

## **The Great Disconnect**

One of the greatest changes in modern medicine is the patient safety movement. It is difficult to date the genesis for this approach to medicine, but the George Washington, of sorts, was Lucian Leape, M.D. Prior to joining the faculty at Harvard in 1988, Lucian Leape was Professor of Surgery and Chief of Pediatric Surgery at Tulsa University School of Medicine and the New England Medical Center. Many say the patient safety movement began with Dr. Leape's article, "Error in Medicine," published in the Journal of the American Medical Association in 1994.

A number of major corporations who pay big health insurance bills came to the realization that the best way to reduce those bills was by making the delivery of medicine safer. Medical and hospital expenses are high for a number of reasons, but the two leading causes are the costs of pharmaceutical and medical devices and the amount of money that has to be spent on a patient who suffers bad medical care. For example, the cost of treating hospital-acquired infections alone is so high that a reduction in hospital-acquired infections to zero, which is theoretically possible, would solve the problem of high health insurance premiums in this country. When a patient acquires a MRSA or staph infection because the doctor has not properly scrubbed or because a nurse has not washed her hands, the cost of sophisticated antibiotics and hospital care is astronomical.

It is ironic that most cases of infection never lead to a lawsuit. The reason for that is that medical liability claims are adjudicated based upon the current science. Medicine has come to accept needless hospital acquired infections as the standard of care, and hence there is frequently no claim or cause of action for those horribly maimed by infections acquired during a patient's hospital stay. The old adage is true that where there is only a carrot, in the way of additional payments for medical care, without a stick, there is little incentive to promote safety.

Pennsylvania was the first state to create a Patient Safety Authority. If Lucian Leape was the Moses of the patient safety movement, then the 1999 Institute of Medicine study, "To Err is Human; Building a Better Health Care System" was the Bible. The IOM study recommended the creation of a national patient safety authority, which never occurred. However, Pennsylvania did create such an authority in 2002. Trial lawyers demanded that if additional barriers were going to be created limiting medical liability claims, at the very least safety in hospitals ought to be a priority.

The message of the apostles of patient safety was that non-punitive measures will prevent needless medical errors. Mistakes are said not to be due to human error but rather are “systemic.” The new paradigm was to shift patient safety away from disincentivising bad care in favor of creating better institutions. The theory goes that if people who deliver health care services are well trained, properly coordinated, and are not financially responsible for their behavior, better care will be rendered. This all sounded good, but it is counter to human nature and it treats medical health care providers as cogs in a well-oiled machine. The truth is that medical care is delivered by real people, some of whom are incredibly dedicated and others of whom only see dollar signs. Some of those who work in medical offices and hospitals have only the best interests of their patients in mind and would not hurt a fly, while others believe they sit at the right hand of G-d.

The patient safety movement has discovered that an efficiently run hospital with non-punitive measures for “no harm events” is no substitute for paying the freight when neglect causes harm to patients. The two systems must coexist or the goal of patient safety to deliver better health care at a lower cost will never be realized.

Whenever I speak to groups I ask for a showing of hands as to how many medical malpractice cases have been filed in Pennsylvania in the last year. In the last 10 years that I have done this, no one has come close to the real average number. That number currently is approximately 1,500 per year. In that same year, the Pennsylvania Patient Safety Authority received 230,000 reports of incidents (no patient harm) and serious events (patient harmed). Therefore it is quite evident that only one half of one percent filed a claim in Pennsylvania who have been subject to incidents or serious events.

The question is often posed as to why the focus has to be on individual practitioners rather than systemic failures. If money is properly to be paid for harm caused to patients because of neglect, why not hold the institution responsible which has failed to create an environment of safety? In a recent case, I discovered that a hospital failed properly to maintain its x-rays or to properly teach and drill its doctors and nurses on the simple and common art of resuscitation. As a result of this, a salvageable baby, who had pneumonia but whose organs were otherwise in good shape, died shortly after birth. Why not hold a hospital responsible for the failure to train, rather than a doctor who may incompetently handle the resuscitation? The answer is one of philosophy, but also one of law.

In Pennsylvania, there exists the Pennsylvania Peer Review Protection Act. All states have the same or similar laws. These laws say that hospital proceedings to learn about the competency of doctors and to develop information about competency levels

must all be kept secret. This secrecy renders almost impossible the ability to pursue a corporate systemic claim. If one cannot find out why an infection committee has failed to reel in sloppy, non-compliant behavior, how is it possible to show that Act 52, Pennsylvania Healthcare-Associated Infection Prevention and Control Act, has been violated? States like Pennsylvania legislate and regulate various ways to achieve safety and then deny to victims the ability to prove that those guidelines and protocols were never met.

There is, in the medical liability sphere, a total disconnect between the goals of patient safety established by private industry and organizations like the Patient Safety Authority with the lack of transparency which the law protects. While the medical community is passionate about its right to hide mistakes under heaps of laws creating artificial immunities, nondisclosure and secret committee meetings, patients still struggle to secure a safe hospital environment.

In every state in America, a neglectful driver who runs a red light pays a cost even if he or she injured no one. It is only in the arena of medical care that we protect shameful neglect by keeping the closet door locked. It stands to reason, that if we expect little from the medical profession, keep their mistakes secret and reward large, profitable insurance companies and hospitals with the ability to hide from the truth, we will have an ever expanding health care bill and very little accountability. That is the current situation, and it seems only to be getting worse.

Doctors often write emotional letters to the editor and appear at legislative hearings, decrying the stress of litigation in connection with medical liability claims. Yet, those same doctors, through their insurance companies and hospitals, frequently turn their backs on mediation, arbitration and other less painful ways of judging the adequacy of medical care. Even worse, those doctors and hospitals could avoid painful trials in court if peer review and hospital machinations were no longer hidden from the public. Mushrooms and other poisonous things grow in damp, dark, dirty places. If consumers had a true report card on hospitals, just like Consumer Reports does for cars, people could know where to shop. The hospitals that support patient safety and punished wrongdoers, would have more business. There is very little incentive in the current system for hospitals or doctors to be safe, where there is much more often than not no slap on the wrist and no cop on the beat.

The Pennsylvania Department of Health, like most state departments of health, is completely ineffective. Those administrative organizations have neither the money nor the time to do anything about patient safety. If a doctor is arrested for selling cocaine or is convicted of a felony, it is likely they will lose their license. If, on the other hand,

the doctor is completely incompetent, neglectful or inept, he or she is likely to be a multi-millionaire if that doctor's personality brings the patients in. One of the saddest jobs I have is to tell people all the time that the medical licensure board and the Department of Health will do and can do nothing about bad behavior and patient harm that should never have occurred.

The great disconnect is that doctors celebrate organizations and laws which are "non-punitive," meaning that one may receive an education when bad medical care is provided, but a curtain of secrecy then descends. In the legal system, accountability and responsibility rule the day, with the negligent party making whole those who have been harmed. These two systems should not be in conflict. Where an incident occurs that does not harm a patient, private reprimands and teaching opportunities are appropriate. However, it is counterproductive to protect institutions that provide bad care because sooner or later it will lead to serious patient harm. Under our system of laws, as old as the Bible itself, remuneration to those harmed by neglect serves both the individual interest and encourages safer institutional behavior.

Clifford A. Rieders, Esquire  
Rieders, Travis, Humphrey, Harris,  
Waters & Waffenschmidt  
161 West Third Street  
Williamsport, PA 17701  
(570) 323-8711 (telephone)  
(570) 323-4192 (facsimile)

Cliff Rieders, who practices law in Williamsport, is Past President of the Pennsylvania Trial Lawyers Association and a member of the Pennsylvania Patient Safety Authority. None of the opinions expressed necessarily represent the views of these organizations.