The Right Intentions: Errors and Accountability

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Long ago, American medicine somehow decided to "outsource" its quality improvement activities to the legal profession. Under the supervision of the courts, physicians have allowed their education in the identification, analysis, and correction of errors in medical practice to be clouded by intimidation, threat, and fear. Patients have been trained to run to lawyers and journalists, not to medical authorities, when a course of treatment goes amiss.

Under the rubric of "malpractice," legal adversaries obscure the distinctions between error, luck, tactical judgment, biological variance, negligence, fraud, and other sources of adverse outcomes. Despite some intriguing initiatives that seek alternatives to the "catch `em and shoot `em" approach, our current attitude toward errors in medicine is to direct all attention to the 2% of cases at the low end of the bell curve, and to ignore the huge body of unexamined practice that "gets by." Most distressingly, there is a persuasive body of data to suggest that the outcomes of malpractice cases are essentially divorced from the truth about physician fault, or lack of it.

The malpractice approach to quality assurance has not been as effective as we would wish. It has not given us a systematic context in which to understand any outcomes, let alone adverse ones. It has not helped identify the major preventable errors in medicine, nor explained which are not preventable, and why. It has not recorded the incidence and prevalence of medical error, by specialty, region, or patient characteristics. Worse, it has not offered solace or compensation to the victims of unavoidable adverse outcomes when they have been unable to obtain satisfaction in a legal jousting match.

In a rational world, doctors and lawyers—and patients, which we all are—would share a taxonomy by which adverse events could be clearly cataloged and reported. We would collect data on patterns of errors in every setting, and develop training programs, warning signals, checklists, simulators, backups, and other systems to reduce their incidence and damage. Our creativity would be directed at inventing new devices to trap errors before they create harm. We would warn interns on their first day about the top five errors to avoid in the coming year. We would know which patient characteristics and behaviors provoke accidents. And, in a better world, aware that unanticipated consequences are inevitable in the most perfectly designed systems, we would make sure that our health care system would automatically compensate victims of adversity, without forcing—or indulging—them to seek their consolation through the tort system.

Sadly, this better world is as remote as the Hale-Bopp comet. Instead, the study of errors in American medicine occupies a dim, nether region of ignorance and shame, where open discussion invites persecution. Our greatest adversaries, ironically, are sometimes the attorneys retained to defend health care professionals and institutions from claims. For many of these protectors, even to use the term "error" creates a disadvantage in the tactical world of torts. To them, analyzing "causes" and "preventability" can be tantamount to giving away the case.

To repair this absurd situation, coolheaded leadership is needed. The paper in this issue of the *Journal* titled "Adverse Events in Primary Care Identified from a Risk-Management Database" by Fischer et al[1] represents an important contribution to this emerging enterprise. The research of Fischer and colleagues represents the new objective approach to errors as phenomena instead of markers of moral turpitude.

The authors' statistics suffer the shortcomings of a young field. They inspire a slew of questions that the design of their study cannot resolve. Great caution must be exercised in trusting any inferences from their statistics because of the biases and shortcomings of the risk-management database they used. Nevertheless, despite skepticism about the numbers, the intentions of the authors are sterling. Efforts of this sort are essential to establish a baseline from which to begin to infer the "normal" prevalence of

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errors in medicine, and to attack them in a constructive way.

The miasma overshadowing attempts to discover a "true" rate of errors derives from the tactics of lawyers on both sides, the current condition of popular journalism, and the steadfast denial by health care professionals. Speculating about which errors are "avoidable" will be unproductive until errors are viewed as dispassionately as microbes—hazards to be classified, counted, compared, understood, and ultimately controlled.

The greatest handicap of research in this field is the lack of a standardized taxonomy for the reporting of adverse outcomes. This deficiency does not escape the authors' notice, but they rely on a risk-management database designed for litigation control and which was hampered by numerous deficiencies.

There is no doubt that medicine is capable of devising a useful taxonomy that would suit this purpose better. A number of schemes for classifying medical errors are in use or in development nationwide. The Physician Insurers Association of America has long used a standard, though rudimentary, claim reporting form. The United States Pharmacopeia, the New York Hospital Association, and Eindhoven University of Technology in the Netherlands, among others, are currently at work on error taxonomies of greater and lesser breadth. One of the most sophisticated is a multi-axial system, under development since 1989, at the Copic Insurance Company of Colorado. The AMA's newly constituted National Patient Safety Foundation considers a taxonomy of errors one of its initial priorities.

Collaboration, it is hoped, will succeed in producing an "International Classification of Errors" ("ICE-1"?) sometime soon. This will be the cornerstone on which to build a scientific study of medical error.

But no reporting system can be used or taken in good faith without a sanctuary where adverse experiences can be objectively investigated and discussed, free from journalistic harassment and the exploitation of litigators. The chief obstacle to instituting a constructive "error reduction" initiative in health care is the tort system. Solving this monumental problem is the sine qua non of medicine's moving from the age of mysticism and alchemy into a happier world of evidence-based practice. Without a legal sanctuary, the study of the causation of medical outcomes cannot proceed, and science is stymied, as in Galileo's time, by paranoia and superstition.

Fischer and associates have correctly indicated some paths along which future work should proceed. It is urgent to discover the causes of medical errors. It is mandatory that we adopt and refine a uniform taxonomy for the reporting of adverse medical outcomes that is distinct from "risk-management" or tort claims systems. It is necessary for the reporting and study of errors to devise incentives that do not have punitive implications. Above all, it is necessary to reform the gridlocked malpractice industry, which in its present form constitutes an intolerable impediment to the identification and control of medical errors.

REFERENCE

1. Fischer G, Fetters MD, Munro AP, Goldman EB. Adverse events in primary care identified from a risk-management database. J Fam Pract 1997: 45:40-6.