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Revolutionizing Medical Malpractice Liability Systems: Improving Transparency Enhances Patient Care

Mia Gavilanes[1] and Johnny Lopez-Figueroa[#]

[1]Commonwealth Parkville School, Puerto Rico
[#]Advisor

ABSTRACT

Excessive legal regulations create environments within medical communities that encourage concealing medical errors, thus hindering the learning opportunities from these mistakes. The application of common law – based on precedents – and civil law unaffiliated with medical knowledge poses a threat to the proper analysis of medical malpractice cases, as there exists a lack of medical knowledge and astute professionalism regarding the complexities contained within the mistake committed. This investigation aims to demonstrate the importance of fostering an environment of transparency regarding medical errors to improve the learning experience that comes with making grave errors, improving patient care, and refining medicine. This qualitative investigation employs a documentary analysis design, incorporating descriptive content analysis and interviews to explore the current state of medical malpractice liability systems. The results reveal that excessive legal regulations and the monetarization of malpractice cases hinder the proper analysis of medical errors, leading to increased costs and a shift in focus from patient care to lawsuit prevention. The study concludes that for this environment to be attained, the medical malpractice liability system must undergo modifications such as the adequate application of common and civil law in a malpractice court case, the implementation of health courts or panels of medical professionals to correctly analyze each case, and begin to try doctors on the bases of several other factors involved with the mistake being made to broaden perspectives and minimize bias. The study reveals that the monetarization of malpractice through frivolous malpractice cases of cases being filed has not only frustrated millions of physicians but has raised the prices for medical insurance and medical malpractice insurance, posing a threat to the focus of medicine as it shifts toward the prevention of potential lawsuit rather than providing the best care. This investigation elucidates the importance of revolutionizing the medical malpractice liability systems to construct a forthright patient-doctor etiquette to refocus medicine toward its ultimate goal: ensuring optimal patient.

Introduction

Physicians, doctors, surgeons, and all healthcare workers risk committing grave errors in their jobs. A conundrum is faced as each professional must decipher whether to act reclusively, keeping the intricacies of the mistakes of each mistake secret, or choose to report all complexities of these cases. Withholding information regarding a medical mistake is detrimental to a physician's integrity and deprives professionals in the field of the opportunity to gain knowledge for future adverse events. By exteriorizing, doctors face the flaws of the medical malpractice liability system, as doctors are often tried by a court unfamiliar with medical knowledge. The current malpractice litigation system acts counterproductively, as it promotes secrecy to avoid doctors being tried by incompetent perspectives to understand the complexities behind the medical error committed. This investigation highlights the weaknesses of the malpractice litigation systems and the hindrance secrecy places on the

evolution of medicine. It questions the implications of economic factors intertwined within the liability system. Recommendations include further empirical evidence on implementing health courts and panels composed of medical professionals to improve the malpractice liability system by cultivating an environment continuously focused on improving patient care. Reports of malpractice featured at the beginning of the literature review effectively reveal the inefficacity of the malpractice liability system through the cyclical reclusive nature of hospitals concerning the error.

Furthermore, the reports rarely considered the hospital's actions to learn from their mistakes nor the enhancements to their procedures to refine patient care. Through these insufficiencies, the investigation correlated a stagnancy in improving patient care with this secretive behavior. The foundational studies within this investigation discuss the potential positive impacts the application of "non-adversary health courts" and panels could have on constructing an educational environment. By removing excessive legal regulations of the currently monetized liability system, medical professionals develop a culture of continuous improvement, restoring medicine's focus on providing optimal patient care. For this study to come to fruition, a qualitative investigation utilizing a documentary analysis design, supplemented by an interview, acted as the groundwork for its methodology. A theoretical framework based on ethics, regulations, economic factors, and organizational learning set the foundation for selecting and analyzing sources utilized to support the investigation.

Problem Statement

In the current medical malpractice liability system, excessive legal regulations and the monetarization of malpractice cases have created a culture of secrecy among healthcare professionals, hindering their ability to learn from medical errors. Discussing this conundrum is critical because it directly impacts patient care quality and trust in the healthcare system. Studies indicate that the focus on litigation and financial compensation discourages transparency and open discussion of mistakes, essential for continuous improvement in medical practice. Despite numerous propositions for reform, there remains a need for empirical evidence on the effectiveness of alternative systems, such as health courts and professional panels. Reluctance to reform perpetuates inefficiencies, increases healthcare costs, and compromises patient care. This research addresses these gaps by analyzing the ethical and legal implications of the current malpractice liability system and proposing evidence-based reforms to foster a more transparent and accountable healthcare environment.

Purpose

This investigation aims to comprehensively analyze the current malpractice liability system and the flaws in the system's intentions to correct doctors' errors. However, such legalities and fear imposed by the liability system consequently lead to no diminishing medical negligence, instead creating an environment of secrecy. The system holds doctors accountable for their actions yet fails to promote permanent change to decrease mistakes. By presenting thorough data and insights, the investigator aims to advocate for systemic reforms that promote transparency, accountability, and the constructive use of medical errors to enhance patient care. Through this analysis, the investigation seeks to demonstrate the necessity of health courts and panels of medical professionals in fostering a more ethical and practical medical malpractice liability system that ultimately prioritizes improving patient outcomes.

Justification

The importance of this investigation lies in its potential to significantly impact the medical and legal communities by highlighting the flaws within the current malpractice liability system. This topic is of critical interest

because it addresses the prevalent issue of medical errors and their handling, which directly affects patient care and trust in the healthcare system. The need for this study arises from the growing concern over how excessive legal regulations and the monetarization of malpractice cases create an environment that discourages transparency and learning from mistakes. By bringing this issue to light, the investigation aims to promote systemic reforms that foster an open and accountable medical practice environment. The originality of this study is found in its comprehensive approach to analyzing both the legal and ethical dimensions of medical malpractice, proposing innovative solutions such as health courts and professional panels to improve the system. By disseminating these findings, the investigation seeks to benefit the broader medical community and society by advocating for a more ethical and practical approach to handling medical errors, ultimately enhancing patient care and safety.

Research Questions

1. How have faults in medical malpractice liability systems led to the inability to decrease patent quality and error?
2. Why should the medical malpractice liability system view errors as learning opportunities as well as a negative outcome?
3. What implementation within institutions could promote transparency of medical, treat mistakes as learning opportunities, and minimize the fear surrounding the legal actions made toward doctors?

Research Objectives

1. Determine the factors within the medical malpractice tort system that have impeded the improvement of quality of care.
2. Expose the impediment the “blame culture” has on progression and revolutionization of medicine to improve patient care and demonstration the inefficacity of harsh punishments.
3. Analyze the role insurance companies have played throughout the year in the capitalization of medicine and the diminishing interest in confronting errors.

Theoretical Framework

Building the foundation of this investigation analysis method on many theories aided in answering the research questions, and the sources supported the thesis. In essence, malpractice cases featured at the beginning of this research presented the complexities behind mistakes doctors made, the lack of in-depth analysis of cases released to research sites, and the questionable ways hospitals reacted to errors. To provide a comprehensive analysis of the malpractice liability system, the foundation of this investigation is composed of the following theories as a guide for examination. The principles contained in the ethical theory of medicine – such as beneficence, non-maleficence, autonomy, and justice - set the groundwork for the investigation to analyze the malpractice liability system from a moral standpoint, considering its ethical implications. This study's transparency and accountability framework correlates the lack of transparency and openness in the work environment to poor patient care, proposing transparency as the solution by supplanting the investigation through the interconnection between the legal/regulatory and economic theories, an assessment of the weaknesses within the excessive legal proceedings and the cost-beneficence of the malpractice liability system. Recommendations this investigation provides for future investigators recommend modifications to the malpractice system based on an organizational learning theory, promoting institutions to create educational environments upon analyzing malpractice cases. Employing the theories above in analyzing each source provides a complete understanding of the problem and

its solutions. Cases such as that in Vasai Hospital, where gauze had been left in a woman's abdomen for over a month, demonstrate the inaction of the hospital regarding the case. Negligence presented itself as a surgical mistake and the hospital's failure to follow up correctly after surgery to check for gauze. Within the report, nowhere did it include measures the hospital took within its administration to correct the mistake, nor did it clearly state the many mistakes the hospital made, in turn making it difficult for readers to learn from the incident and prevent future mishaps (Parmar, R., 2018).

Furthermore, other malpractice cases such as Stephanie Valdez (Cheakalos et al., 2003) and Kellie Van Gool (Clara Pirani, 2003) delineate the lack of transparency in the reports of malpractice and expose the hospital for their reclusive behaviors hindering the exteriorization of the errors being made. Suggestions to revolutionize the medical malpractice liability system arise as transparency within the community seems necessary to improve patient safety. Health courts, physician-lead panels, and medical "common law" propose a more productive and efficient alternative to the malpractice liability systems in place, as they deviate the focus from the excessive legalities of cases and toward what should be the focus for the analysis of these case: how to improve from the mistake (Sloan & Chepke, 2008). Alongside changes to the legal systems intertwined with malpractice, efforts to create a safe environment to foster transparency between doctors, higher authorities, and patients – such as the Sorry Works! Policy at some hospitals is crucial to maintaining an environment fueled by the desire for better patient care (Berenson, 2005).

Definition of Terminologies

The term medical malpractice liability system refers to the legal framework that governs how medical professionals are held accountable for errors and negligence in their practice. This system encompasses the rules and procedures for filing claims, conducting trials, and awarding damages to affected patients (Sloan & Chepke, 2008). Health courts are specialized courts designed to handle medical malpractice cases, staffed by judges with medical expertise and often excluding juries, to ensure more informed and efficient adjudication of complex medical issues (Berenson, 2005). Lastly, transparency in healthcare denotes the practice of openly sharing information about medical errors and outcomes with patients, healthcare providers, and the public to promote accountability and continuous improvement in medical practice (Gawande, 2002).

Review of Literature

Gauze Removed from Woman’s Abdomen 40 Days after C-Section

In an idyllic world, a situation in which a forgotten gauze is removed from a woman’s abdomen 40 days after her surgery would be nothing more than a hypothetical example brought to medical students in a class analyzing case studies; however, this is the actual recounting of said example come true in the case of a 30-year-old whose complaint of abdominal pain 40 days post-C-section led the surgical team to find the piece of gauze left in the patient’s abdomen. Before the hospital visit, the patient complained of severe abdominal pain alongside a peculiar scent permeating from the abdominal region. Although she was recently admitted to the civic hospital back on the 27th of April to deliver her first newborn, when symptoms arose, sonograms identified the 3”x2” piece of gauze responsible for the patient’s abdominal pains. Later, Shabbir, Shama’s husband, contacted the civic hospital to get the gauze removed. After the surgery, Dr. Gaytri Gorakh reported that the 40-day-old gauze had been removed; however, he had been unaware of its presence during the C-section in April, further refusing to comment on the actions taken against the surgeon for malpractice. The article suggests that the gauze would be undetectable if the patient had not been tested with a sonogram or X-rays. Hadn’t it been for her visit to the private hospital, there would have been a high probability of having faced fatal consequences:

June 11--A piece of gauze (3"x2"), used during surgeries to absorb blood, was removed from a 33-year-old woman's abdomen on Saturday at a civic hospital in Vasai. The piece was left inside the woman's abdomen by a surgeon of the same hospital who performed a caesarean section (C-section) on her in April. Though the hospital admitted to removing the gauze, they were "unaware" of its presence during C-section. The woman's husband has filed a complaint at Tulinj police station and demanded that a case of negligence be filed against the surgeon who forgot to remove the gauze Gaytri Gorakh, in-charge of the civic hospital, said the gauze was removed from the patient 40 days after she delivered. But she said they were unaware about how it was left inside the patient's abdomen. (Parmar, 2018)

The following source exemplifies the superficiality of reporting medical errors, as the article focuses solely on addressing the news but fails to address the hospital's intent to utilize this case as a precedent for future C-sections. According to the report, the patient needed to be sent to a private hospital to be tested using sonograms, and later, the patient was sent back to the civic hospital to remove the gauze. From these reports, it could be deduced that the hospital initially responsible for making a mistake may not have been well-captured for proper post-operative care to ensure no complications could arise, raising the suspicion that a medical error was more prone to happen. Nevertheless, the reclusive nature of the hospital, as it fails to take accountability for the woman's critical state, does not stem from the hospital's lack of resources; instead, it is the product of the toxic recondite nature involved in medical errors. If it had not been for the patient's husband informing the civic hospital of the gauze inside of his wife and preparing for its removal, the patient's outcome would have been unknown. The likelihood that the family could afford the procedure in the private hospital is unlikely; for this reason, going back to the civic hospital was their only option. The husband's actions represent the transparency and effective communication needed between doctors, surgeons, and medical professionals, for if it had not been for him, Sharma's fate would remain a mystery. Occurrences such as these highlight the institution's failure in communication, having needed other means to ignite the patient information to be transmitted. By adopting better means of communication and implementing systems between institutions, the focus veers toward correcting mistakes in collaboration with other hospitals, improving overall patient outcomes.

The Malpractice Case of Stephanie Valdez

In the case of Stephanie Valdez, a woman who wanted a tubular ligation reversal, the following investigation indicates how her litigious journey began after a twelve-hour surgery left her battling for her life. Upon responding to a growing infection post-operation, during the removal of her fallopian tube and an ovary, the doctors found the true culprit of the disaster: a forgotten piece of gauze on her pelvic floor. Although Stephanie Valdez has won the $1,85 million settlement, she suffers irreparable damage due to negligence. Valdez reported severe abdominal pain soon after her reverse tubal ligation. A wrathful infection forced surgeons to remove her fallopian tube as well as one of her ovaries. Operating under the presumption that cysts had incited the infection, surgeons were astounded upon discovering a roll of gauze inadvertently retained within the patient's pelvic region. For twelve hours, the surgical team diligently endeavored to preserve Valdez's life, striving to correct their error. Subsequently, the single mother won the $1.85 million settlement, suing for the surgeon's negligence and malpractice. Nevertheless, neither the surgical teams' effort nor the victorious verdict served immunity to the suffering she must inevitably face. Stephanie Valdez now faces decreased bowel movements, extreme fatigue, and the crushed dreams of ever becoming a mother of three:

As lawmakers debate placing a $250,000 cap on punitive damages in malpractice suits, some patients say their suffering is beyond repayment. Here are six stories of people who claim that doctors' negligence or incompetence devastated their lives: Left alone with two children after a 1997 divorce, Stephanie Valdez had her tubes tied. "I thought I'd never marry again," she says. Three years later the Dallas-area phone company rep met a man who wanted kids. So, on Sept. 19, 2000, she had her tubal ligation reversed.

Soon after, Valdez, 32, developed severe abdominal pain. Blaming cysts, her surgeon removed an ovary and a fallopian tube. But the real culprit was a roll of gauze he'd left in her pelvic cavity--and overlooked in the follow-up surgery. It festered for nearly a year, causing a raging infection. "She was dying in front of our eyes," says her mother, Cathy Orsbun, 53, with whom Valdez lived when her fiancé left and she grew too ill to work or care for her kids, now 11 and 13. (Cheakalos et al., 2003)

This source delineates the need for more publication of information regarding recommendations for the betterment of patient outcomes accompanied by the high capitalization of the medical liability system, turning medical errors into a failed investment. Mistakes are unavoidable, especially human error in medicine; therefore, actions to punish them harshly are counterproductive. Sharing the efforts to evaluate medical errors solely through harsh penalties and legalities indirectly dismisses the importance of sharing the hospital's response to these errors or future strategies to better their care for patients. In Stephanie Valdez's case, mistakes include the neglectful piece of gauze left behind and the later assumption of operating on cysts rather than the gauze. Although doctors successfully removed the gauze and the patient won the case, the single mother's difficulties will forever be a reminder of the doctors' mistakes. The 1.87 million dollars not only falls short of recompense for the pain the patient will confront in the future but demonstrates the justice system's inaction to enforce institutional changes to ensure gauze counts and proper protocol are followed. Victories for victims of medical malpractice cannot be seen as a loss for hospitals but rather a way to reinforce the error-minimizing systems within the hospital.

Surgical Error: Gauze for Concern

The primary aim of this newspaper article is to narrate another occurrence involving gauze inadvertently left inside a patient following childbirth. The source further confronts the hospital’s failure to uphold its commitment to better the standard of care. Days after giving birth to her first child, Kellie Van Gool found herself in such pain that sitting down soon became a distress. Upon arrival at the hospital, doctors soon deduced from her widespread infection that a piece of gauze had been left inside the mother at the time of giving birth. The family quickly files complaints against the hospital, demanding an apology for their lack of diligence and inadequate patient care. In response, the hospital expressed regret, ensuring they were prompted to review surgical counting practices and other modifications to prevent future missteps. However, the hospital’s assertion of enhancing patient care proved insufficient when they neglected to address the mother’s complaints, with the nurses only fully disclosing the hospital’s error two years after the incident:

“Mrs Van Gool's poor experience appears to have been made worse by difficulty in presenting a complaint to the hospital. However I am advised that hospital did meet with Mrs Van Gool on January 14.” “If the complaint process has let the patient down, then I am determined to ensure that the process is improved. ‘Details of the incident come two years after nurses at Campbelltown and Camden hospitals first went public with allegations that mistakes and sub-standard care had caused patient deaths at the hospitals. However, the hospital said yesterday that full disclosure was made to Mrs. Van Gool at the time the gauze was discovered. ``It appears now that we have had a breakdown in communication, and we would like to apologize again,' Dr Saxton said. Opposition Leader John Brogden sai disciplinary action should be taken against the hospital's then acting general manager, who he claims failed to contact Mrs. Van Gool despite her calling three times to lodge a complaint. `Joanne Fisher needs to explain why she refused to contact Kellie and she also needs to unreservedly apologize. `Despite the rhetoric being peddled by the Government that things are getting better in the South-western Area Health Service, Kellie Van Gool's experience proves nothing has changed.' (Pirani, 2003)

Regarding the main objectives contained in the thesis of this investigation, Kellie Van Gool’s case showcases the negative implications of an ineffective correction system within institutions. Rather than disdaining medical errors for years, problems that arise must be discussed with members of the faculty to clarify the intricacies of the mistakes made. Although medicine is inherently bound to human error and institutions are

often oversaturated by complaints, negligent behavior extends not only from the mistake when institutions consecutively ignore these complaints or make no corrections in the system to improve it. The greater the delay to confront potential flaws in cases is a step back from innovation and a halt in the progress toward lower error rates. Aside from the potential stagnancies in revolutionizing the procedures put in place to supposedly minimize error (such as countings, scanning of gauze pieces, repetition of orders, etc.), this case highlights the systemic secrecy engraved in the medical community, where grave errors are frowned upon, creating a toxic environment for doctors as they are unable to learn from their mistakes in a constructive environment. Under these conditions, the expectation for doctors to thrive dwindles to merely surviving in such a destructive atmosphere. The implications of this secretive behavior not only hold implications within the system but also extend to the forefront of research regarding medical malpractice. For studies measuring the rates of medical malpractice, the level of secrecy in the workplace and particular work ethics determine the number of complaints filed and reported within the department. Recording high levels of medical malpractice compared to very low levels of malpractice wouldn't correlate to the actual quality of care but rather the level of transparency regarding errors made in that department.

Sponge Left in Patient

The unfortunate repercussions that stem from medical malpractice in the case of Dennis H. Madigan, who lost his leg because of a sponge left in his leg is demonstrated in this section. Originally, in June of 2006, Madigan was scheduled to undergo a tibial artery bypass to redirect the blood flow past the blockage in his leg. The surgery intended to improve the circulation in his lower leg, reversing the effects of his diabetes; however, it ended in yet another dwindling in his quality of life. Madigan reported feeling "better" after his surgery; nevertheless, he noticed his incision's delay in healing. At the wound doctor around August of that same year, they discovered the raving infection and deduced amputation was the only alternative to prevent the infection from spreading. Later, it was discovered that a sponge was left inside the patient's leg, being the probable cause of the infection, despite the Hospital's denial of any correlation with his infection. A lawsuit was filed against the surgeon and the Hospital, blaming them for the new challenges he must face following the amputation. Nevertheless, the Hospital, nurses, and surgeons denied responsibility for leaving the sponge in his leg aside from claiming a delusional correlation between the sponge and the infection. In their defense, they claimed that leaving foreign objects in a patient was a "rare occurrence," with only a couple of 1,000 cases of objects left in patients out of 13 million surgeries performed. Despite inevitable "human error," the attorney in Madigan's defense claimed that even one slip-up can be disastrous. The attorney argues that mistakes are the direct result of negligence. Therefore, the technology implemented to aid in tallying – such as microchips of gauze – equipment and standard procedures makes it nearly impossible to oversee any equipment left behind. The attorney in the Hospital's defense proved their compliance with "reasonable patient care," assuming no responsibility for having left Dennis Madigan without his lower leg. Left without closure, Madigan's positive attitude is the propelling force to discover the quality life holds, that which his surgeons failed to gift him:

Both defendants acknowledge that a sponge was left in Madigan's leg but both deny responsibility for leaving it there. While reports of left-behind items can be shocking, such mess-ups are rare. A national study of 13 million surgeries found that fewer than 1,000 patients emerged with foreign objects in their bodies, according to Health Grades Inc. But one oversight can be devastating. "Should this happen? No," said Terry Sibbernsen, Madigan's attorney. "Does it happen? Sometimes. You can have all the policies and procedures set out, but you're still relying on human beings." Experts say such oversights are avoidable. Hospitals have policies requiring the repeated tally of equipment and sponges in the operating room. Those policies boil down to: You leave the operating room with what you brought in, except in cases where an organ is transplanted or a device such as a pacemaker is inserted. (Cooper, 2007)

In correlation to the thesis of this investigation, Madigan's case unveils the complacent and distant attitude that attorneys have placed on medical malpractice. Refusing the doctor's mistake through the defense of "compliance with reasonable standards of care" is condoning negligence and avoidable occurrences. Although not in the doctor's intentions and an accident, merely deeming this mistake acceptable creates ambiguity and leads other doctors to question the concept of "reasonable patient care." By failing to complete the procedure tallying, it is clear that there has been a breach of the standard of care. Complications such as slight infections, stroke, or extensive bleeding may arise from these surgeries; however, complications that deviate from those inherently bound to a procedure and have been mentioned to the patient before surgery are results of negligence and should be deemed in the court of law as an act of negligence. Criteria of care ensure efficacity and a degree of success; therefore, if basic tallying fails, doctors must be deemed responsible for their mistakes. Without responsibility, there is no room for growth and development, neither for the doctor nor the institution. Placing responsibility on doctors does not equal blame, for negative connotations are tied to blame, and responsibility promotes improvement. The administration must fulfill its duties in constructing an adequate environment that balances correcting their doctors' faults while avoiding demonizing mistakes.

Surgical Error at Simi Valley Hospital

California fined Simi Valley Hospital $25,000 after self-reporting an incident where a four-year-old gauze sponge from a previous hysterectomy was found during a patient's removal of a mass. In 2007, Simi Valley Hospital surgeons performed the hysterectomy; however, they failed to follow the proper post-op guidelines. According to the hospital's reports, the surgical crew only reviewed the list twice rather than tallying the equipment used three times. Four years later, the same patient was admitted to the hospital to remove a mass on the woman's small intestine. Surgeons noticed the "white gauze and light blue fibers" from a surgical sponge during the surgery. The sponge could easily be hidden within the intestines, as it is primarily used to improve the surgeon's visualization during surgery, accentuating the crew's obligation to recheck the surgical equipment list after surgery. No information was disclosed concerning the woman's outcome due to patient confidentiality; however, the report highlights the dangers of infection and bowel obstructions stemming from foreign objects forgotten in the body. The state's investigation, compiled by the findings of a group of state hospitals, found that surgical tools, such as gauze and sponges, are amongst the most common mistakes ending in penalties for the hospital in the state. Simi Valley Hospital hastened to declare patient safety as their priority, ensuring re-education of procedures for staff, emphatic review processes, and X-ray screening be implemented to prevent further mistakes. In addition to the hospital's actions, beginning in 2009, the state of California raised fines for medical malpractice, starting from $50,000 at the first report, all the way up to $100,000 if a third account:

State Department of Public Health officials announced Thursday that the hospital is being fined $25,000 and is one of 14 California hospitals facing fines totaling $825,000 for alleged violations that caused or could have caused death or serious injury. A Simi Valley Hospital spokeswoman said Thursday the hospital is not appealing the penalty and emphasized the facility's commitment to patient safety and quality care. "Our patients are our families, our neighbors and our friends, and we take our responsibility to them very seriously," said spokeswoman Alicia Gonzalez, "which is why this error is regrettable. This is the first fine for our hospital, which we self-reported. We constantly strive to improve our processes in order to continue making our hospital even safer. "According to the state findings, a mass in the woman's small intestine was discovered and removed during abdominal surgeries at the hospital in 2011. Between 1 and 2 inches in size, the mass contained a white gauze material with light blue fibers from what a surgeon described as a 4-by-4-inch surgical sponge. (Kisken, 2012)

In contrast to the sponge left behind in Madigan's leg, this case presents the responsibility the staff assumes regarding their incompliance with tallying procedures. By accepting the mistake, the hospital was prompted to enforce better regulations to diminish the occurrence of negligence. However, the institution is

responsible for ensuring that doctors are mentally and physically apt to follow these regulations, being aware of the stressors in the environment that may trigger poor decision-making, leading to potential failures to comply with optimal patient care. Additionally, a healthy environment in which to report these incidents is necessary for the institution to improve upon these experiences. Superiors should be willing to receive these complaints, focus on the patient's care and the potential ramifications of the mistake, and come together to form a consensus and evolve as a team. Legal aspects of the case, such as lawsuits, fines, and other punishments, should be contemplated in the context of the mistake; however, the hospital's responsibility is to improve upon these mistakes and protect the lives of their patients while it is the legal system's team to deal with the extent of punishment. However, the legal system investigating the crime brings into question the proficiency of its members since they need the proper qualifications to judge a medical malpractice case scientifically and unbiasedly. Creating a panel of entities with cast medical knowledge and familiarity with the stressors characteristic of the field of medicine is critical to maintaining the focus on advancement rather than adding the pressures of dealing with the legal system. Increased tension for doctors arises when in doubt about placing the responsibility to judge their case in the hands of individuals unknown to the experience medical practitioners must face daily.

Additionally, by concentrating on the medical aspects (such as protocols, tallying procedures, re-education programs, and technology) of a malpractice case, the possibility of placing more importance on the legalities of the case is further diminished. The state's actions to increasingly raise the fines by the reoccurrence of a mistake could be deemed an adequate consequence for the doctor's crimes; however, it could equally prioritize the legal aspects over the case rather than monitor the changes implemented by the institution following the allegations. Nevertheless, the state government must balance the legal and medical aspects of the case to ensure the hospital's goals are being fulfilled: providing optimal patient care.

Malpractice Makes Perfect

Obama's words, "You cannot let your failures define you. You must let your failures teach you," echo throughout innovative efforts to reshape the healthcare system. Advocating for Cal, Susan Sheridan, alongside thousands of medical malpractice victims in the US, suggests that inadequate legal proceedings and endorsement of evasive behavior are the causes of the healthcare system's failure to improve patient care. Alongside her supporters, Sheridan founded the "Consumers Advancing Patient Safety Corporation" to dismantle the complacency behind medical oversights by forming a collaborative environment and a trustworthy relationship between the patient and healthcare provider. For example, the corporation urges hospitals to implement the Sorry Works! Routine, where doctors and surgeons are strongly encouraged to be transparent when communicating faults with the patient and their family. Promoting honest relationships, rather than covering up the mistake, understanding, forgiveness, and effective collaboration could lead to better patient care and decreased medical malpractice suits – as patients truly comprehend the doctors' altruistic intentions. The routine shifts the negative perspective on errors, viewing them constructively and allowing healthcare workers to learn from their mistakes in an uplifting environment, viewing every mistake as a learning opportunity rather than a fault forced to be hidden. An estimated 90 percent of medical malpractice lawsuits are dropped, sealing all evidence on the case and refusing to disclose it to either side, patient or health care workers. Through the collection, analysis, and publication of these medical mishaps, hospitals and care centers nationwide can learn from these mistakes to improve techniques and technology to improve patient care. Not only does the organization criticize the deep-rooted secretive tendencies of the healthcare system, but also the incompetent legal system surrounding medical malpractice and the charlatan political leaders responsible for altering the healthcare system. Currently, the legal system is designed to judge medical cases with trial attorneys, juries, and judges, all lacking a vast medical knowledge background.

Moreover, leaders like President Busch plunge forth actions to lower the plaintiffs for medical malpractice without thorough investigation supporting their decision, contributing more of the money designated

to improving the experts of the healthcare system, instead, in the hands of lawyers and court operations. Great disappointment in the current legal and political systems drove the Institute of Medicine (IOM) to propose a "non-adversary health court." With this alternate legal system specialized for medical malpractice suits, the jury is removed, and judges or settlement mediators are required to hold medical experience. Familiarity with medical knowledge blocks plaintiff attorneys from raising contingency fees due to the certainty of the court's ruling. Another essential modification the "non-adversary court" proposes is the change of basis against which physicians are held up. Rather than deciding upon a physician's negligence, an act of sub-optimal patient care, the court rules based on "avoidability," a standardized list of precautions and scenarios physicians must avoid. While negligence requires veridical evidence, extensive legal proceedings, and debates on the expertise of each witness to prove a physician failed to offer maximal care, "avoidability" provides a precedent for all cases, eliminating the often-prolonged court proceedings and concession of malpractice suits. "Non-adversary courts" and Sorry Works! Routines are small steppingstones building toward revolutionizing the healthcare system, bettering patient outcomes, starting at the individual level – offering transparency, trust, and breaking down walls – rising to the institutional level – changing court systems:

Meanwhile, trial attorneys reasonably assert that the problem with the malpractice liability system is actual malpractice, plain and simple. But they don't own up to the fact that state-based variations in the current tort system don't deter substandard care. If lawsuits inspired better medicine, the current system's inefficiency--60 percent of its costs support lawyers, expert witnesses, and court operations rather than compensating injured patients--might be acceptable. But, while malpractice insurance costs and payouts keep rising, health care does not get appreciably safer. For example, adverse drug events are estimated to kill or injure more than 770,000 people in hospitals each year, with prescribing errors as the most frequent source. Efforts to improve the situation have focused on computerized order-entry systems, but even these have not greatly reduced prescription errors. With some notable exceptions, such as the efforts by the American Society of Anesthesiologists to reduce anesthesia injuries--and malpractice claims--starting in the 1980s, the malpractice system has not been successful at enhancing patient safety. (Berenson, 2005)

The following source elucidates the various options to revolutionize how medical malpractice is viewed to prioritize the learning experience any medical practitioner can gain from the experience while diminishing the excessive negativity placed upon doctors, which inhibits them from accepting their mistakes and utilizing them as fuel to become better professionals. In terms of the investigation, the source agrees with the main objectives of this investigation, as it intends to create an environment where doctors can be transparent about their mistakes, conscious of the possible penalties they could receive, however, none of which impede them from overcoming their errors to become better doctors. The "Sorry Works" program is critical to promoting this environment, as it fortifies the honesty between mentor and student, refining these doctors' skills to a greater extent and fostering a learning-oriented mentality rather than one consistent with demonizing inevitable mistakes. Further, the efforts to change the courts into "medical courts" and basing judgment on avoidability rather than negligence strengthen doctors' trust in correctly judging their cases, thus lowering the doctors' stress levels surrounding the case. Although negligence plays an integral role in deciding whether the doctor provided optimal care, the extent to which an outcome could be avoided must also be analyzed. Both scenarios must be balanced to decide what would constitute an outcome caused by the actions of the doctor, any unexpected outcomes, or unavoidable outcomes. Specific adverse outcomes that could be avoided –through procedures, protocols, or routines – and occurred due to incompliance with these proceedings must be deemed as an act of negligence, therefore being judged on both bases by the panel of doctors to decide the measures they must take to decrease the repetition of the mistake, provide ideal patient care, and accepts mistakes as learning opportunities. Unexpected outcomes out of the doctor's control – already initially warned – should be judged meticulously to ensure a doctor attempted everything in his/her power to ensure the unavoidable remained avoidable.

Nevertheless, suppose a known complication arises, which was previously noted by the patient. In that case, the panel is responsible for deciding the verdict depending on the level of avoidability and frequency of

the complication arising. Depending on the risks pertinent to the procedure, the panel should come to a verdict based on the potential acts of negligence intertwined in the case. The classification of cases not only speeds up the legal proceedings, but the administration can also reconstruct its protocol systems and reevaluate its staff effectively. Weaknesses categorized by negligence or avoidability aid the administration in aligning reform plans, whether to improve the conditions to diminish negligence or acquire better technology to lower the risk in specific surgical procedures.

Medical Malpractice and Quality Assurance

Medical malpractice is initiated to ensure maximal patient compensation for any error made by the physician responsible; however, it fails to do so, as there is no correlation between the consequences directed to the negligent parties and the betterment of the system. Consistent studies have shown that medical malpractice suits do not deter injuries; some professionals strongly believe the system is the problem and culprit for such a stagnant system. Existing malpractice legal proceedings tend to veer their focus to pointing the blame rather than taking the necessary steps to ensure improved patient care – a learning experience from any mistake. Based on tort laws – laws aiming to compensate for the negligence and harm inflicted on another person – accusing the individual of an error committed by a complete team and institution. Accusing individuals rather than institutions rarely generates any changes in the system, as it is the institution's responsibility to introduce modifications to their systems – not a single individual. The likelihood of a single individual revolutionizing the system further disintegrates, as insurance premiums alleviate most of the financial burdens on physicians, eliminating the consequences of physicians that could ignite them to promote betterment in patient care. General belief tends to see insurance companies overcompensating for injuries, whereas the reality is quite the opposite. Studies show malpractice claimants are often under-compensated, reaching only half the compensation price. Only 22% of cases show overcompensation, while another 26% received no compensation. Courts prove themselves failures to offer adequate recompense for injuries, as each state court defines the limits between error and no error, resulting in 19% of patients receiving compensation for no errors or evidence of injury and the remaining 82% compensated for grave mistakes. Countless flaws in the present medical malpractice system paved the way for the following newfound adjustments: no-fault insurance, health courts, alternative dispute resolutions, private contracts, and enterprise damage and insurance to ensure measures to improve patient care are practiced and insured with each case. No-fault insurance ensures patient compensation regardless of who is at fault, quickening the compensation process for patients and decreasing administrative costs. Critics point out that if the approach truly is "no-fault," the public should be obliged to pay the tax, not just physicians and hospitals. However, no U.S. state had approved it. Hospitals offer no-fault insurance at more affordable prices than standard torts, demonstrating a commitment to optimizing patient treatment and encouraging more patients to use the hospital's facilities. However, opting to sue under no-fault rather than tort requires "prior regulatory approval," depending on the authority enrolling people into the plans. Private contracts between the patient and the provider substitute tort laws as well. While tort laws decide reimbursement based on standards of care, private contracts acknowledge the patient's choice of standard care – as everyone holds their perspectives on "standard care." Therefore, private contracts established "standard care" conditions tailored to each patient. Courts have overturned the decision to implement such contracts, arguing that patients who are at higher risk of injury are likely to pay higher rates for prevention, aside from pointing out that physicians hold greater power over patients when signing it, as the patient is not properly suited to discuss the contract's conditions comprehensively. Aside from private contracts, enterprise insurance delegates the insurer's role to the hospital. Access to operations and procedures facilitates understanding cases, promoting more stable insurance prices. Similarly, enterprise liability ensures excellent care and rigorous preventive measures, as hospitals are determined to seek out highly qualified professionals to fortify their staff. Due to the rigorous technical nature of medical treatment, regular courts fail to truly comprehend the intricacies within each case and injury, merely focusing on the superficial

and legal aspects. For these reasons, experts opt to direct medical malpractice suits to be judged in a health court. Judges specializing in medical malpractice would work full-time in these courts and remove the jury. Most importantly, science-based common law would ascend to hold legal standards, specializing in observing each case through the lenses of empirical, unbiased principles. However, state law formulates its corresponding science-based common law, lacking federal oversight and bringing rise to inconsistencies within the system. Aside from health courts, court-appointed experts, expert panels, and alternative dispute resolution provide scientific and medical insight into a court, all intending to facilitate recompensing at the least sacrifice for the patient. Alternative dispute resolutions offer convenience – while avoiding vast legal costs – by settling the dispute outside the court through arbitration or mediation. Arbitration mimics the proceedings of litigation – however simpler and ignores casting verdicts –while a third party to find common ground between the parties is utilized in mediation:

Some critics of medical malpractice contend that being at the cutting edge technologically makes a physician more vulnerable to being sued. There is no empirical evidence that being sued is an indicator of superior performance. However, there is evidence that physicians with no claims histories were rated by their patients as being, or at least appearing to be, more understanding, more caring, and more available. Overall, it is untrue that only good doctors are sued, but at the same time, being sued is not a marker of being a bad doctor either. The myth that there are too many malpractice claims is a bit more complex. There are two path-breaking studies showing that there are both too many and too few malpractice claims. The first of these studies was conducted in California in 1974. The second, the Harvard Medical Practice Study, was conducted in New York in 1984. In both studies, surveys of medical records of hospitalized patients were conducted to ascertain rates of adverse events attributable to provision of medical care to these patients and rates of adverse events due to provider negligence, termed "negligent adverse events." The California study revealed that of the 5% of patients who experienced an adverse health event while in the hospital, 17% suffered a negligent adverse event. In New York, the corresponding rates were 4% for adverse events, of which 28% were negligent adverse events. The authors found that "invalid" claims, those not matching the study's determination of liability, outnumbered valid claims by a ratio of three to one. However, they also found that only 2% of negligent adverse events resulted in medical malpractice claims. There were 7.6 times as many negligent injuries as there were claims. Thus, there were errors in both directions: Individuals filed too many invalid claims and not enough valid claims. The public's view of juries leads to the inference that outcomes of litigation are often random. Actual data, however, leads to the opposition conclusion: Outcomes are not random. There is a definite relationship, albeit an imperfect one, between independent assessments of liability and outcomes of legal disputes alleging medical malpractice. One study estimated that payment is made in 19% of malpractice claims when there is little or no evidence of errors. In contrast, when the evidence of an error is virtually certain, payment occurs 84% of the time. Using the results of this study, claims not involving errors accounted for 13 to 16% of the system's total monetary cost. The way one views this percentage (substantial or small) depends on where one draws the line between error and no error. Unfortunately, the New York study conclusions do not stress or even mention that the estimates of error are subject to a very high degree of uncertainty. (Sloan & Chepke, 2008)

The following source contributes to this investigation, as it demonstrates the role that higher authorities take up, as they must ensure preventive measures are being taken to diminish medical malpractice or assume responsibility for cases of medical malpractice, even if by the fault of an individual doctor or small team. Supervisors and directors must take responsibility for any malpractice committed and oversee all operations adequately. Ensuring optimal care for the patient implies that high officials monitor their doctors meticulously to ensure they are apt to perform to their highest degree physically, mentally, and emotionally. For this reason, if errors become more consistent, higher officials must analyze the situation and work to find the root cause for any consistent negligence – if any negligence per se. Balancing schedules, limiting rotations and rest, and fostering a workable environment all fall under the duty of supervisors and directors. Although the individual doctor and the administration are responsible for improving patient care, the administration must supervise to

ensure the physician takes proper measures to improve their skill. Physicians are responsible for taking proper measures to improve practice and increase focus in the workplace. At the same time, the administration's job is to ensure the physician demonstrates their investment for improvement. Modifications to the legal system utilized to castigate and draw verdicts upon medical malpractice cases help further veer the focus of malpractice as a learning experience and prohibit excessive legality from convoluting the essence of the case to compensate for the lack of care for any patient. The introduction to panels and health courts comprised of well-versed professionals who are genuinely apt to judge certain cases helps create awareness of the contribution that this mistake could have in the face of medicine. Legal proceedings and general laws poorly apply to the scenarios inside a hospital and medical offices, for they are in place to incriminate those guilty of misdemeanors, felonies, and other crimes from which their nature deviates from that of medical malpractice. If all doctors follow their code of ethics, a doctor's intentions can never be to inflict harm; therefore, degrees of crime become merely applicable and often create ambiguity. Creating a common law for medical malpractice crimes is critical to setting up a precedent that all doctors are conscious of and must abide by. Establishing such laws minimizes ambiguity in cases, speeds up legal proceedings, and could potentially create more consistency in compensation for patients who unfortunately fell victim to the mistakes made. However, common "medical" law is distinct to each state, creating more significant inconsistencies in patient care throughout the country and challenging the efficacy of the health department to oversee its operations as complications arise due to accommodations the federal government must make to comply with state law.

For this reason, the wait for change to occur in the system is prolonged until it becomes nearly impossible to consider and intend to solve the nationwide dilemma. By considering common medical law on a federal level, where all states' laws must abide by the law of the land, decisions made by the Department of Health apply to all states, insinuating the route to changes in the system more efficiently and more equally balanced. Treating all states in equal measure will limit disadvantages and create a standard of care that must unalienably be met by all hospitals, regardless of where the patients are.

Malpractice of Malpractice

Although physicians tend to be shamefully blamed for medical errors, the source exposes the flaws within the medical malpractice system that hinder the evolution of more diligent and near-flawless forms of medicine. Deprecating aspects of the medical malpractice system include the inclination to conceal any errors made, lack of legislation to enforce apology and protect the doctor from apologizing, unqualified courts, and the bases under which these physicians should be tried; nevertheless, all of which the source proposes tested solutions, promoting their implementation within the American medical malpractice realm. Upon negligence or error, doctors and physicians have repeatedly been encouraged – by their authorities – to avoid disclosing such errors, simply dismissing them, causing them to develop a feeling of secrecy and growing anguish around their abilities. Rather than analyze mistakes and truthfully admit to their wrongdoings, mistakes are often better yet ignored than approached – all to avoid expensive lawsuits and potential removal of medical license. According to Harvard physician David Blumenthal, physicians tend to administer medical errors ineffectively, as shown in their secretive tendencies and reluctance to revisit even the slightest mishaps – only looking into cases with grave consequences for the patient. Johns Hopkins physician Marty Makary finds that inefficiency stems from the over-concealment of information and the lack of information disclosed to the public and the medical community. Releasing full disclosure of cases and any errors committed is crucial to better the system by analyzing the mistakes and finding solutions. This belief was held when fatality rates due to heart procedures in New York were reduced by 41%, followed by the state's mandate for hospitals to reveal all coronary bypass surgery deaths four years prior. Chronicled cases brought forth prevention methods such as counting sponges and gauze, bar code instructions on gauze, surgical checklists, and excessive marks on the operation site. However, mistakes still prevail in the medical field regardless of the implementation, and doctors tend to maintain a fixed anxiety

regarding mistakes. To effectively gain insight from medical malpractice cases, the system under which these scenarios are managed must be altered. In the context of the United States, the nation is one of the few to try the doctors in front of a jury, lacking professional knowledge. Instead, most European countries, Canada, and Japan either put commissioners on the jury, utilize health courts (courts held in the absence of the jury, with experienced judges), or impose a professional panel. Under these methods, physicians fall guilty or not of malpractice based on the standard of care offered, the extent to which the injury was avoidable, and if they could have acted differently under the given circumstances. The end goal for all these methods is to constructively analyze each mistake made, intending to offer optimal compensation for the patient and the protection of physicians. Like all humans, doctors are bound to make mistakes. However, the institutions and systems surrounding them tend to dehumanize them, being the true culprits, not their lack of willingness, to create grave fear surrounding mistakes:

There are four elements to a malpractice case: the accuser (or plaintiff) is owed a duty; the accused (or defendant) violated that duty; the accused departed from the accepted standard of care that a reasonable peer professional would have provided in the same or similar circumstances; and the accuser had a significant injury as a result of the negligence, resulting in damages. The health care professional has a duty to warn the patient about medical risks, known as the duty of informed consent. On the other hand, a lawsuit cannot be sustained if the alleged harm is accepted by the patient as a possible outcome for a given condition, or if the disease progresses when the patient is in treatment The patient also has a duty under informed consent to provide pertinent information, such as furnishing a complete health and medical history, and to adhere to the treatment plan. In a lawsuit, a patient can seek damages for economic losses and pain and suffering. While punitive damages can be sought from a health care professional or a medical facility (on allegations including the deliberate harm to a patient), these damages rarely are awarded in a malpractice suit. The most common types of breaches in the medical profession involve failures to diagnose; misdiagnoses; misreading or ignoring laboratory results; unnecessary surgery; surgical errors or wrong site surgery; incorrect medication or dosage; poor follow-up aftercare; premature discharge; disregarding or not taking appropriate patient history; failure to order proper testing; and failure to recognize symptoms. In the U.S., the leading cause of malpractice suits is diagnostic error, which account for around 40% of cases, costing insurers an average of $300,000 per case to settle. (Klebanow, 2013)

The following source presents statistics that contribute to improving diminishing medical malpractice through modifications regarding the distribution of information (transparency) and the efficiency of health courts. A decline in surgery mistakes was unveiled after New York passed a law to enforce transparency of surgery outcomes. For this reason, it is of utmost importance to enforce transparency between hospitals; however, it must be enforced nationwide – rather than merely statewide. Nationwide transparency promotes a consistent standard of care all hospitals must abide by while allowing for more information regarding mistakes to learn about and prevent further mistakes. Greater awareness of the weaknesses other hospitals face – as seen through their mishaps – helps hospitals to self-evaluate and improve their technology, procedure, and staff more effectively, as the aspects they must improve are targeted and more identifying through the information shared. Concealment of errors deprived the medical community of the opportunity to develop the necessary protocol and technology to make further advancements in medicine, hence the need for transparency and the construction of a suitable environment for doctors to be at will to report any shortcomings to their superiors. To build an environment apt for doctors to practice transparency, the implementation of health courts and other alternative forms of the applications of law into medicine is vital, as it lessens the stress surrounding the misjudgment by juries unfamiliar with the practice of medicine and provides a more empirical, unbiased analysis of the cases at hand.

Most importantly, these health courts veer the focus of these cases toward their possible contribution to medicine, as the mistakes are often discussed on a panel with other physicians. Discussing among professionals inherently manifests itself in their own professional lives as they work more consciously to avoid any

mistakes that have already been made. Health courts' goal accommodates medicine's goal more adequately: to optimize patient care. Since the ultimate goals of criminal court laws and medicine rarely coincide, by disregarding these laws and developing more applicable laws, the court and the physicians can work together to provide adequate patient compensation while acting in the best interests of advancing medicine.

When Doctors Make Mistakes

Atul Gawande, a surgical resident, reflects on his negligence when assigned a complex trauma case and reveals the flaws in the medical malpractice systems impeding him from taking autonomy of his mistake, prolonging the learning process that all physicians must undergo to strive for perfection and flawless care. Media tends to portray negligence and medical mistakes as abnormal, deeming doctors who make these mistakes as "bad physicians." However, this common misconception stems from the medical malpractice system's consistent demonization of mishaps, causing additional – and unnecessary – shame for professionals. All doctors are prone to make mistakes at any point in their career; however, the institutions' procedures are in place to minimize these mistakes by supporting struggling doctors to ensure a prosperous future for patient outcomes. Medical malpractice should focus on constructing a better system, not deconstructing a physician's will to pursue their passion. Atul Gawande shares his experience with a trauma patient – an unidentified female unrestraint driver unresponsive at the scene of a car accident – and the precautions he failed to comply with. Atul's failed attempt at a tracheostomy could have potentially left his patient a vegetable, brain dead. Upon reflection, he revealed his regret for not having called for help before the patient's condition became critical, overwhelmed with shame for his mistake while encouraged by the hospital to hide his mistakes to avoid legal attacks. According to Harvard professor of law Troyen Brenan, medical malpractice suits unsuccessfully reduce negligence as no evidence links decreased medical malpractice and litigation against doctors. Contrary to the belief that the system advocates diminishing negligence, malpractice suits halt doctors from fully acknowledging their mistakes, as hospital lawyers advise them to refrain from fully disclosing their errors to the patient for fear of being used against them in court. For this reason, doctors founded the Morbidity and Mortality Conference to hold no restraints on the elements of each case, highlighting errors and coming up with alternate outcomes or solutions for prevention. Nevertheless, the mere discussion of mistakes makes no sufficient contribution to improving the medical system, bringing forth the first in-comprehensive look into the weaknesses in medicine – in this case, anesthesia. Bioengineer Jeffrey Cooper interviewed hundreds of anesthesiologists and compiled a list of 359 errors: consistent malfunctions due to poorly built machines, misreading, disconnections of cables, failure to maintain a patient's breathing stable, and many others. A noteworthy example of this would be machine dials, where some turn clockwise while others turn counterclockwise, which are likely to cause errors. Jeffrey concluded that failure to fully understand the machines, fatigue, insufficient familiarity with the machines, inattention, and poor team communication all contribute to the accidents. His findings were shared internationally, causing manufacturers to begin standardizing dials, implementing locks, and implementing proper training for new hospital equipment. Jeffrey Cooper's initiative became the cornerstone for advancements in medicine, as it encouraged the community to look at errors as clues hinting toward the next innovation. On the contrary to inefficient malpractice methods, Jeffrey Cooper laid the groundwork for a more prolific method of addressing negligence yet to be applied to all sects of medicine to offer superior outcomes for future patients:

The result was the first in-depth scientific look at errors in medicine. His detailed analysis of three hundred and fifty-nine errors provided a view of the profession unlike anything that had been seen before. Contrary to the prevailing assumption that the start of anesthesia ("takeoff") was the most dangerous part, anesthesiologists learned that incidents tended to occur in the middle of anesthesia, when vigilance waned. The most common kind of incident involved errors in maintaining the patient's breathing, and these were usually the result of an undetected disconnection or misconnection of the breathing tubing, mistakes in managing the airway, or mistakes in using the anesthesia machine. Just as important, Cooper enumerated a list of contributory

factors, including inadequate experience, inadequate familiarity with equipment, poor communication among team members, haste, inattention, and fatigue. The study provoked widespread debate among anesthesiologists, but there was no concerted effort to solve the problems until Jeep Pierce came along. Through the anesthesiology society at first, and then through a foundation that he started, Pierce directed funding into research on how to reduce the problems Cooper had identified, sponsored an international conference to gather ideas from around the world, and brought anesthesia machine designers into safety discussions. It all worked. Hours for anesthesiology residents were shortened. Manufacturers began redesigning their machines with fallible human beings in mind. Dials were standardized to turn in a uniform direction; locks were put in to prevent accidental administration of more than one anesthetic gas; controls were changed so that oxygen delivery could not be turned down to zero (Gawande, 2002).

In contribution to the thesis of this investigation, the following article conveys that the present medical malpractice liability system fails to diminish errors in the workplace and instead adds unnecessary stress to the doctor, which impedes them from comprehensively analyzing their own mistake and learning. As outlined in the article, there is no correlation between malpractice suits won by the patient and a decrease in negligence. For this reason, the malpractice liability system's ultimate goal must focus on the best patient recompensating and ensure doctors receive adequate consequences for their actions; however, they are guided to learn from their mistakes and eventually get back into the surgery room. Although there are some outliers of doctors who acted to cause harm to a patient intentionally or are conscious of their inability to work at their full potential, mistakes such as Atul's are, at best, opportunities to learn and evolve as a physician. However, doctors may only analyze their mistakes properly in an environment that promotes transparency and taking responsibility for mistakes rather than conceal them. Often, concealment comes from fear of significant litigation or high fines. Therefore, the first step in improving the liability system for malpractice would be to eliminate the fear that causes concealment, in this case, through the health courts. As shown through the study on anesthesiologists, the publication of investigations regarding the causes for the hundreds of errors made by anesthesiologists prompted manufacturers, hospitals, and professionals themselves to identify the root causes for mistakes: lack of rest, unfamiliarity with machines and the confusing mechanisms of which are prone to mistake. In the example of the consuming knobs, of which some turn clockwise and others counterclockwise, the sharing of this information reached manufacturers and prompted them to change their designs by adding locks, creating consistent turning patterns, and other modifications to facilitate its operation in the hospitals. Not only does this show the utmost importance and grave impact transparency has on the advancement of medicine, but it also shows that by recounting the entire picture surrounding a mistake, it brings to the awareness that some mistakes are not caused by one individual doctor, but by a plethora of factors all leading to a chain of events ending with a grave mistake. Understanding that most errors stem from a system of errors made not only allows institutions to improve all aspects of the system to prevent further errors but also alleviates the pressures often placed on a single individual due to a mistake, thus creating a more comfortable environment to report mistakes and genuinely work in ways to improve.

Interview with Trauma Doctor Administrator

The interview serves the purpose of exalting the reality of the medical responsibility system, or the "liability" system of malpractice, in Puerto Rico. Presented by "Centro Medico's" past Trauma Doctor Administrator, a comparison between the management of malpractice cases between private and public organizations (under government criteria) demonstrates the failures, not only in the system of responsibility before the doctor, but the saturation of the part of frivolous accusations preventing a doctor from exercising his profession correctly. In Puerto Rico, the Medical Center is the leading health center in the country, functioning as an autonomous institution under the management of the government department of the Puerto Rico Medical Services Administration (ASEM). The hospital provides educational opportunities, thus being a learning hospital, forming part

of the University of Puerto Rico with the branch of the Medical Sciences Campus – the island's prestigious medical school. During the years that Dr. Víctor Medina worked as director of the surgical unit, which exposed him to a plethora of unexpected circumstances, complex problems, and, most importantly, the handling of malpractice cases during his years as director. Through several interviews, Dr. Medina presents the complex panorama of what a case of malpractice entails, comparing the protocol of a governmentalized hospital such as a Medical Center versus some privatized ones to address erroneous or false concepts about the penalty, due to the "lack of responsibility" of a doctor. If a case arises of a failure in a surgery, if the doctors do not detect it and the patient is dismissed, the case is usually handled through the lawyer of the affected patient.

Furthermore, with access to social networks, both the patient and the patient use them to compile evidence against them since the abundance of information often creates "cyber doctors," which creates distrust between the experienced doctor and the patient because of unreliable information. Due to the saturation of frivolous accusations, the hospital receives the lawsuit and decides whether it is necessary to intervene with the doctor or not, meaning that the majority of malpractice lawsuits do not reach the hands of the doctors, demonstrating a lack of care in the medical liability system or abuse of the legal system to recover insurance money. However, in extreme cases – demonstrating a significant failure on the part of the medical team – it occurs during the "Mortality and Morbidity" session, where the procedure that was carried out is reviewed, and protocols are modified according to the limitations affecting effectiveness. Of the doctor and reorient the medical team to be on par with the new criteria. Especially in "teaching hospitals," such as the medical center, attending these sessions emphasizes taking advantage of medical errors and increasing learning. However, compared to private institutions, due to the lack of filtering of lawsuits against doctors, hospital directors or senior executives usually hide the lawsuits from their doctors, simply claiming and paying to eliminate the problem. Even though private hospitals tend to be able to pay any claim, public hospitals – like Centro Médico – limit the claim's value to one million dollars. Private hospitals ignore errors and do not conduct adequate reviews in malpractice cases, removing the opportunity for information exchange between hospitals and forming an attitude towards collective progress. However, in both hospitals, doctors tend to practice preventive medicine, requiring unnecessary tests from the patient to protect themselves from negligence in their work legally. As frivolous lawsuits and orders to practice preventive medicine increase, the price of medical plans and doctors' insurance increases even more, worsening the economic, legal, and administrative problems within hospitals in Puerto Rico. Therefore, the malpractice management ruling contains the biggest failure in the courts. By having a jury and judge affiliated with knowledge of the law, there is a dearth of scientific and medical knowledge within the court to analyze the case according to the standards set by medicine, not simply by civil law:

1. La medicina se convirtió en la guagua de los abogados:
    a. El seguro paga
    b. Demanda que el seguro paga
    c. Se aumenta el seguro
    d. La vida te la dañan
    e. Desaforar el abogado
        i. Una reclamación
        ii. Es pro-paciente
        iii. Decisión difícil
        iv. No esta al día con los estándares
        v. Con hace 30 años atrás
        vi. El medico no es, los otros lo cuenta
        vii. Si se queda una gaza, fue alguien más
        viii. Cuadra el conteo
        ix. La medicina ya no es el medico como protagonista, ya que hay muchos más que intervienen con ese paciente

x. Te llevas toda esa gente enredada

2. Menos Nacimientos:
    a. Dejando el oficio
    b. Tiene hasta 21 años para demanda
        i. Complicaciones
        ii. Porque el entiende que tuvo
    c. Estados unidos, ellos te pagan la impericia
    d. En Texas, los bienes privativos no son para una demanda
    e. Bienes privativos no se tocan
    f. Debe haber una ley que lo que es privado de una persona
    g. Van en contra de lo que tienes
        i. Hay varios estados en la misma
3. Impacto Psicológico:
    a. Demandas frívolas deben ser adjudicadas
    b. Debe de haber una contra demanda
    c. Fundamentos no hay
    d. Sellos – tribunal
4. Junta como amigos del tribunal:
    a. Si o no tiene merito
    b. Todo el mundo puede demandar
5. Si él se siente cómodo sin tener medicina defensiva:
    a. Ordenar todo para que no te demanden
    b. Esta mal también
    c. Hacer pasar el paciente por cosas innecesarias
6. Necesitamos un cambio de sistema:
    a. Impericias
    b. Ellos tienen derechos
    c. Más del 70 demandas que son frívolas
7. Aumentado:
    a. Mas demandas
    b. Fuera de series
    c. Cambio de redes sociales
    d. Todos son médicos, Wikipedia
    e. Aumento de información falsa
    f. Tecnología está ahí para ayudar al médico
    g. Tecnología
    h. Saturación
    i. No hay un filtro
    j. O lo hace los médicos o una junta
        i. Aquí no funciona

(Gavilanes, 2024)

This source contributes significantly to this investigation as it displays the realm of the medical malpractice liability system on one of the United States territories – Puerto Rico – to indicate the consequences of an unexclusive federal government, the need for personalization of each medical malpractice case, and the threat the misinformation in the media pose on frivolous lawsuits – of which saturate both the legal system and medical community, leading to stagnancies to solve the problems at hand. Additionally, this source discusses the impacts

of preventive medicine on monetizing medicine and exposes the insurance's role in covering medical malpractice suits for doctors. As medical referrals for examination and incoming frivolous malpractice cases continue to rise, the price for patient and doctor insurance rises, depicting medicine not as a system in place to serve the public but as a commercialized system seeking to gain profits. To protect themselves legally, especially from courts unfamiliar with the nature of medical mistakes, preventive medicine is a tool doctors resort to deem as evidence to support their innocence. Additionally, the media's misinformation allows patients to gain false insight regarding their procedures, causing them to doubt their doctor's abilities based on information extrapolated from unreliable sources. Based on this false evidence, doctors are consistently tried for trivial cases, of which no error sometimes occurs. Lawsuit filters are essential to cast out any fake malpractice suits to diminish the stress placed on doctors and allow doctors to prioritize the actual mistakes that need to be analyzed rather than fall oversaturated by nonexistent mistakes. If no saturation of these types of suits occurs, doctors would potentially view all errors as frivolous and begin ignoring the importance of analyzing the factual mistakes due to the oversaturation of these lies. Often, these frivolous cases are used to gain profit from these cases, therefore contributing to the view of medicine as becoming a business rather than an entity to protect the public.

Further monetarization of medicine comes from the inadequate funding and lack of accommodations made – in this case by the federal government (USA) – to grant Puerto Rico's public hospital funding to be able to counter medical malpractice as well as lack of incentive for the hospital to be able to implement such systems to diminish the errors. Health courts, panels, extra training, and equipment replacement are all funded by the federal and local governments; however, Puerto Rico's territorial status becomes a hurdle to access the resources required to implement better malpractice liability systems. In turn, hospital initiatives, such as a potential "cloud of information," promote error transparency and stimulate the flow of new information from which hospitals all over the island can learn. Reevaluation of cases, extensive studies, and retraining all contribute to the reintegration of a doctor back into their work if deserving of the opportunity. Health courts and the personalization of the malpractice case analysis contribute to the doctors' reintegration back into their jobs, as it diminishes the fear surrounding punishment while ensuring the doctor's consciousness surrounding the graveness of their mistake. Standards of care and a code of laws created by medical guidelines create a precedent for other cases while maintaining a degree of personalization by including a panel of expert doctors called in to analyze the entirety of the case. In retrospect, health courts, panels, and lawsuit filters help decrease the commercialization of the medical malpractice liability system and promote a learning opportunity for doctors by diluting the number of cases to those unaffiliated with frivolity, in turn lowering the prices of doctor insurance from medical error, veers the focus from money to medicine, and decreases the need for excessive preventive measure – of which also contribute to rising prices of the system – because doctors are aware of the expert eyes analyzing their cases.

Methods

This investigation utilized a computer with an internet connection and an internet browser (Ebsco host). The Google search engine was paramount for pinpointing the necessary sources to elucidate the research question. Although the internet connection was unstable at times, it proved sufficient to conduct all the required constituents of this investigation. Even though some sources are not peer-reviewed, the investigation mentor played a crucial role in revising and approving them, confirming their validity. All these components, including the invaluable input of the research advisor, created the optimal conditions for the consummation of this project.

The investigation was mainly qualitative, utilizing a documentary analysis design supplemented by an interview. To populate this research, it was necessary to specify the purpose of each of the ten sources used. Furthermore, it was essential to recognize the source's design and approach, indicate the target audience, highlight their limitations, and determine their recommendations and findings. An analytical component outlining

the significance of the data presented in the inquiry was generated, so a descriptive content analysis methodology had to be utilized for this investigation.

In terms of methodology, the descriptive content analysis was thorough and detailed, following a structured outline where students evaluated the article's purpose, design, and methodology, analyzed the target population, synthesized summaries, discussed limitations, delineated conclusions or results, and provided recommendations. The document selection process utilized EBSCOhost and Google Scholar, ensuring that all sources were peer-reviewed articles approved by the research advisor.

Results & Limitations

The utilized search engines Ebsco Host and Google Scholar proved most beneficial for the selected sources of this investigation. One of the sources was recent (2018), and it dealt with information regarding the case of a piece of gauze removed from a woman's abdomen weeks after a C-section was performed and discusses the hospital's handling of the news surrounding the mistake. The second and third sources were not recent since they were published in 2003. Respectively, they dealt with the malpractice case of Stephanie Valdez and the reporting of yet another case where gauze was found inside the patient after the operation. In both reports of the incident, actions the hospital undertook in response to the news of a medical mistake were merely discussed, displaying the dismissive behavior showcased by the hospital regarding mistakes made in their institution. The fourth source was not recent (2007). It discussed information regarding the consequences of Dennis H. Madigan's lawsuit against his doctors after he lost his leg because of a sponge left post-operation. The fifth source was not recent (2012), and it recounts when the Simi Valley Hospital was fined once for negligence from medical malpractice suits. The sixth source was not recent (2005), describing how physician Susan Sheridan developed the Sorry Works! Program to support the movement to promote transparency of errors to improve the hospital systems' efficacy in handling medical errors in their institutions. The seventh source was not recent (2008), and it delved into the plethora of methods hospitals could implement in their institution to maximize improvement and learning from malpractice cases while diminishing the legalities convoluting improvement of the systems of malpractice liability; measures included health courts, physician-patient contracts, or no-fault coverage. The eighth source was not recent (2013), and it demonstrated that the malpractice liability systems' tendencies to conceal errors are counterproductive. Therefore, the source promotes methods to increase transparency and learn from mistakes to improve patient care. The ninth source was not recent (2002). It validated the fact that surgical resident Atul Gawande reflects on his mistakes as a resident, how the malpractice protocols in the hospital hindered the development of his skill following the accident, and the complexities behind an error: letting it be not single individual falling responsible, but the entire system surrounding the mistake. The tenth source was a very recent interview (2024), and it elucidated the measures taken by hospitals to insinuate learning from mistakes, the difficulties that come from the control that insurance companies have on doctors' actions, and the consensus for change in the system to filter frivolous cases from serious ones.

For the investigation to come to fruition, the scope of the research question had to be more encompassing to find more information on the subject, which permitted the optimal conditions to answer the research question. If the original research question had not been changed, the essay would not have been written as well, given that the research question would have been challenging to complete. Sources related to reports of malpractice cases lacked in their presentation of the hospital's actions regarding the errors made; rather, through the lack of this information, it was deduced that secretive nature and no disclosure demonstrated the secretive nature of these errors. An internal threat is posed in analyzing the data in terms of the research question, where bias may overlap with the data each source presented since different perspectives may interpret the acts of the hospital differently than that of this investigation. External threats arise from the authors or voices extrapolating the information. Articles proposing to revolutionize the malpractice liability system favor patient outcomes and tend to bias against doctors, deeming them as the villains of the scene. However, interviews led by doctors

suggest that the true culprits for the malpractice conundrum stem from frivolous cases, overpowered insurance companies, and the monetarization of malpractice by lawyers. To minimize bias within the investigation, perspectives from both sides are woven, and the investigation acts as a consensus between the clashing perspectives. The research questions the efficacy of the present medical malpractice liability system, claiming that the reclusive nature and lack of transparency fostered by the excessive legalities surrounding medical mistakes threaten improving patient care. This investigation outlines the current legal system's stagnancy, as failing to disclose such information withholds an in-depth analysis of the mistake and deprives professionals of the learning opportunity (Sloan & Chepke, 2008).

The limitations that the research encountered are as follows: Firstly, the literature review, while comprehensive, needed to sufficiently explore the patient's perspectives and experiences regarding medical malpractice, which is crucial for understanding the full impact of the liability system. Additionally, the review needed a cross-cultural analysis, limiting the comparative context with other countries' medical malpractice systems. Although disparities between the Puerto Rican liability system and that of different sectors of the United States demonstrated a grave difference– regarding budgets, attitudes toward patients, and cultural work ethics – between the regions, since Puerto Rico essentially makes part of the United States as an unincorporated territory, domestic classification of Puerto Rico hinders the investigation from considering it as a cross-culture analysis. The lack of empirical evidence on the effectiveness of health courts and professional panels diminishes the validity of proposed potential solutions, limiting the conclusions and recommendations the investigation provides. Sources lacked insight into the economic implications of implementing such reforms, leaving a gap in the investigation's analysis of the potential financial benefits of these changes. Despite the comprehensive methodology employed in the investigation, limitations still exist. The study lacked detailed explanations of the data collection processes, including the specific selection criteria for documents and the interview process. Additionally, while the structured outline aimed to ensure thorough analysis, the reliability and validity of the findings needed to be thoroughly discussed, which could affect the study's credibility.

While this investigation faced several significant threats to its internal and external validity, it also presents exciting opportunities for future research. The internal threats, including potential biases in document selection and the subjective nature of descriptive content analysis, are crucial areas that could be further explored to enhance data interpretation. Similarly, the external threats, such as the limited generalizability of findings due to the study's focus on the US and Puerto Rico, are important factors that could inspire future studies to broaden their scope and increase the applicability of their results.

Discussion & Conclusion

This investigation sheds light on the ethical complexities stemming from the inefficiencies of the current medical malpractice liability system. The research revealed that excessive legal regulations and the monetarization of malpractice cases create an environment of secrecy, hindering the learning opportunities that arise from medical errors and ultimately deteriorating patient care. A thorough analysis of peer-reviewed articles and a descriptive content analysis determined that reforms such as implementing health courts and professional panels are essential to promote transparency and accountability in the medical field. The following research questions posed at the beginning of this investigation were: How have faults in medical malpractice liability systems led to the inability to decrease patient quality and error? Why should the medical malpractice liability system view errors as learning opportunities and adverse outcomes? What implementation within institutions could promote transparency of medical errors, treat mistakes as learning opportunities, and minimize the fear surrounding legal actions against doctors? The study answered these questions by demonstrating that the current system's focus on litigation and financial compensation often discourages transparency and learning. Instead, promoting a system that views errors as opportunities for improvement through implementing health courts and medical professional panels can significantly enhance patient care and reduce medical errors. Altering common law to

accommodate medical criteria reinforces an educationally constructive environment surrounding a malpractice case, ensuring the unbiased and scientific integrity behind a court's analysis of any case. Recommendations for future investigations include conducting more comprehensive studies that incorporate patients' perspectives and psychological impacts regarding medical malpractice. Comprehensive cross-cultural analysis would provide substantial comparisons for the study to identify the most effective medical malpractice liability systems. Research should consider performing pilot programs and case studies to extrapolate empirical evidence to support the investigation's claim regarding the efficacy of health courts and medical panels led by professionals in the field. Additionally, future research should explore the economic implications of implementing these reforms and investigate the role insurance companies play regarding medical malpractice litigation within the economic aspects of malpractice litigation. By addressing the gaps and limitations in this study, future research can further contribute to developing a more ethical and practical medical malpractice liability system that prioritizes patient care and physician care and fosters a culture of continuous learning and improvement.

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