tort system to blame the individual and claim negligence.

The proponents and researchers of no-fault approaches suggest a step by step approach to reform, rather than a sudden system-wide change. Some of the considerations are outlined in the Studdert/ Brennan article listed below. Some issues that would need to be addressed are the role of existing malpractice insurance carriers, informed consent for patients who participate in a no-fault system and realistic choice alternatives, rights of appeal, etc.. There would also be enormous opposition by those with vested interest in the current tort system. Hospitals and systems who become part of demonstration projects could outpace their competitors by offering patients the chance to both opt out of the current system while having access to fairer system of compensation, and a deeper commitment and willingness to take action to address safety issues in the system. Some trials have limited the no-fault approach to certain specialties. When used in combination with channeling approaches of hospitals and physicians, can provide even greater incentive to do everything possible to promote patient safety.

Explanations of the process, benefits, costs, and more can be found in the following reports:

[Patient Safety and Medical Malpractice: A Case Study](#) Troyen A. Brennan, MD, JD, MPH and Michelle M. Mello, JD, PhD, MPhil, 19 August 2003 | Volume 139 Issue 4 | Pages 267-273 Annals of Internal Medicine
Malpractice Liability and Medical Error Prevention: Strange Bedfellows? Paper Prepared for the Council on Health Economics and Policy Conference on Medical Malpractice Practice in Crisis: Health Policy Options March 2003
Michelle M. Mello, J.D., Ph.D., M.Phil. Article is linked on Kaiser's site at:
http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=796

[Policies to Foster Patient Safety](#) Michelle M. Mello, J.D., Ph.D., M.Phil. Assistant Professor of Health Policy and Law Department of Health Policy and Management Harvard School of Public Health

[Can the United States Afford a "No-Fault" System of Compensation for Medical Injury?](#)

David M. Studdert, Eric J. Thomas, Brett I. W. Zbar, Joseph P. Newhouse, Paul C. Weiler, Jonathan Bayuk and Troyen A. Brennan.† Cited: 60 Law & Contemp. Probs. 1 (Spring 1997)

No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention. Studdert, DM and Brennan, TA, JAMA July 11-2001, Vol 286, No., 2.

The biggest opposition and obstacle to the plan is the lobby of trial attorneys since it essentially cuts medical malpractice claims out of the system. In one attempt in Utah and Colorado to implement a trial project, the primary opposition was led by attorneys. Malpractice insurance companies were also not interested in supporting the reform. (Source: Mello, Michelle M. and Troyen A. Brennan (2002), "Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform," Texas Law Review 80: 1595-637.)

We must not let those obstacles prevent us from working to implement this and other solutions. It makes sense to start on a small-scale basis to determine effectiveness. The well-being of patients, physicians, through more ethical health partnership, even in the most difficult circumstances, must become our priority.

Support of Patient and Physician or Nurse when Injury Occurs:

Physicians and hospitals need to make every effort to provide support for the patient who is injured. That means helping them through the medical process and through subsequent interactions with you in an ethical and compassionate manner. Whether that involves on-going or subsequent care, offering referrals, being available for questions related to the injury, the recovery process, living with the disability, or even informing about changes in procedures that have come about as a result of their injury. Patients need information and caring from beginning to end. They need to know that they matter as human beings and that what happened to them matters.

As stated, injuries to patients can have a profound effect on the physician(s) or nurse(s) most directly involved. These professionals also need systems of support from colleagues, the hospital, and sometimes availability of professional support. In talking with physicians who had been sued, researchers found that the isolation and lack of expressed support by colleagues was a very painful part of the process.

Sorry Works: A Similar Alternative:

Sorry Works! is an Illinois-based coalition just starting a major push for change. The group was started by Doug Wojcieszak, a public relations professional after working on malpractice issues in his work and after losing his brother because of a medical error. He and the family sued to try to find out what happened and trying to ensure it would not happen again. They describe the the main elements of the program as:

- a) Every adverse event is reviewed by hospitals and physicians.
- b) Physicians and hospital administrators meet with patients and families to explain what happened.

c) If a mistake was made, the doctor and hospital apologize and offer the family fair compensation if investigation reveals there was medical error.

d) They also explain how the problem that caused the error will be corrected.

For more information see [Preventing Lawsuits: Coalition Pushes Apologies and Cash Up-front.](#)

4. Improve the system of care based on what is learned from the injury

When injury occurs and the process of repair is accomplished through compassionate communication, speedy compensation, support of physician and patient through the process, there is one more very important step which brings the process full circle -- using the injury to change the system to prevent future injuries of others. Not only does this improve patient safety for all patients, it also helps give meaning to a painful experience for the patient, and sometimes for the physicians or nurses involved in the care of the patient.

Specialties probably already know many of the most common injuries for their particular area. Identifying the most common and creating action plans for reducing those areas are vital and are a proactive way to improve safety, care of the patient, and self-care. For example, if injury to the common bile duct is one of the most common injuries, why is it not a standard of care to use cholangiograms to identify not only stones in the duct, but the structure of the biliary tree to help prevent injury? Or perhaps, there is another way in teaching surgeons the technique of laparoscopic surgery how to reduce risk of that injury.

The Future We Co-create:

It is time for something new, something that transcends what we have instead of simply placing bandaids on it. It is time for fairness and justice for patients and for physicians, nurses and other healthcare professionals. It is time to bring mutual respect, compassion and valuing of all partners back into our relationships and interactions with one another -- even in the most difficult of circumstances. It is time for all of us to act with integrity. We are all responsible for making it so.

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