

# Error, Blame, and the Law in Health Care—An Antipodean Perspective

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Patients are frequently harmed by problems arising from the health care process itself. Addressing these problems requires understanding the role of errors, violations, and system failures in their genesis. Problem-solving is inhibited by a tendency to blame those involved, often inappropriately. This has been aggravated by the need to attribute blame before compensation can be obtained through tort and the human failing of attributing blame simply because there has been a serious outcome.

Blaming and punishing for errors that are made by well-intentioned people working in the health care system drives the problem of iatrogenic harm underground and alienates people who are best placed to prevent such problems from recurring. On the other hand, failure to assign blame when it is due is also undesirable and erodes trust in the medical profession. Under-

standing the distinction between blameworthy behavior and inevitable human errors and appreciating the systemic factors that underlie most failures in complex systems are essential for the response to a harmed patient to be informed, fair, and effective in improving safety.

It is important to meet society's needs to blame and exact retribution when appropriate. However, this should not be a prerequisite for compensation, which should be appropriately structured, fair, timely, and, ideally, properly funded as an intrinsic part of health care and social security systems.

*Ann Intern Med.* 2003;138:974-979.

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See editorial comments on p 996 and pp 997-998.

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Until recently, while people understood that disastrous outcomes can result from avoidable failures in health care delivery, most people believed that these outcomes were fairly isolated events. In the last 10 years, however, reports from several countries have drawn attention to the fact that harm to patients receiving health care is not rare but common, systematic, ubiquitous, and, all too often, severe (1–6).

Much of this harm is attributed to “error,” which in its broadest sense includes systemic problems in the organization of health care (7). However, the term often embraces widely diverse events, failing to distinguish true errors from behaviors that should properly be classified as violations. This failure may extend to behaviors at supervisory, administrative, and political levels—should appropriate root-cause analysis be performed (8, 9).

When things go wrong, the usual human response is to apportion blame, demand retribution and compensation, and seek assurance that the error will not occur again. Such redress is usually done through the legal system. However, less than 1% of people suffering preventable harm receive any compensation through the tort system, and there is little relationship between successful litigation and the degree to which negligent practice has contributed to harm (3, 10).

Theoretically, tort should help promote high standards and provide compensation for injured patients. In practice, it often does neither; is grossly wasteful of resource; and is

time-consuming, threatening, and unpleasant for both plaintiff and defendant. It may be thought that a “no-fault” system of compensation, such as in New Zealand and the Scandinavian countries, would solve these problems. However, whichever approach is used, it is common that neither patient nor physician feels well served and that few initiatives to improve safety eventuate (1, 8, 11). In the Scandinavian systems, approximately half the people who apply for compensation cannot demonstrate the causal connection or fulfill other eligibility criteria; in New Zealand, compensation has been limited in both scope and amount (11).

These problems are largely attributable to a failure within the legal and health care systems to understand the causes of system breakdowns, and attribute blame when none is due or to obtain compensation through tort (11). In this paper, we consider the concepts of error and violation, the proper attribution of blame, and the role of the legal system in health care, and we outline some of the approaches that are being considered in several countries.

## ERRORS

Health care is an unusually complex system. Some features that predispose to errors and aggravate their consequences coexist and interact to a degree that is seldom found in other human endeavors. These features may not only set the stage for incidents and accidents but may be

\*Steven Small, MD, participated in the early stages of the series on Patient Safety and the Reliability of Health Care Systems.

the prime causes (3, 8, 9). Health care is delivered in a dynamic environment with complex interactions between pathophysiologic and disease processes, medical staff, infrastructure, equipment, and policies and procedures (9, 11). Challenging procedures must be undertaken, sometimes under circumstances that are not chosen or controlled by those at the “front line.” While this is mostly successful, errors do occur.

There are several definitions for the term “error” (1, 9, 11). We propose “the unintentional use of a wrong plan to achieve an aim, or failure to carry out a planned action as intended.” An important feature of this definition is its focus on the thoughts and actions involved—not the outcome.

Errors are intrinsic to normal cognitive processes (8, 9). Moreover, an error thought to be preventable in an individual case may, in fact, be statistically inevitable in the career of a physician (12). Giving one drug to one patient correctly seems simple, but for an anesthesiologist, administering a half-million intravenous injections during an entire career, often under difficult circumstances, without ever making a mistake is almost impossible without technologic support systems (13).

The consequences of errors may be severe, and such failures should not be accepted simply because they reflect an intrinsic human characteristic. However, it is irrational and unjust to hold an individual who makes a genuine error while trying to do his or her best morally culpable (11). Berwick stated that “every system is perfectly designed to produce the results that it does” (14). The solution to error lies not in accountability or punishment for individuals (although these have a place) but rather in re-designing the system to reduce the risk for error and limit and manage the consequences when errors occur (1, 3, 7–9).

Designing health care systems specifically to compensate for the propensity for error on the part of physicians has, at least until recently, run counter to a powerful medical culture that led physicians “to expect to function without errors” and to “view error as a failure of character” (15). This reluctance to admit error, coupled with advice from insurers that nothing should be said to injured patients, for fear that it be taken as an admission of liability, led to a conspiracy of silence that inhibited the development of systemic safety approaches and has had a corrosive effect on trust in the medical profession.

A prerequisite for making systems safer is understanding why and how errors occur. Because most of the things that go wrong occur infrequently (3, 16) and few data about system failures or human error are recorded in the medical record (17), information has to be gathered after the event. Eliciting detail about contributing factors in incident reports dealing with “near misses” or events with only minor outcomes, as well as by root-cause analysis after serious or “sentinel” events, is vital to find out not only what is going wrong but how and why these problems are

occurring, so that appropriate preventive and corrective measures can be devised (3, 7, 18). If those who provide this information are personally and professionally threatened by the very process necessary for the solution of the problem, the information will not be forthcoming. Separating the processes for accountability and system improvement and the importance of a “blame-free” environment for the latter are discussed later in this paper (11). Making some errors is normal and inevitable. Most individuals who make errors are not morally culpable, and outcome is a poor index of moral culpability.

## VIOLATIONS

Violations are quite a different matter—while errors are unintentional, violations are deliberate. A violation may be defined as “a deliberate—but not necessarily reprehensible—deviation from those practices appreciated by the individual as being required by regulation, or necessary or advisable to achieve an appropriate objective while maintaining safety and the ongoing operation of a device or system” (11). Again, the definition focuses on the mental state and actions involved—not on the outcome. Violations are common in all human activities—exceeding the speed limit while driving, for example. Speeding is not usually an error (although it may be) because the driver usually chooses to break the rule. There is no intention to harm associated with most violations—the operator believes that the violation will produce a successful result, and it often does (getting to one’s destination more quickly, for example). Violations may even be necessary at times—for example, speeding may be justified in an emergency (9). Sometimes they are forced on people by the system—working beyond safe limits in the case of junior physicians, for example.

However, violations increase the risk for error, or for the consequences of error (speeding and drunk driving are obvious examples). Furthermore, violations are always deliberate, and they can be avoided by choice. For example, hospital management could choose to organize their services to avoid excessive physician fatigue. In contrast to error, harmful violations might be prevented by deterrence, provided the deterrent measures are well targeted. Punishing a junior physician for making an error after the violation of working excessive hours was forced on her by the system would be wrong, even if the patient died, as in a notable Irish case (19). On the other hand, prosecuting the hospital authorities for corporate manslaughter might produce desirable change.

Strategies to reduce violations (and some errors) include automating tedious checking, documentation, and monitoring tasks and improving compliance with protocols by ensuring that they are appropriate, flexible, and readily accessible. Continuous monitoring is necessary after such changes because each change will offer opportunities for new problems (3, 8). Strategies at the system or health

care level include setting appropriate standards for safety and quality and making proper compliance a condition for accreditation; currently, some gross violations of industry standards are the norm in sections of health care (working hours, for example).

### BLAME AND THE LAW

Before the Industrial Revolution, the law had generally considered that people were strictly liable for harm that was caused by their actions; they would be punished and would have to compensate the wrong. However, with the burgeoning of new industries and risks, concepts of strict liability were seen as an inappropriate brake on the innovation of the new entrepreneurs and the view became that there should be “no liability without fault” (20). This was the birth of the concept of fault as an essential component of the tort system (“tort” is derived from the word “wrong” in Latin).

In practical terms, fault implies blameworthiness. Blame is of major emotional significance to those blamed, and people wrongly blamed have a powerful sense of being the victims of injustice. Some lawyers dismiss the distress of physicians publicly and formally declared negligent for their role in a medical disaster as simply being a manifestation of epistemologic naiveté—in legal terms, negligence does not imply moral perfidy, only that there was a failing in the duty of care that led to harm. However, inappropriate attribution of blame inhibits open disclosure to both victims and those in a position to rectify antecedent causes, and may harm health care professionals, seriously impede patient safety initiatives, and damage physician–patient relationships.

Blame is a deeply rooted human response to harm, particularly in health care, where the patient expects that he or she will be helped. Again, several features of health care may considerably influence the propensity for and appropriateness of blame.

One of the most powerful is “outcome bias.” We have argued that outcome is a poor index of blameworthiness. Unfortunately, the tendency to relate blame to outcome is common in the community. It has been conclusively shown that a finding of substandard care is much more likely when harm is severe, quite independent of any consideration of compensation (21).

Because blame is one of the “gates to entitlement” to compensation in the tort system, there are often powerful incentives to attribute blame. These may be particularly strong when the victim is young, has dependents, or is in a situation where social security and other support systems are unavailable or poorly developed. This incentive is less in Sweden, for example, where assistance is readily obtained outside the compensation system.

There may also be a strong desire to punish a physician and, in most countries, initiating tort directly achieves this. The need to blame and punish for egregious acts is

not negated by mandating a no-fault system. In New Zealand, the failure to recognize this resulted in people resorting to the criminal justice system (11). This desire to blame and punish is more likely if a patient was not properly informed about material risks or could not fully participate in the decision to proceed, if the physician seemed not to care and did not express regret, or if the problem was not acknowledged and there seemed to be no attempt to prevent the problem from recurring (8, 11). There is no doubt that public blaming (“naming and shaming”) through a finding of negligence is an extremely powerful punishment that strikes at the heart of the professional’s self-image as a caring and competent physician. Thus, such retribution should be exacted only when appropriate.

The relationship between levels of blame and a legal finding of negligence is complex. Five “levels of blame” have been proposed (11). However, legal negligence can be found in circumstances where the error was statistically inevitable, there was no intention to harm, and there was no moral culpability. In this context, a finding of “misadventure” would ameliorate unjust retribution but still allow for appropriate compensation, with only a change in terminology. Although the law does not, in theory, require perfection from a health care professional, failing to recognize the intrinsic limitations of the human condition in the context of an event, outcome bias, and desire to compensate may, in practice, lead a judge or jury to attribute blame where none is due.

Even when violations are involved, there may be circumstances that mitigate against blaming individuals. Many health care professionals are required to work, at least occasionally, under conditions they would rather avoid. Physicians who have to work a full day after being up all night and nurses who have to work back-to-back shifts are not uncommon. Such exploitation of the intrinsic altruism of health care professionals by institutions or corporations is widespread. In reality, the violations are by the corporation, and more attention should be given to demanding organizational compliance with appropriate standards.

Wrongly blaming health care professionals is very damaging. Measures to pre-empt or minimize blame include properly informing patients about the risks and benefits of what is being proposed and involving them in the decision to proceed. If a problem does occur, full early disclosure of all relevant details, an apology, and help with immediate support and getting compensation will mitigate against blame, anger, loss of trust, and litigation.

At an organizational level, the process for ensuring accountability must be dissociated from that for obtaining the necessary information for system improvement. Organizations need to articulate the difference between behavior that is culpable and unacceptable and will not be tolerated, and behavior that, although perhaps in error, is more understandable and will be encompassed within a system of self-reporting and detailed analysis. Such systems have been

**Table 1. Comparison of Features of the Systems for Responding to Iatrogenic Injury in Some Countries\***

Country (Reference)	No-Fault Compensation	Tort Litigation	Mediation Used	Structured Settlement	Capped Awards	Open Disclosure
Australia (25)	Proposed†	Yes	No	Proposed	Proposed	Proposed
Canada (26, 27)	No	Yes	Tort litigation reform considered 1998		No	No
New Zealand (24, 28)	Yes	No‡	Yes§	Yes	Yes	No
Scotland (29)	Proposed	Yes	Yes	No	No	No
Sweden (29, 30)	Yes	Yes	NA	Yes	Yes	Yes
United Kingdom (30)	Proposed	Yes	Yes	Proposed	Proposed	Proposed

\* NA = not applicable.

† Although proposed at a national summit, initial steps have been limited to tort law reform.

‡ Eligibility for no-fault compensation prohibits tort litigation; other cases can litigate. In theory, action for exemplary damages remains possible, but the threshold is very high.

§ A Health and Disability Commissioner was appointed in 1994.

|| Schemes similar to that in Sweden exist in Denmark, Finland, and Norway.

developed independently by the U.S. Department of Veterans Affairs and the Australian Patient Safety Foundation, which enable the separation of the processes for accountability and for “system learnings” (3, 22). The provision of an appropriate system of anonymous or confidential and legally privileged reporting takes nothing from the rights of patients but adds a powerful tool for making health care safer (23).

Ideally, legislation to protect the confidentiality of individual reporters and institutions engaging in quality- and safety-improvement activities should be developed. Although such legislation exists in Australia at both federal and state levels, there are moves to unify and strengthen it (3). Such protection is patchy in the United States, of limited applicability in New Zealand, and nonexistent in the United Kingdom. Removing the need to find blame in order to award compensation, combined with clear systemic responsibility for effective system changes to prevent recurrence, may ultimately be vital foundation stones with which to fundamentally improve the health care system.

## COMPENSATION

The theory of distributive justice argues that the main purpose of tort law is to work out how the costs of losses should be borne. It moves them from the harmed patient to a wider group—this same theory underpins the “mutuality” concepts of insurance and medical defense. However, it is neither easy nor inexpensive for a patient to bring a successful claim in tort, and the tort system serves a tiny fraction of people who have been harmed (10). As such, it can reasonably be argued that, in this respect, it has failed.

In New Zealand, in response to these deficiencies in the tort system, a 1967 inquiry identified five principles: community responsibility, comprehensive entitlement, complete rehabilitation, real compensation, and administrative efficiency. In New Zealand, the cost of compensating all injuries and rehabilitating the injured was placed on the community, originally on a no-fault basis. Regrettably, the scheme has changed several times, and, recently, fault has been reintroduced, with a requirement to determine the presence or absence of so-called medical error (essentially, negligence) as one of two gateways to compensation

(the other is that the problem must be “severe” and occur less than 1% of the time) (24).

In this respect, the Scandinavian approach may be preferable. The social security system picks up the bulk of care costs, medical costs, and compensation for lost earnings, and a no-fault scheme tops up a lump sum for full compensation; the right to sue is retained. However, very few patients opt to sue because the compensation payable under the statutory scheme already uses common-law damage assessment principles without the need to show fault.

A system with combined no-fault and fault-related benefits has been proposed in Australia. This would remove the care costs from the tort system and provide health, rehabilitation, and care services on an ongoing basis; a single lump-sum payment for these costs is a poor way to adequately and effectively meet these needs. However, the tort system would remain for noneconomic loss and lost earning capacity. Unlike the Scandinavian approach, where social security remains the first port of call for loss of earnings, the Australian system requires the money to come from the compensation payers. Unfortunately, this will retain an incentive to attribute blame where this may be unjust to the health professional.

There is considerable activity in these areas, as evidenced by the initiatives proposed or under way in some countries (Table 1) (25–31). The Australian Council for Safety and Quality in Health Care has initiated several projects to develop national standards to improve patient safety (Appendix Table, available at [www.annals.org](http://www.annals.org)) (32). Unfortunately, even with such reforms, piecemeal “Band-Aid” solutions to the problem of providing reasonable compensation may be adopted; it has happened in New Zealand and will happen in Australia (25, 28) if the fundamental systems remain blame-based or changes are limited to tort law reform (25). We agree with Studdert and Brennan—“the patient safety reforms spurred by the IOM [Institute of Medicine] report are on a collision course with the medical malpractice system” (33).

## CONCLUSION

Current malpractice systems attribute blame when none is due, place enormous obstacles in the path of those

Table 2. Key Points

The term "error" often embraces widely diverse events, with a failure to distinguish true errors from behaviors that should be classified as violations.
Making some errors is normal and inevitable; most are not morally culpable, and outcome is a poor index of moral culpability.
Blaming and punishing for the inevitable errors that will be made by well-intentioned people working in health care drives the problem of iatrogenic harm underground and alienates those who are best placed to prevent such problems from recurring.
Failure to assign blame when it is due is also undesirable and erodes trust in the medical profession; there must be robust mechanisms for dealing with practitioners or units whose performance is unacceptable.
The tort system has been a major driver of these problems—it has effectively inappropriately apportioned blame, thus inhibiting system-wide improvements, while compensating less than 1% of those harmed by health care.
There is little relationship between successful litigation and the degree to which negligent practice has contributed to harm.
As some preventable iatrogenic harm is inevitable, it should be regarded as an intrinsic part of health care and compensation should be quick, equitable, fair, and timely.
Fundamental reforms are required away from tort and toward mediation and transparency for a just system that is fair to both patients and health care professionals.

seeking compensation, inhibit system improvement, and are associated with inadequate responses to unacceptable behavior or performance (Table 2). Current no-fault systems have unfair barriers to access and have been criticized for not adequately promoting system improvements.

Several influential commentators have been highly critical of the negative effects of the tort system on clinical medicine and the physician–patient relationship (8, 11, 22, 33, 34). The attributes of a fair system have been outlined (11): 1) Patients who have been injured during health care should have timely access to adequate support, rehabilitation, and compensation without the burden of proving negligence. 2) The improvement of safety within the health care system must be a priority. 3) There must be effective systems for the early identification and control of those physicians (and other health professionals) who are grossly negligent, incompetent, or impaired. 4) There should be a more sophisticated understanding of the nature of error and a less punitive approach to those conscientious and competent physicians who, in the course of a medical career, will inevitably make a mistake at some time. 5) The adversarial response to accidents needs to be replaced with a climate in which trust between physicians and patients is re-established, the role of blame is reduced, and the focus is placed on cooperation.

Studdert and Brennan (33) have proposed a virtually identical range of reforms. Preventable iatrogenic injury is an inevitable, intrinsic component of health care, and whoever pays for health care should also pay for the things that

go wrong—albeit with some financial incentives for practitioners and facilities to continuously strive to improve their performance. The system for investigating and responding to these problems should be blame-free and afforded qualified legal privilege. To balance this, patients must be fully informed at all stages, and there must be robust mechanisms for dealing with practitioners or units whose performance is unacceptable. The attribution of blame could then be limited to those individuals or corporations responsible for unequivocally egregious acts. This will require fundamental reforms away from tort and toward mediation and transparency but will lead to a just system that is fair to both patients and health care professionals.

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**Acknowledgment:** The authors thank Dr. Klee Benveniste for conducting the literature search on open disclosure, mediation, and tort law reform in various countries.

**Potential Financial Conflicts of Interest:** None disclosed.

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**Appendix Table. Patient Safety Initiatives of the Australian Council for Safety and Quality in Health Care\***

Develop patient safety standards in core areas, such as open disclosure and credentialing.
Work with stakeholders to develop national actions for reform of standard setting and review processes.
Develop strategies to ensure acceptance and uptake of standards and guidelines.
Produce a national template to improve understanding and administration of qualified privilege schemes.
Implement a national approach to serious adverse events and coordinating action to improve system learning.
Maximize the value of existing mortality or morbidity data sets to better understand system failures.
Develop and promote tools and resources to improve collection and use of patient safety data by health care services.
Develop national specifications for incident reporting and encourage greater participation and reporting.
Develop a national "snapshot methodology" to improve the capacity to measure rates of adverse events and trends as indicators of patient safety.
Continue work on key safety and quality terms to ensure greater consistency in the use of safety and quality terminology.
Develop and implement national standards for open disclosure.
Provide reliable information to consumers about health care safety.
Facilitate a national approach to consumer reporting of adverse drug events.
Better use of complaint information.
Work to improve the uptake of electronic prescribing tools that have been shown to effectively reduce medication errors.
Promote the development and uptake of local initiatives to improve patient safety through the Safety Innovations in Practice program.
Improve undergraduate, postgraduate, and continuing education and training for health care professionals by developing core curricula and national education strategies on patient safety.
Build a strategic research agenda for evidence-based safety improvement.

\* There are several projects relating to specific areas, such as falls, adverse drug events, and nosocomial infection. Data obtained from Kennedy (31).