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A missed opportunity: new guidelines avoid the central issue

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In this issue

The new end-of-life guidelines from NSW Health have been long awaited. In the first of our three articles it is argued that, though in many ways they will be useful to health care practitioners, and to patients and their families, they side-step the critical issue: an explanation of the legitimate limits to medical endeavour.

In recent years, hospitals and other health and aged care facilities have welcomed the assistance not only of clinical ethics committees but also of individual clinical ethicists. Stephen Buckle reviews a new book in which it is argued that clinical ethicists should see themselves less as consultants with specialist knowledge of ethically-sound practice and more as mediators between parties who are in conflict with each other.

And we reprint an article by Fr Kevin O'Rourke OP in which he argues that, in the midst of efforts to correct systems failures which result in medical errors, the best protection against error remains the doctor's traditional sense of professional responsibility.

For some years, Terry Schiavo's personal tragedy was deepened by arguments between her parents and her husband and by battles between politicians and the judiciary in her home state of Florida. Had this happened to her in New South Wales, would she have been better served? I fear not. For, though they remind health care practitioners to avoid life-sustaining treatments which are inappropriate, NSW Health's recently-released *Guidelines for end-of-life care and decision-making*¹ contain nothing to help people – patients in hospital, residents of nursing homes, doctors, nurses, family, etc – to judge whether a life-sustaining treatment would be inappropriate. Let me explain.

The *Guidelines* rightly point out that there is a great difference between euthanasia and assisted suicide on the one hand and lawful decisions to limit treatment on the other. They rightly point out that euthanasia and assisted suicide both involve the intention to end a person's life. They rightly point out that euthanasia and assisted suicide may be accomplished by either an act or an omission (by doing something or by failing to do something). And they rightly point out that euthanasia and assisted suicide, as well as being crimes, are inconsistent with the duties

of a doctor. But they never give a *principled* reason as to why some decisions to limit treatment are perfectly good medical practice and perfectly legal (or, in the words of the Guidelines 'appropriate') in NSW. And so they leave open the possibility that 'appropriateness' might be decided on irrelevant grounds: say, what would satisfy a demanding but self-serving relative, or what would balance a hospital's budget, or ... etc.

Of course, there are *various* ways in which the key idea – that sometimes a life-sustaining treatment may reasonably be judged to be 'inappropriate' for a particular patient – might have been explained. The one I happen to know best is found in the *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia* which says that a treatment may legitimately be forgone if it either makes no significant contribution to cure or improvement or if the benefits hoped for do not justify the foreseeable burdens of treatment. No doubt there are other explanations of this idea which is intuitively known by experienced doctors. My point is that, on their own, the words 'appropriate' and 'inappropriate' will tell an *inexperienced* doctor nothing.

The explanation that I have just given, as with *any* sound explanation of the idea that there are *proper limits* to medical endeavour, needs both unpacking and application in particular circumstances. Just what are the benefits and the burdens of medical treatment *in general*? What are the benefits and burdens of artificially-supplied nutrition and hydration *specifically*? How are these things to be assessed, and by whom? In what ways do the hopes and desires and fears and expectations of individuals (and, indeed, the *past* hopes and desires and fears and expectations of people who – like Terry Schiavo – are no longer responsive to us) make a difference to our answers to these questions? And how should background questions about the proper stewardship of community resources enter into our decision-making as we strive to provide just and compassionate care to all those in need?

So, I am not suggesting that what is missing from the *Guidelines* is a formula which would have automatically avoided the seemingly-intractable difficulties in which Terry

Schiavo's care became enmeshed. What I am saying is that we could have reasonably expected these new *Guidelines* to have given us the tools (the 'principles') to enable us to work out answers to these questions, that is, to decide, on relevant grounds, whether providing nutrition and hydration to someone in Terry Schiavo's condition would have been an 'appropriate' or an 'inappropriate' life-sustaining treatment.

In some ways, of course, the *Guidelines* do advance professional standards. They remind doctors to avoid both over-treatment and under-treatment. They reinforce the individual's (moral as well as legal) right to be truthfully informed about his or her condition, prognosis, treatment options, etc. They state that what is central to treatment decisions, and to treatment *limitation* decisions, is what is in the patient's best interests and not, say, what is demanded by a self-serving or a regretful relative. They encourage collaborative decision-making within the health care team and between the health care team and the family. They remind practitioners that they must not discriminate against the aged and the disabled. They encourage forward planning. And, critically, they set out useful *processes* both for minimizing the likelihood of the kind of conflict which arose in the Terry Schiavo case and for resolving such conflict if in fact it does occur.

But, as I say, in spite of the fact that they contain a paragraph which is intended specifically to address the issue of artificially-supplied nutrition and hydration, the new *Guidelines* are silent on *the* central issue. Though they contain lots of good practical advice to doctors, nurses and others about how to ensure that the treatment provided to patients is humane, respectful, trustworthy and appropriate to their condition, these *Guidelines* are therefore unlikely to have helped those who were involved in the care of Terry Schiavo.

Footnote

1. An abbreviated version of this opinion piece appeared in the *Sydney Morning Herald* on 22 March, 2005. Further copies of the guidelines can be downloaded from NSW Health website: www.health.nsw.gov.au

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Bioethics as Dispute Resolution

A Review

Stephen Buckle

The first thing to be said about *Bioethics Mediation* by Nancy Dubler and Carol Liebman is that this is an excellent book, with a clarity of focus and of presentation that is the mark of extended reflection on bioethical practice in major public hospitals.¹ This shows up not only in the clarity of the writing, but also in the well-chosen examples of bioethical problems, and in the detailed attention (in the latter chapters) to methods by which skills and techniques in bioethical mediation may be developed.

The book is also built around an interesting thesis: that bioethical disputes are, at bottom, *conflicts*, such that their resolution depends on the techniques of conflict mediation. As such, it encourages a “paradigm shift” in the bioethical consultant’s self-conception – and a corresponding shift in the bioethicist’s role. For these reasons – whatever one’s final opinion on the views presented in its pages – it is difficult to imagine that practising bioethicists would not profit from close acquaintance with its argument, examples, and recommended methods.

The organization of the book is as follows. The first part presents a framework for understanding mediation in the bioethical sphere. This includes an account of what bioethics mediation is, distinguishing it from bioethical “consultation”, and an account of the ways in which bioethics mediation differs from mediation in other settings.

The second part provides a practical guide to bioethics mediation. It sets out the necessary preparations for a mediation, including who should conduct the mediation,

what that mediator needs to know, and who should be included in the mediation itself. It then provides a detailed, step-by-step account of the different stages of the mediation process, and describes the main practical techniques available to the mediator for helping the process along.

The third part is devoted to a number of case studies, in order to show the methods of bioethics mediation in practice, and the sorts of results it can generate. This part completes the positive case for bioethics mediation: the subsequent parts are aimed at helping one to do it. The educational technique here is role playing. The fourth part provides practice at bioethics mediation skills by designing role plays around specific cases, including instructions for each participant in each case. The fifth and final part provides annotated transcripts of two actual role plays.

For the purposes of a review, it is more appropriate to focus attention on the more theoretical parts. (The later parts of the book are best tested by the actual participants in bioethical consultancy and mediation.) One important issue of a theoretical nature can be introduced by noting that there is some shifting in the meanings of terms. The authors present bioethics mediation as a variation on the established practice of mediation in conflicts, and so as a kind of social practice involving the affected parties. In this sense, a mediation is something one attends. But at the same time it is presented as a precisely-specified kind of activity – the employment of conflict-resolution techniques – that the official bioethics mediator may or may not use in an actual mediation. In this sense, mediation is what the bioethics mediator does when *not*

acting as a bioethics consultant – even when in a mediation session.

The issue here is not merely verbal, because it helps to bring out what is distinctive about a bioethics mediation as conceived by the authors. In a classical mediation (say, the resolution of conflict over dividing the assets in a divorce case), the mediator's task is to resolve the conflict. There may be some further constraints – such as the need to keep the resolution within the bounds of legality or obvious fairness – but these need not be expected to be recurring obstacles. The mediator's task may be difficult, but the *nature* of the task is not.

In contrast, the authors point out, the bioethics mediator has to wear two hats. The complication arises from the fact that the bioethics mediator is also a bioethicist. As such, the mediator cannot allow the mediation to ignore established principles in bioethics, and so must swap hats when those principles are endangered or ignored. On such occasions, the bioethics mediator must resort to the prior role of bioethics consultant: that is, a professional bioethicist with specialist knowledge of principles that are not to be violated.

However, given the authors' acceptance of the four "Georgetown principles" – beneficence, non-maleficence, respect for autonomy and for distributive justice – as adequate specification of those principles, this may seem more of a problem than it really is. This is because bioethics consultancy can be defined as the insistence on the authority of these four principles in any actual mediation, whereas bioethics mediation requires *practical* priority to be given to the third principle, respect for autonomy. It is, they say, *the* value underlying mediation. (p. 12) But such practical priority in no way denies the importance of the other principles, so the shift to consultant mode is not a shift to an incommensurable attitude, but the factoring in of the three further principles.

This means that the role shift that the mediator will have to negotiate should not be overly difficult: it requires only that, at some point in the proceedings, the mediator remind the participants that there are constraints on the decisions at which they can arrive: conclusions which fail to regard the patient's welfare and the limitations imposed by distributive justice (for example, unjustifiable monopoly of scarce resources) cannot be accepted. The additional principles can and should function in much the way that legality will function in the mediation: as a background framework that will need to be adverted to when violated, but which otherwise need not intrude into the discussion. The mediator could even preface the meeting with a statement of these constraints, or (as the authors put it in their step-by-step description of the process) build it into the information-gathering part of the mediation (p. 67).

What this means is that the contrast the authors draw between bioethics mediation and consultation, and therefore the degree of change of role required of the mediator, is somewhat overstated. "Mediation," they say, "is more inclusive and empowering, and consultation is more authoritarian and hierarchical." (p. 14) This does make it sound as if the bioethics mediator must wear two different hats. In contrast, the view offered above suggests that the mediator is a bioethicist who, for practical reasons, suspends overt attention to principles of welfare and justice in order to discover common ground between the contending parties.

If this is to the point, it might seem to be a conclusion the authors would welcome: it suggests the task of bioethics mediation is less difficult than might have been imagined, and so bring out the *practicability* of their proposals. On the other hand, though, it might not be welcomed, since it might suggest that their views are less *distinctive* than they seem – that bioethics mediation is not so different from bioethics consultation after all.

The best response to this conundrum is to accentuate the positive: that the significant bioethical issue is, very commonly, the *resolution of conflict* – and that the relevant practical skills are therefore *mediation techniques*. In other words, whether or not mediation and consultation are as sharply different as the authors take them to be, the bioethicist needs to recognize that, in practice, bioethical problems are very often conflicts, and reasonable mastery of mediation techniques is therefore a necessary part of his or her professional armoury. This suggestion also fits in with the authors' insistence that mediations, no less than consultations, must arrive at *principled resolutions* of the problems they address. (p. 11)

In this light, then, *Bioethics Mediation* seems best considered as an argument (with detailed illustration) for the central importance of mediation in bioethical practice. So it is important to recognize the potential problems that it will face. The authors attend to this issue primarily by contrasting bioethics mediations with the typical mediation practices employed in legal and related settings. They provide a list of salient differences, and assess their implications. Some of these differences need not concern us here, since they merely point up matters like the greater complexity of the bioethics mediation (it is almost always a multiparty event) and its deliberately non-legal status (no legal documents are signed). Some others deserve closer attention.

The first is that the bioethics mediator is not an independent third party, but an employee of the hospital. This is no accident, since hospitals are unlikely to put sensitive (not least, legally-sensitive) information into the hands of strangers. So an immediate possible liability is that the mediator may not be recognized by all parties as a neutral presence. This possibility should not be exaggerated, however. As the authors point out, the bioethical personnel called to mediate “do come as new actors into a stale, and stalemated, context”. (p. 22) So they are not hamstrung by the disputes that have led to the need for the mediation; and, in addition,

their knowledge of the staff and of the hospital and its workings and legal obligations makes them much better-placed than an outsider to tackle the problems.

On the other hand, there are potential problems here for the mediator. The hospital staff present at the mediation may question the mediator's institutional loyalties. Given that such staff may include hospital administrators with *their own* intra-institutional loyalties (and perhaps also powers), this may amount to a significant problem. In a large, state-owned institution, the problem may not be acute, but in a private institution, in particular, there may be considerable potential cost for a mediator in the independent pursuit of a principled resolution. Careers could be damaged or jobs lost; and the fear of this happening could seriously undermine the mediator's capacity to pursue an independent course. On the plus side, any hospital has reason to welcome successful mediations, since it would mean both the avoidance of legal wrangles and the protection of good reputation.

A further distinctive feature of bioethics mediation, which follows from the above, is that in a bioethics mediation the mediator and the treatment team are “repeat players”. (p. 23) The problem here should be plain: the mediator and treatment staff confront the patient's family as experienced insiders who know each other and the process itself. It is therefore to be expected that, should they want to, they will be well placed to manipulate the process to their own ends. The authors suggest that this problem can be offset by the presence of an attorney or other advocate for the family. They do not, however, notice that this may lead to undercutting the mediator's role: if identified as part of the power imbalance that the attorney's presence is meant to correct, the mediator may find him- or herself in the role of treatment team spokesperson, and therefore as its own advocate. Should this situation arise, it would create the need for a further (independent) mediator, as is the judge in a court of law. It is impossible to tell in advance whether such a situation is likely

in any given case. But the possibility does suggest that standard mediation procedures should include a contingency plan to this effect.

A third feature worthy of consideration is that, in a bioethics mediation, the person with the greatest stake in the dispute, the patient, is often not at the table. Attempts to fill this gap with advance directives, such as living wills, are not, however, always helpful. As the authors note, "because the circumstances rarely fit the specifics, they are often irrelevant and thus easy to ignore". (p. 28) Nevertheless, the main problem with advance directives is that they typically do not exist. This is not surprising, since the future is not predictable: any unexpected illness or accident will catch out even the prudent. The mediator's task thus includes the untidy but necessary business of trying to elicit a picture of the patient by seeking information about his or her prior attitudes towards medical treatment. This is obviously a "less-than-satisfactory" state of affairs, but it "reflects the reality that while ethical principles and the law are clear, the world of patients and their decisions is messy".

A fourth feature is that, in contrast to a legal mediation, the participants in a bioethics mediation have a common interest in the well-being of the patient. This is indeed a significant difference, but it does not apply with equal force to all participants. Administrative or medical insurance representatives will, *qua* hospital employee, be concerned about the patient's well-being only indirectly, in that endangering the patient is likely to bring damaging publicity and legal action. In fact, the very necessity of the mediation in the first place shows that this confluence of interests does not rule out deeply-entrenched disagreements. With these caveats in mind, however, it remains true that the shared interest in the patient implies that optimism about finding a resolution is appropriate, and this optimism can itself be expected to help the process along.

These issues can all be expected to generate complications in particular cases. Equally, however, they do not represent insuperable problems for bioethics mediation. Much the same can be said regarding the more theoretical aspects of mediation as a bioethical practice. Not all problems for the bioethicist will be best treated as conflicts, nor will it be the case that the four Georgetown principles will be adequate to every issue. But the relevance of both to practical problems is difficult to deny, and this is sufficient to establish the book's value as a handbook for the engaged bioethicist.

To conclude *Bioethics Mediation* is without doubt a very valuable contribution to bioethical literature. It is plainly the fruit of long experience guided, in particular, by reflection on the communication problems that arise in modern medical treatment, with its team of different specialists and their differing concerns - and, not least, the patient and family who have to cope, in times of great personal stress, with this (relatively) unfamiliar world and its complexities. It is very difficult to see how a practising bioethicist would not benefit from careful attention to its method and examples. This is not to say that there are no questions one can raise about its prescriptions and recommendations, but to do so is not to detract from the book's primary purpose, nor from the clarity and humanity that it brings to its task.

Footnote

1. Nancy Dubler and Carol Liebman, *Bioethics Mediation* (New York: United Hospital Fund, 2004).

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Medical Error: Some Ethical Concerns

Kevin O'Rourke

In the past few years, medical error has surfaced as a prominent concern among health care professionals. The event that drew attention to the problem was the publication, by the Institute of Medicine (IOM), of *To Err Is Human: Building a Safer Health Care System*.¹ This study informed us that more lives are lost each year to medical errors than to breast cancer, highway accidents, or AIDS. While admitting that human beings in all lines of work commit errors, the study's authors maintained that errors can be prevented by designing systems that make it hard for people to do the wrong thing and easy for people to do the right thing. They offered four recommendations to reduce medical error and thus improve patient safety:

- Congress should establish a national Center for Patient Safety that, by establishing leadership, research tools, and protocols, would enhance the knowledge base concerning safety.
- Congress should establish a mandatory reporting system that would enable people to identify and learn from errors.
- Congress should pass legislation extending peer-review protection to the activities of oversight organizations and professional societies.
- Health care organizations should create safety systems through the implementation of safe practices at the delivery level.

To Err is Human was followed a year later by another IOM publication: *Crossing the Quality Chasm: A New Health System for the 21st Century*.² As the title indicates, this second study was designed to supplement the initial work by presenting more specific plans for the renewal of health care in the United States.

Since 2001, as a result of the publicity surrounding the IOM studies, medical error has become the subject of many other books, articles, seminars, and symposia. Although the experts do not agree on the specific causes of medical error, they do say it arises not only from negligence on the part of physicians and other health care professionals but also because of systemic errors – that is, as a result of processes and practices in the provision of medical care. They also agree that errors in health care can be reduced dramatically.

In this article, I do not propose to offer solutions to the medical error problem. Instead, I want to suggest some fundamental truths about medical care, truths that, I will argue, have been insufficiently considered by those writers who *have* offered solutions to the problem.

Why Has the Problem Attracted Attention?

Errors have occurred in medical practice since its very beginning. Why such great concern about them at this time? Two main factors have focused public attention on medical error. The first factor, I would argue, is the contemporary concentration on “informed consent.” The second factor is society's success at reducing error in other organized forms of human endeavour, in aviation and nuclear energy plants, for example.

Informed Consent

For many years, the patient was considered a passive person in the physician-patient relationship. The physician was considered the only person in the relationship with the knowledge necessary to make decisions about the proper methods of combating illness. The

patient was relied upon mainly to describe the symptoms that had persuaded him or her that medical care was needed in the first place. The physician saw no need to tell the patient much about the illness, or to offer him or her a choice concerning the therapy through which the illness was to be alleviated.

In the 1960s, however, the physician-patient relationship began to change. As the result of agitation by a new type of health care professional - the bioethicist - physicians began to see that patients *did* have the right to be informed concerning their medical conditions, as well as the right to choose among an array of therapies, in accordance with their values. As a result of the bioethicist movement and other influences, both doctors and judges began to recognize patients' ethical and legal rights.

In 1973 the American Hospital Association formulated a document entitled *Patients' Rights*, which, although it was never adopted universally by hospitals, did give a good summary of what a patient should be aware of when evaluating his or her rights vis-à-vis a physician or health care facility. Those rights could be summarized as follows:

- The right to be told the whole truth
- The right to privacy and personal dignity
- The right to refuse any test, procedure, or treatment
- The right to read and copy medical records³

Some lawyers and ethicists were so intent upon promoting informed consent as a patient right that they envisioned a time when the patient would be equal to the physician, insofar as knowledge is concerned, and would be considered legally and ethically on a par with the physician. They proposed patient autonomy as a basic building block of the physician-patient relationship. Error detected on the part of the medical provider evoked the thought that "someone has to pay." Some bioethicists, contemplating the future of health care, seemed to advocate the slogan *caveat emptor* (let the buyer beware). There was a growing tendency to view the therapeutic relationship as adversarial.

The new emphasis on informed consent and an adversarial relationship led to a prolific

increase in malpractice litigation. While some health care professionals berated the increase in malpractice cases as an affront to the medical profession, others realized that one constructive way to limit malpractice cases was to reduce the number of medical errors.

The effort to reduce error was aided by the studies of human error in other sectors of the economy and by a more structured study of human error itself.⁴ Especially helpful was the realization that error may be the result of a system failure, as well as of human negligence. Simplifying and standardizing procedures, building in safety checks, seems to reduce the possibility of negligence. It has, for example, aided a restructuring of the methods used in prescribing medications. Today most hospitals utilize computers to generate prescriptions, thereby eliminating the potential for errors that might result from trying to decipher physicians' handwriting.

Success in Other Fields

A second factor in the effort to reduce medical error is the success that other industries employing sophisticated technology have had in limiting adverse events. The aviation and nuclear energy industries, for example, both realized that it is helpful to study not just events that actually cause damage, but also those events known as "near misses" in which damage could have occurred but, for some reason or another, did not. In general, these high-tech industries did not penalize people when error or near misses occurred, unless obvious negligence was involved.

My purpose is not to consider in detail the means that other industries employed to reduce error and adverse events, but simply to call attention to the fact that the results of serious efforts to limit errors in these industries encouraged leaders in medicine to face the same task openly.

The Physician-Patient Relationship

Any effort to reduce medical error must begin with an accurate understanding of the physician-patient relationship. It is erroneous to presuppose that the relationship should be adversarial. The health care professional is

not simply a scientist-technician; he or she is a quasi-religious figure as well. Asclepius, an ancient Greek hero who is considered the father of Western medicine, was looked upon as a god. His priests presided over shrines where the sick came to worship, sleep, and have their dreams interpreted. The caduceus, a staff with entwined serpents – the serpent was the cult animal of Asclepius's shrines – remains today the symbol of the medical profession.

The Asclepian myth manifests a basic truth about the medical profession: the physician retains something of a priestly aura. The medical profession's direct relation to life and death inevitably gives it a fundamentally religious character. A patient's trust in the physician resembles a religious trust. One well-known medical ethicist has referred to the physician-patient relationship as a "covenant," suggesting that the physician holds a position similar to that of Yahweh in his relationship to the Chosen People.⁵ To this day, trust remains a basic characteristic of the physician-patient relationship.

No wonder, then, that the physician is a charismatic figure surrounded by a religious or priestly atmosphere, as current television programs about doctors demonstrate. Although this trust has been at times abused, and although some modern bioethicists and lawyers would like to make a more "deconstructed" and legalistic relationship the basis for the practice of medicine, patients will continue to have an element of trust in and a trace of religious respect for their physicians.

People working in other occupations are not looked upon as quasi-religious figures by the people they serve. This does not mean that some of the methods used to reduce error in those occupations cannot also be applied successfully to health care. But it does suggest that the medical profession should keep people's quasi-religious respect for it in mind as it plans for the future.

Physicians As Scientists

The contemporary medical professional is also seen as a scientist. The scientific, or empirical, side of medicine already was

understood in the time of Hippocrates, about 400 B.C. It was recognized as well by medieval Arabian, Jewish and Christian physicians. But not until the 19th century did science become a notable characteristic of the profession, probably because it was during that century that modern chemistry and biology began to make their great modern strides.

Because medicine's scientific aspect soon overshadowed its traditional priestly aspects, certain difficulties arose. The physician often became a dogmatic figure, both in medicine and in other matters as well. The medical profession began to jealously guard its authority and prerogatives and to refuse to discipline its members or even to admit publicly that they sometimes made errors. As I noted earlier, physicians denied patients the right to have an opinion in regard to proper medical care; malpractice litigation they considered a social abuse.

However, no matter how strongly physicians emphasize the scientific aspects of their discipline, they will never entirely slough off its priestly aspect. The priestly characteristic will remain a significant element in the physician's persona. And, because this is so, trust will always be at the foundation of the physician-patient relationship.

This being so, it would seem that reducing error in medical practice – whether the error stems from negligence or from faulty systems – must rely heavily on the conscientious attitude of medical professionals themselves. Yet neither IOM study emphasizes the intrinsic motivation of physicians as a method of eliminating error. *To Err is Human*, as its writers say, "focuses primarily on the external environment and the policy and market strategies that can be employed to encourage actions by health care professionals and health care organizations."⁶

But the focus, it seems to me, should instead be on the intrinsic motivation of health care professionals; intrinsic motivation should remain the key incentive in any effort to reduce errors in medicine. Medical and nursing schools – and other facilities that prepare young people for the profession of medical care – must focus on the personal responsibility of the professional and the

covenantal relationship between the professional and the patient. The professional's personal responsibility should be presented as a sacred trust.

As for fostering a more error-free health care system, the IOM studies appear to me to rely too heavily on the "external environment" to solve the problem. Although the Joint Commission on Accreditation of Healthcare Organizations and professional medical societies will certainly play an important role in improving safety in U.S. health care, such agencies – whether governmental or private – will not supplant personal responsibility as a force for renewal of the health care system.

Because this is so, it seems to me that the *continuing* education of health care professionals also must be emphasized. Professionals require intense preparation for licensing as health care specialists; at present, however, they need meet few requirements to *maintain* that licensing. The various professional specializations in medicine (of which there are more than 25) would thus seem to have a serious obligation to strengthen continuing education programs to help remove error from patient care.

Medicine is Not an Exact Science

Another factor that must be kept in mind when considering medical error is the *nature* of medical care. As medicine's scientific side grew dominant, the myth was developed (and propagated) that it was an exact science. Some people are led by the myth to believe that the only sources of error in medicine are ignorance and negligence. But medicine is *not* an exact science. One of the foremost principles of medicine enshrines this realization: "First of all, do no harm."

An exact science is a body of knowledge that allows one to draw certain conclusions from causes and to apply that knowledge without fear of error. Mathematics is an exact science. Only human error causes defects in mathematical reasoning. While medicine relies on exact sciences such as biochemistry and pharmacology, it applies this scientific knowledge – not to inanimate objects – but to living human beings. Hence the specifying element of all the knowledge and techniques utilized in medicine is the individual. Medical

care can be provided without negligence and still result in error because of this fact. Consider, moreover, that medicine is concerned with preventing and curing illness. In so doing, physicians cannot formulate specific norms that are certain for all people at all times.

Some critics of modern medicine maintain that its scientific side has been so overrated as to destroy its true worth.⁷ True, general norms can be formulated to limit the occurrences of specific diseases, but there is no certain connection between lifestyle and a particular disease. Some who have a lifelong habit of smoking cigarettes never contract lung cancer. Pharmaceuticals affect different people in different ways. For some people, penicillin is an effective remedy for microbial infection; for others, it may cause a toxic or allergic reaction that could be fatal. People respond to therapy in ways that are not scientifically predictable.

Thus the necessity for an *art* of medicine. This art is operative when science is applied to individuals. Indeed, because a physician assumes responsibility for helping patients improve their health, his or her discipline is a *unique* form of art. In the physician's case, the work of art produced is not a more appealing object, but rather, a better human being.

Another factor limiting the certainty of medical judgements is the difficulty of obtaining sufficient empirical evidence to ensure the certainty of a medical diagnosis. Clinical judgment combines both inductive and deductive reasoning and is inevitably filled with uncertainty.⁸ Different illnesses may exhibit similar symptoms. Moreover, laboratory tests that are used in making diagnoses vary widely in reliability and accuracy. The fact that a person happens to have a high "bad cholesterol" reading does not in itself ensure that his or her arteries will become clogged.

In one study, as many as 100,000 deaths were attributed to medical error or adverse events.⁹ This figure was called into question by other studies.¹⁰ Be that as it may, it seems a mistake to associate death with medical error or to think of it as an "adverse event." Death is a *natural* event. No matter how excellent and error free the medical care

patients receive, some of them will still die.

Perhaps it would be more accurate to say that many deaths occurred *with* medical error, rather than *because* of medical error. A pathbreaking study of seriously ill hospital patients has shown that many people die as a result of their illnesses despite extensive therapy expended on their behalf.¹¹ Because death is a natural event, it should not be equated with medical error, unless it clearly results from an error that so alters the patient's condition that he or she would not have died if the error had not occurred.

Verifying this type of error is very difficult, and the data cited in the IOM studies do not, in fact, provide verification. It seems likely that physicians would address the error issue more realistically if they and their leaders were to admit that medicine is *not* an exact science and communicate this fact to the public. If physicians were more realistic about error in health care, the public might become more realistic as well and, as a result, reduce the number of malpractice lawsuits.

Protect The Element of Trust

I have intended in this article neither to excuse the medical profession of errors nor to suggest that the effort to reduce errors in medicine should be minimized. But efforts to reduce error in medicine should not be unrealistic; some error is endemic in medicine because of its very nature. Moreover, although some error is the result of poorly planned systems, the best protection against it remains the personal responsibility of the medical professional. Because that is so, we must as we strive to make medical care ever more safe, take great care never to attenuate the element of trust in the physician-patient relationship.

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References

1 Institute of Medicine, *To Err is Human: Building a Safer Health Care System*, National Academies Press, Washington, DC, 2000.

2 Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century*, National Academies Press, Washington DC, 2001.

3 Benedict M. Ashley and Kevin D. O'Rourke, *Ethics of Health Care*. Catholic Health Association, St. Louis, 1986, p.36.

4 H. Van Cott, "Human Errors: Their Causes and Reduction," in Marilyn Sue Bogner, ed., *Human Error in Medicine*, Lawrence Erlbaum Associates, Hillsdale, NJ, 1994; James Reason, *Human Error*, Cambridge University Press, Cambridge, England, 1990.

5 Paul Ramsey, *The Patient as Person: Explorations in Medical Ethics*, 5th ed., Yale University Press, New Haven, CT, 1980.

6 *To Err is Human*, p.23.

7 L.E. Goodman and M.J. Goodman, "Prevention—How Misuse of a Concept Undercuts its Worth," *Hastings Center Report*, vol. 16, no.2, April 1986, pp. 26-28.

8 See, for example, Atul Gawande, *Complications: A Surgeon's Notes on an Imperfect Science*, Metropolitan Books, New York City, 2002.

9 L.L. Leape, D.M. Berwick, and D.W. Bates, "What Practices Will Most Improve Safety, Evidence-Based Medicine Meets Patient Safety," *JAMA*, vol.288, no.4 July 2002, pp 501-507. An "adverse event" is one that is unforeseen and serious but not fatal.

10 R.A. Hayward, "Counting Death Due to Medical Error," *JAMA*, vol.288 no.19, November 2002, pp.2, 404-2,405.

11 SUPPORT Principal Investigators, "A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients, *JAMA*, vol.274 no. 20, November 1995, pp. 1,595-1,598. (SUPPORT stands for Study to Understand Prognosis and Preferences for Outcomes and Risks of Treatment).

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