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Quality of Health Care and the Role of Relationships: Bridging the Medico-Legal Divide

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QUALITY OF HEALTH CARE AND THE ROLE OF RELATIONSHIPS: BRIDGING THE MEDICO-LEGAL DIVIDE

Sagit Mor[†] *and Orna Rabinovich Einy*[††]

ABSTRACT

This Article focuses on an often overlooked barrier to efforts to enhance the quality of health care: the relationship crisis that currently exists between physicians and patients. This state of affairs has resulted from the divide between the medical and legal worlds. The medical arena has understandably tended to view the doctor-patient relationship as a purely medical issue, ignoring the law's impact in generating and sustaining problematic relationship patterns. The legal world has yet to fully recognize this state of affairs, and the law's role in its evolution and persistence. We offer a relational approach to health-care law as a means of bridging the divide between the two disciplines. In the malpractice context, this would entail adopting a no-fault compensation scheme, which is committed to strengthening collaborative doctor-patient relations, enhancing patient safety and systemic learning, while providing adequate compensation.

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INTRODUCTION

Over a decade ago, the Institute of Medicine (IOM) published *To Err is Human*,[1] marking a dramatic shift in the understanding of quality of care within the medical arena. The report reframed the debate about the nature and sources of medical errors, underscoring systemic and structural elements as opposed to the traditional emphasis on individual fault and incompetence.[2] It contained shocking data on the prevalence of medical errors and related injuries and deaths,[3] and also offered innovative structural measures for preventing errors and enhancing patient safety.[4]

The recommendations contained in the IOM report were also significant for another, more subtle, reason: they reflected an understanding that a transformation in the quality of health-care services requires a broad-based approach that recognizes the role played by the law in shaping and structuring the manner in which health-care services are organized and delivered.[5] Unfortunately, the legal and medical fields have failed to cooperate in generating a mutual, comprehensive, and effective effort towards reducing medical errors, enhancing patient safety, and improving the quality of medical services. Our inquiry

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[1] INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Linda T. Kohn et al. eds., 2000), *available at* http://www.nap.edu/openbook.php?isbn=0309068371.

[2] Paul Barringer et al., *Administrative Compensation of Medical Injuries: A Hardy Perennial Blooms Again*, 33 J. HEALTH POL. POL'Y & LAW 725, 751 (2008); David M. Studdert & Troyen A. Brennan, *No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention*, 286 JAMA 217, 217 (2001); David A. Hyman, Commentary, *Medical Malpractice and the Tort System: What Do We Know and What (if Anything) Should We Do About It?*, 80 TEX. L. REV. 1639, 1647 & n.28 (2002).

[3] TO ERR IS HUMAN, *supra* note 1, at 1-5.

[4] *Id.* at 6-14.

[5] In the years following the publication of *To Err is Human*, the Harvard group published a series of articles advocating the shift to a no-fault enterprise liability model as a superior means for achieving the broader, systemic goals of prevention and learning and the individual goal of compensation. *See* Studdert & Brennan, *supra* note 2, at 220; Barringer et al., *supra* note 2, at 751; Allen Kachalia et al., *Beyond Negligence: Avoidability and Medical Injury Compensation*, 66 SOC. SCI. & MED. 387, 387 (2008).

focuses on one realm in which a clear chasm exists: the role of relationships in providing high quality medical care and reducing malpractice claims. In this Article, we offer a new framework that connects quality of health care with relationships by bridging the gap between medical and legal responses to the quality crisis. As we show below, relationships play a central role in the provision of medical care. Effective communication is a crucial component of physicians' ability to accurately diagnose medical conditions, prevent prescription-related mistakes, and ensure that patients adhere to treatment plans.

While the medical profession has recognized the impact of relationships on quality of care, the legal community has yet to incorporate these concerns into the design of legal arrangements and institutions. In exploring this reality, we reveal two areas of disconnect. While many medical professionals recognize the significance of relationships, they have overlooked the elusive role the law has played in hampering the doctor-patient relationship. Similarly, the legal field has narrowly understood the impact of legal arrangements on doctor-patient relationships. Legal reforms have largely been relegated to addressing post-error doctor-patient interactions, missing the subtle ways in which the shadow of malpractice law has shaped the entire continuum of care. Furthermore, the law has failed to provide adequate incentives for the generation of rich information on the sources of errors by remaining committed to a torts-based system that is focused on personal blame and individual deterrence. The legal regime has not only failed to remedy errors and prevent future mishaps, it has generated a relationship crisis in health care.

We therefore advocate that the law adopt a relational perspective when regulating the realm of medical malpractice. A relational approach to medical errors is rooted in relational theory, as developed by feminist theorists and communitarians.[6] This theory highlights the importance of relationships in human interaction. In the legal realm, such theories have emphasized the need to design legal rules and institutions that promote such values as care, interconnectedness, and solidarity. Specifically, in the area of medical error and quality enhancement, adopting a relational approach requires the replacement of the current torts-based liability regime with a no-fault system designed

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[6] *See* CAROL GILLIGAN, IN A DIFFERENT VOICE: PSYCHOLOGICAL THEORY AND WOMEN'S DEVELOPMENT (2d ed. 1993); Robin West, *Jurisprudence and Gender*, 55 U. CHI. L. REV. 1, 2-3 (1988); WILL KYMLICKA, MULTICULTURAL CITIZENSHIP: A LIBERAL THEORY OF MINORITY RIGHT 75 (1995); CHARLES TAYLOR ET AL., MULTICULTURALISM: EXAMINING THE POLITICS OF RECOGNITION 25 (Amy Gutmann ed., 1994).

with relationships in mind. Such a system would be equally committed to strengthening the doctor-patient relationship, enhancing patient safety, providing adequate compensation, and promoting ongoing learning efforts by health-care providers on the sources of errors and avenues for redress and prevention.[7] While no-fault systems are by no means new, former proposals for no-fault regimes in this area were designed to advance other goals, and therefore could not bring about a deep transformation of doctor-patient relations.[8]

In Part I, we examine the connection between the doctor-patient relationship and the quality of health care. The medical field has recognized the role effective doctor-patient communication plays in ensuring better and more satisfactory care. However, the efforts to improve such communication have failed to bring about real change. While such failure has typically been tied to professional culture, we identify the role played by the shadow of malpractice law in hindering communication. Therefore, in Part II, we uncover the ways in which the existing fault-based malpractice regime has contributed to the current relationship crisis between health-care providers and patients. While the law's negative impact has been recognized in the realm of post-error communication, we maintain that its influence has been much broader. In Part III, we advance a legal reform proposal that recognizes both the significance of doctor-patient to health-care quality, and the negative impact legal arrangements have had on doctor-patient relations. We therefore propose a shift from a fault-based to a no-fault based liability scheme, based on a relational justification for such change. By designing such schemes with relationships in mind, the goals and means for achieving them differ substantially from previous proposals for no-fault compensation systems in the malpractice arena. We conclude with a call for the law to recognize that "to err is human" by cultivating learning that would allow the doctor-patient relationship to flourish.

I. RELATIONSHIPS AND QUALITY IMPROVEMENT IN THE MEDICAL FIELD

In recent decades, medical literature has increasingly recognized the importance of relationships in the provision of medical care. While doctors traditionally employed a paternalistic approach,[9] more

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[7] *See infra* Part III.

[8] *See infra* note 16 and accompanying text.

[9] DEBRA L. ROTER & JUDITH HALL, DOCTORS TALKING WITH PATIENTS 27-31 (1993). For further discussion on the paternalistic model, *see* Ezekiel J. Emanuel &

recently, patients' rights advocates have promoted a shift toward a more open, mutual, and collaborative doctor-patient relationship,[10] supported by empirical findings on the connection between this mode of interaction and the quality of care.[11] There is a clear link between collaborative relationships and providers' ability to obtain relevant information regarding a patient's medical condition.[12] In addition, patients' motivation to seek medical care and adhere to prescribed treatments depends on the nature of their relationship with their physician and the quality of information provided to them.[13]

There is indication that even health outcomes, perhaps the most central component of health-care quality, depend on the nature of the doctor-patient relationship. Research indicates that open and collaborative interactions can actually lead to "improved recovery from surgery, decreased use of pain medication, and shortened hospital stays, as well as improved physiological changes . . . and better management of chronic conditions."[14] Furthermore, collaborative doctor-patient relationships help generate high levels of patient satisfaction, and are more valued by patients than other factors such as the scope of tests ordered and adequate documentation.[15] Finally, collaborative doctor-patient relationships also enhance the physicians' wellbeing and satisfaction.[16]

These findings underscore the significance of relationships in ensuring the quality of medical care, alongside the more traditional parameters of technical competency and clinical expertise. Indeed, in the last two decades, medical education has undergone significant changes, with the introduction of communication skills and a relation-

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Linda L. Emanuel, *Four Models of the Physician-Patient Relationship*, 267 JAMA 2221, 2221 (1992).

[10] We define a "collaborative relationship" as one that is premised on a mutual, open and cooperative discourse. The term collaborative communication draws on a powerful typology developed by Roter and Hall, distinguishing between paternalistic, consumerist, default and mutual prototypes of the doctor-patient relationship. ROTER & HALL, *supra* note 9, at 5.

[11] *Id.* at 28-30.

[12] M. Robin DiMatteo, *The Physician-Patient Relationship: Effects on the Quality of Health Care*, 37 CLINICAL OBSTETRICS & GYNECOLOGY 149, 152-55 (1994).

[13] *Id.* at 153-54; Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 478-82 (2002); Jonathan Todres, *Toward Healing and Restoration for All: Reframing Medical Malpractice Reform*, 39 CONN. L. REV. 667, 690-91 (2006).

[14] DiMatteo, *supra* note 12, at 158; *see also* ROTER & HALL, *supra* note 8 at 3.

[15] Gerald B. Hickson et al., *Development of an Early Identification and Response Model of Malpractice Prevention*, 60 LAW & CONTEMP. PROBS. 7, 9-12 (1997).

[16] Michelle Mello et al., *Caring for Patients in a Malpractice Crisis: Physician Satisfaction and Quality of Care*, 23 HEALTH AFF., July-Aug. 2004, at 42, 43.

al prism to the core curriculum.[17] Such a relational perspective was evidenced in new schools of thought, which emphasized the centrality of relationships, and situated care, empathy, and connectedness at the heart of clinical practice. The writing on ethics of care has sought to infuse a new set of principles and values into classical medical ethics, such as "human connection, responsibility, care, and context."[18] Similarly, "narrative medicine" aspires to teach physicians to listen to their patients and to convince them that staying connected with their feelings improves their clinical performance and their own satisfaction with work.[19] The importance of doctor-patient relationships was also apparent in the 2001 IOM report *Crossing the Quality Chasm*, which described patient-centered care as a key dimension of high quality health care.[20]

However, the impact of these developments has been limited, and physicians' prevailing mode of interaction with patients remains defensive, closed off, or confrontational.[21] Similarly, the traditional hierarchy between professional and communication skills has persisted, partially due to the persistence of a professional culture enshrining scientific knowledge and technical expertise above all else.[22]

Communication failures are particularly evident during post-error interaction between providers and injured patients or family members.

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[17] Bobbi McAdoo, *Physicians: Listen Up and Take Your Communication Skills Training Seriously*, 29 HAMLINE J. PUB. L. & POL'Y 287, 290-93 (2008).

[18] Amy Freedman, *The Physician-Patient Relationship and the Ethic of Care*, 148 CANADIAN MED. ASS'N J. 1037, 1037 (1993); Rosemarie Tong, *The Ethics of Care: A Feminist Virtue Ethics of Care for Healthcare Practitioners*, 23 J. MED. & PHIL. 131, 132 (1998); MEDICINE AND THE ETHICS OF CARE 13 (Diana Fritz Cates & Paul Lauritzen eds., 2001).

[19] Miriam Divinsky, *Stories for Life: Introduction to Narrative Medicine*, 53 CANADIAN FAM. PHYSICIAN 203, 204 (2007); Rita Charon, *Narrative and Medicine*, 350 NEW ENGL. J. MED. 862, 863 (2004).

[20] INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY (2001), *available at* http://www.nap.edu/openbook.php?isbn=0309072808.

[21] Stephen Langel, *Averting Medical Malpractice Lawsuits: Effective Medicine—Or Inadequate Cure?*, 29 HEALTH AFF. 1565, 1566-67 (2010).

[22] Marlynn Wei, *Doctors, Apologies, and the Law: An Analysis and Critique of Apology Laws*, 39 J. HEALTH L. 107, 147-49 (2006); DiMatteo, *supra* note 12, at 149 (stating that "[t]he role of communication in the physician-patient relationship, however, is sometimes trivialized. It may seem natural to achieve therapeutic success by placing great emphasis on physical examinations, blood tests, x-rays, sonograms, medications, and surgeries. However, available information suggests that when this is done to the exclusion of a meaningful exchange of information and ideas…several critical elements of patient care are adversely affected."). This is also fostered by the fact that the system reimburses physicians for procedures done to patients and not for talking to them and is evident in the prominent definitions of quality of care in the field. *Id.* at 153.

Physician communication in the aftermath of a medical error has a direct impact on a patients' inclination to sue.[23] Patients' and family members' motivation to sue is most often spurred primarily by their desire for information about the source of the error, their need to hear apologies and expressions of empathy by medical staff, and their desire to prevent future mishaps, rather than by their desire for monetary compensation.[24] An innovative effort to transform this reality was the publication of the Harvard Hospitals' consensus statement, entitled *When Things Go Wrong*,[25] which offered a model protocol for disclosure of medical mistakes by medical staff and institutions. Various medical institutions adopted similar post-error disclosure protocols and programs, typically providing their staff with training aimed at enhancing their communication skills.[26]

However, post-error communications between doctors and patients is too narrow a set of circumstances to engender a deep change in the culture of communication between doctors and patients. The above-mentioned initiatives have contributed to the development of a more interactive environment by emphasizing the significance of relationships and communication. But the emphasis on post-error communication may cause the goal of lawsuit deflection to overshadow the broader benefits of learning and quality improvement through collaborative communication.[27] This misguided focus perpetuates a narrow understanding of the ways in which law shapes medical interaction and treatment. The quality debate and the efforts to reform medical care have focused on measures that are internal to the medical profession, assigning a limited role to legal mechanisms in enhancing

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[23] Tamara Relis, *"It's Not About the Money!": A Theory on Misconceptions of Plaintiffs' Litigation Aims*, 68 U. PITT. L. REV. 341, 366 (2006); Carol B. Liebman & Chris Stern Hyman, *A Mediation Skills Model to Manage Disclosure of Errors and Adverse Events to Patients*, 23 HEALTH AFF., July-Aug. 2004, at 22, 23-24; Hickson et al., *supra* note 15, at 12.

[24] Relis, *supra* note 23, at 361, 363-67.

[25] *See* Liebman & Hyman, *supra* note 23, at 22; MASS. COAL. FOR THE PREVENTION OF MED. ERRORS, WHEN THINGS GO WRONG: RESPONDING TO ADVERSE EVENTS: A CONSENSUS STATEMENT OF THE HARVARD HOSPITALS (2006), *available at* http://www.macoalition.org/documents/respondingToAdverseEvents.pdf.

[26] *See* Langel, *supra* note 21, at 1567. Sporadic successful initiatives have been introduced. *See, e.g.*, Jonathan R. Cohen, *Advising Clients to Apologize*, 72 S. CAL. L. REV. 1009, 1010-11 (1999). However, the general view is that the medical profession has yet to undergo a real shift from a hierarchical mode of communication to a more collaborative one. *See* McAdoo, *supra* note 17, at 290-93 (describing the impressive efforts to introduce communication skills training into the curriculum of medical schools in the years since the publication of *To Err is Human*).

[27] For a more detailed discussion of learning, *see infra* Part III.

patient safety and quality.[28] In fact, as we demonstrate below, the impact of the law extends well beyond the moment of error. The shadow of malpractice law has had a more subtle and elusive impact on the conduct, demeanor, and communication of health-care providers. It infiltrates the entire continuum of care, whether an error occurs or not. While physician communication patterns have typically been tied to longstanding professional and organizational cultures,[29] the law plays a role in cutting off communication channels between providers and patients in contexts that extend beyond the realm of malpractice lawsuits.

II. THE LEGAL VIEW OF RELATIONSHIPS AND QUALITY IMPROVEMENT

The laws regulating medical issues are characterized by a compartmentalized approach. Each medical topic is addressed separately, often differently, resulting in incoherent and inconsistent approaches.[30] This compartmentalized approach is most evident in the area of medical errors, which are addressed under the law of malpractice. Malpractice is an isolated domain, addressed separately from other, sometimes-related topics such as managed care and bioethics.[31] As opposed to the broad, comprehensive view of what constitutes health care conveyed in *Crossing the Quality Chasm*, the law has become narrowly focused and fragmented. The dissection of health care into discrete areas runs counter to quality-enhancing efforts, in that it excludes important information regarding the sources of problems and barriers to effective care, and also obscures possible solutions to such difficulties.

Within the domain of malpractice, legal compartmentalization has proven particularly problematic with respect to learning and quality improvement efforts. The legal regime governing medical errors has identified individual compensation and deterrence as its primary goals. The focus is on establishing individual blame in order to justly compensate the injured, and stigmatize and deter careless doctors.[32]

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[28] *See* CROSSING THE QUALITY CHASM, *supra* note 20, at 218-19.

[29] Jay L. Hoecker, *Guess Who is Not Coming to Dinner: Where are the Physicians at the Healthcare Mediation Table?*, 29 HAMLINE J. PUB. L. & POL'Y 249, 252 (2008).

[30] For a view that fully rejects the attempt to find coherence in the field, *see* Henry T. Greely, *Some Thoughts on Academic Health Law*, 41 WAKE FOREST L. REV. 391 (2006).

[31] Mark A. Hall, *The History and Future of Health Care Law: An Essentialist View*, 41 WAKE FOREST L. REV. 347, 348-54 (2006).

[32] Wei, *supra* note 22, at 116-17.

Over the years, the system has proven ineffective in realizing the very goals it was designed to promote,[33] and also serves as a barrier to learning about errors and their sources.[34] Providers are less likely to report adverse events[35] or investigate their root causes because of fear of liability.[36] *To Err is Human* made clear that promoting quality necessitates a thorough inquiry into the details surrounding both adverse events and near-adverse events. At the same time, the report also recognized that the current legal regime presents real barriers to such efforts.[37] The report mobilized the legal community to support the foundation of a nationwide database of medical errors that would improve documentation and monitoring, although it provided no avenue for comprehensive reform.[38]

The law impacts the quality of medicine in other subtle, yet significant, ways. This impact has extended beyond the realm of data collection and learning, infiltrating the doctor-patient relationship. Some research portrays contemporary doctor-patient relations as a battle zone with most physicians viewing "every patient as a potential malpractice lawsuit."[39] Studies have also demonstrated that patients complain that their physicians treat them brusquely, and fail to provide honest and full information.[40] While the law has sought to address the debilitating effects that malpractice has had on doctor-patient communication in the aftermath of errors—whether through

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[33] Lucian L. Leape, *The Nature of Adverse Events in Hospitalized Patients: Results of the Harvard Medical Practice Study II*, 324 NEW ENG. J. MED. 377, 380-82 (1991); Paul C. Weiler, *The Case for No-Fault Medical Liability*, 52 MD. L. REV. 908, 912-16 (1993); Barringer et al., *supra* note 2, at 740; Hyman, *supra* note 2 at 1645.

[34] Studdert & Brennan, *supra* note 2, at 218; Kachalia et al., *supra* note 5, at 387-88.

[35] The literature on medical errors has distinguished between "medical errors" and "adverse events." An adverse event is defined as "an injury that was caused by medical management rather than the patient's underlying disease. . . . An adverse event may or may not result from an error." WHEN THINGS GO WRONG, *supra* note 25, at 4. Medical errors are defined as "the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Medical errors include serious errors, minor errors, and near misses. . . . A medical error may or may not cause harm." *Id.*

[36] Liebman & Hyman, *supra* note 23, at 25; Todres, *supra* note 12, at 684-85.

[37] TO ERR IS HUMAN, *supra* note 1, at 3-5, 14-15.

[38] Michelle Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1601-02 (2002); *see also* Studdert & Brennan, *supra* note 2, at 219-20. Despite support of such measures, they have yet to be implemented.

[39] Mello et al., *supra* note 16, at 48-49.

[40] Todres, *supra* note 13, at 689 (showing that "[a] dehumanized response by doctors undermines the care relationship and destroys the trust that patients have in their doctors").

"apology laws" or mandated "disclosure conversations"[41]—it has overlooked the deeper, more elusive impact it has had on the entire doctor-patient relationship. Alongside the emergence of defensive medicine,[42] physicians have adopted a defensive mode of communication with patients throughout the interaction, even before an error has occurred.[43]

Clearly, the law's impact on the doctor-patient relationship has been far-reaching, and attempts at reform or intervention have often resulted in unanticipated consequences.[44] For example, the mobilization of the patient's rights movement, which has led to the empowerment of patients through informed consent, has also undermined doctors' authority and created suspicion and defensiveness by medical staff.[45] Therefore, any effort to significantly reform the delivery of health-care services and advance quality in medicine must consider the complex interconnections between law and medicine and include close scrutiny and reform of existing legal arrangements. At the same time, the design of new legal schemes for health care must be guided by the health-care arena's defining features. The various relationships that populate the health-care system, particularly doctor-patient relationships, constitute one of the field's most central features.[46]

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[41] The adoption of "Apology Laws" sought to encourage physicians to provide patients with information on medical errors by excluding the admission at trial of any statements of sympathy made by physicians during such disclosure. Cohen, *supra* note 26, at 1061-64; Jonathan R. Cohen, *Legislating Apology: The Pros and Cons*, 70 U. CIN. L. REV. 819, 820 (2002). Critics have claimed, however, that apology laws have been unsuccessful in overcoming other barriers that discourage physicians from disclosure of errors. Wei, *supra* note 22, at 117-19. In addition, some states have adopted "mandatory disclosure laws," which have in effect forced providers to conduct conversations with patients and families in the aftermath of "serious events." Liebman & Hyman, *supra* note 23, at 23. Here, like in the apology context, it is insufficient to allow for (or even mandate) such conversations to take place. For these talks to be fruitful and responsive to patient needs, they need to be conducted in accordance with patient expectations regarding provider demeanor and information provision in the course of the conversation. *Id.* at 26-27.

[42] Todres, *supra* note 13, at 677. An additional result of this reaction is the growing practice of defensive medicine; *see id.* at 684-85.

[43] Orna Rabinovich-Einy, *Escaping the Shadow of Malpractice Law*, 74 LAW & CONTEMP. PROBS. 241, 241, 248 (2011) (defining defensive communication as "a mode of interaction designed to protect practitioners from malpractice suits, but which in fact breeds conflict and serves as a barrier to resolution efforts").

[44] Emily R. Carrier et al., *Physicians' Fears of Malpractice Lawsuits Are Not Assuaged by Tort Reforms*, 29 HEALTH AFF. 1585, 1585 (2010).

[45] DiMatteo, *supra* note 12, at 154-55.

[46] Einer R. Elhauge, *Can Health Law Become a Coherent Field of Law?*, 41 WAKE FOREST L. REV. 365, 369-70 (2006); M. Gregg Bloche, *The Emergent Logic of Health Law*, 82 S. CAL. L. REV. 389, 410-12 (2009).

As explained below, our approach draws on the literature that has singled out the importance of relationships in the health-care arena and leads us to advocate for a relational approach to health-care law. With regard to medical errors, such an approach requires the replacement of the destructive malpractice regime with a no-fault compensation scheme centered on strengthening the doctor-patient relationship, alongside the more familiar goals of learning, safety, and compensation.

III. BRIDGING THE DIVIDE: ADOPTING A RELATIONSHIP-BASED NO-FAULT LEGAL REGIME

Relational legal and political theory was initially introduced by feminist scholars and communitarians and has promoted a moral and political vision that fosters care, mutuality, and human connectedness in protecting and promoting the rights of women and traditionally disempowered and oppressed groups.[47] We draw on this school of thought to highlight another type of social interaction that is currently in crisis and needs to be cultivated: the doctor-patient relationship.

The atomistic culture that characterizes the legal system has proven destructive to various spheres of human interaction and is similarly detrimental to the doctor-patient relationship. It has failed to create an environment that nourishes constructive relationships between patients and providers and does not account for the broader context of health-care law in which those relationships are situated. As an alternative, a relational approach to health-care law fosters interdependence and collaboration, considers the wellbeing of both patients and physicians, and provides mutual benefits in terms of satisfaction and quality of care. By placing relationships at the fore, this new approach undermines the harmful hierarchy between clinical and communication skills, emphasizing the contribution that effective and healthy doctor-patient relations can have on the quality of care.

Our relational understanding of health-care law challenges the current approach to malpractice and the legal treatment of medical errors. The no-fault option is a comprehensive alternative to the existing fault-based torts regime that governs medical errors. Our justification for no-fault is based on a relational approach and is aimed at transforming the doctor-patient relationship.

The failure of piecemeal efforts, such as the introduction of disclosure conversations and apology laws, to transform the prevailing communication culture in the health-care arena demonstrates the need

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[47] *See supra* note 6.

for comprehensive legal reform.[48] Only by displacing the current torts system in its entirety will it be possible to escape the shadow of malpractice law and to transform doctor-patient relations in a meaningful manner. We therefore support the implementation of a no-fault compensation scheme, an administrative mechanism that forgoes the question of negligence or personal blame and provides compensation based on a triggering event.[49]

While no-fault compensation schemes have been around since the 1970s,[50] prior justifications for such reform were different, and overlooked the impact such proposals could have on the doctor-patient relationship. Originally, no-fault proponents hailed such reform proposals for their promise of a just, simple, and efficient framework in lieu of the complex, cumbersome, unpredictable, and costly tort system.[51] However, interest in this avenue waned in light of mounting criticism. One major critique related to the high costs associated with the larger pool of claimants.[52] The other central line of attack against these systems was that by shifting the emphasis from individual liability to systemic responsibility, they fail to deter wrongdoers.[53] In addition, it became clear that the passing such reform was highly unlikely in light of strong political opposition, by such groups as the Bar.[54]

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[48] Studdert & Brennan, *supra* note 2, at 218, 222; *supra* note 41.

[49] Studdert & Brennan, *supra* note 2, at 219.

[50] Clark C. Havighurst & Laurence R. Tancredi, *"Medical Adversity Insurance"—A No-Fault Approach to Medical Malpractice and Quality Assurance*, 51 MILBANK MEMORIAL FUND Q. 125, 125 (1973); Jeffrey O'Connell, *No-Fault Insurance for Injuries Arising from Medical Treatment: A Proposal for Elective Coverage*, 24 EMORY L.J. 21, 21 (1975); Eleanor D. Kinney, *Malpractice Reform in the 1990s: Past Disappointments, Future Success?*, 20 J. HEALTH POL. POL'Y & L. 99, 106 (1995); Studdert & Brennan, *supra* note 2, at 219; Barringer et al., *supra* note 2, at 728; Weiler, *supra* note 33, at 910-11.

[51] Studdert & Brennan, *supra* note 2, at 219; Barringer et al., *supra* note 2, at 731.

[52] Barringer et al., *supra* note 2, at 748; *contra* Weiler, *supra* note 33, at 921-25.

[53] Studdert & Brennan, *supra* note 2, at 220. For counterarguments, *see* Mello & Brennan, *supra* note 39, at 1603-06 (addressing the critiques voiced against the no fault option based on deterrence).

[54] Barringer et al., *supra* note 2 at 728-29. The recent Health Care Reform Grants project, which calls for the development of alternative liability schemes, may alter the political economic climate, generating a broader support-base for such reform and setting the stage for states to experiment with such regimes. American Medical Association, *Federal Funding to Test Medical Liability Alternatives*, AM. MED. ASS'N (June 2010), http://www.ama-assn.org/ama1/pub/upload/mm/399/mlr-federal-grants.pdf. No less important in our view is the fact that existing calls for adopting no fault schemes have failed to address the broader connection between medical errors and the doctor-patient relationship.

With the dawn of the twenty-first century, in the aftermath of *To Err is Human*, a renewed understanding of the malpractice crisis has emerged, paving the way for a revived interest in no-fault. The crisis is no longer perceived as one relating to rising insurance premiums, but as a quality crisis that requires enhanced learning on the sources of errors and a focus on patient safety.[55] The realization that medical errors often stem from systemic deficiencies rather than individual mistakes[56] has shifted the emphasis to data collection on the conditions that give rise to such errors. No-fault systems are a means of reducing physician defensiveness, thereby allowing for a more inclusive and sincere analysis of errors and near misses to take place.[57]

Our relational justification for no-fault systems diverges from former justifications in that it highlights the benefits reaped in terms of the doctor-patient relationship, benefits that would buoy efforts to enhance patient safety and the overall quality of medical care. A relational no-fault system should realize the following goals: (1) addressing the monetary, informational, and emotional aspects of individual claims; (2) learning on the connection between adverse events and doctor-patient communication; and (3) generating broader insights on patient safety and quality assurance. Therefore, a central feature of such a system is "learning." By "learning" we mean that the system is committed to collecting a broad base of data on medical errors and their relational aspects. In addition, a learning system must continuously reevaluate its own goals and the means for achieving them, or in other words, "must commit . . . . to relentless self-examination and continuous improvement."[58]

Designing a no-fault system with relationships and learning in mind differs from previous models of no-fault systems in several important respects. First, it would eliminate the combative and confrontational nature of doctor-patient interactions in the aftermath of an error, strengthen efforts to uncover the sources of an adverse event, and create opportunities to learn how to prevent such harm from recurring.[59]

Second, it would free the doctor-patient relationship from the more elusive impact of the torts regime, which has extended well be-

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[55] Barringer, *supra* note 2 at 745-48; Kachalia et al., *supra* note 5, at 400.

[56] For example, the administration of the wrong medication is tied to the labeling of the medication rather than a particular individual's carelessness. *See* Studdert & Brennan, supra note 2, at 218.

[57] Barringer et al., *supra* note 2, at 726; Studdert & Brennan, *supra* note 2, at 219.

[58] WHEN THINGS GO WRONG, *supra* note 25, at 2.

[59] Studdert & Brennan, *supra* note 2, at 219-20.

yond the moment of error, permeating the entire continuum of care and indirectly shaping medical professionals' routine interactions with patients during visits, tests and procedures.

In addition, a relational no-fault regime would broaden the category of problems that receive attention and would provide the basis for learning about errors and problems. While the torts system has remained focused on medical injuries that constitute a malpractice claim, the relationship-driven alternative recognizes that there are other types of problems that impact the doctor-patient relationship, such as physician demeanor, manner of interaction, or delays that are rooted in institutional constraints. Such problems affect the quality of services provided to patients, but are irrelevant under the current negligence-based system.[60] A relationship-based, no-fault system would ensure that a broad spectrum of problems are reported and addressed, and that data on such encounters—even where they have not resulted in injuries—is gathered and compared to the data collected on adverse events.

Furthermore, a relationship-based, no-fault approach would recognize that in order to gain a better understanding of the sources of medical errors, one must not only examine a broader range of problems and complaints than those defined as "errors," but also examine problems that arise outside the scope of the doctor-patient relationship. This relationship exists within a broader web of relations, feeds into them, and is shaped by them (e.g., relationships within the healthcare team, between providers, hospitals, managed care organizations, and the like).[61]

Finally, such an alternative would provide a better fit to what injured patients want, cultivating an atmosphere that allows for more affective and effective communication in the aftermath of an adverse event, and in other instances.[62]

A no-fault compensation scheme devised with relationships in mind would therefore enhance the quality of medical care, first and foremost, by fostering a collaborative doctor-patient relationship, which has been shown to engender better health outcomes.[63] In addi-

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[60] Rabinovich-Einy, *supra* note 43, at 241, 248.

[61] Langel, *supra* note 21.

[62] Hoecker, *supra* note 29, at 258; Cohen, *supra* note 26, at 1061-65; Liebman & Hyman, *supra* note 23, at 24; Thomas H. Gallagher et al., *Choosing Your Words Carefully: How Physicians Would Disclose Harmful Medical Errors to Patients*, 166 ARCHIVES INTERNAL MED. 1585, 1585 (2006).

[63] *See* ROTER & HALL, *supra* note 9, at 5. Our claim is that the current torts regime does not allow for a collaborative relationship to develop. Only by replacing the fault-based regime with a no-fault one, can such relationship be expected to evolve and flourish.

tion, such a system would create a richer information pool on problems and errors. It would also generate deeper and more rigorous learning that extends beyond medical errors and near misses to include such matters as professional practices and patient expectations. Finally, we can expect this type of system to reduce the overall rate of conflict by addressing a broad range of disputes, leading to enhanced physician wellbeing, satisfaction and productivity, and, consequently, an increase in the quality of work that they perform.[64]

CONCLUSION

This article focuses on an often overlooked barrier to quality enhancement efforts in the health-care arena: the relationship crisis that exists between physicians and patients and permeates the broader web of relations that encompass the doctor-patient relationship. While the medical community has recognized the significance of a collaborative doctor-patient relationship to the quality of care, a closed and unilateral mode of communication among physicians has persisted. The common view has attributed this state of affairs to the culture of the medical field. Therefore, efforts to transform this culture have been relegated solely to reforms in the education and ongoing training of physicians.

There is, however, an additional source sustaining traditional communication patterns between doctors and patients and co-opting reform attempts—the elusive impact of the shadow of malpractice law on physician conduct and communication. Fear of liability has made doctors suspicious of patients, and has prevented the establishment of collaborative relationships between physicians and their patients. This reality has not only been unpleasant to physicians and patients alike, but has also hampered reform efforts geared towards other, related ends, such as the prevention of medical errors, the promotion of patient safety, and the advancement of quality of care. Efforts to address the relationship crisis, to date, have typically focused on post-error communication between physicians and patients, and have met with limited success.

This state of affairs has resulted from the divide between the medical and legal worlds. The medical arena has tended to view the doctor-patient relationship as an exclusively medical issue, ignoring the role law has played in generating and sustaining problematic relationship patterns. The legal community has yet to recognize the full scale of the relationship crisis and its role in the evolution and persistence

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[64] *See* Mello et al., *supra* note 16 at 43.

of that crisis. We offer the framework of a relational approach to medical errors as a means of bridging the divide between the two disciplines. In the malpractice context, a relational legal reform would entail adopting a no-fault compensation scheme committed to strengthening the doctor-patient relationship, alongside the more familiar goals of such systems, which include enhancing patient safety and learning, and providing adequate compensation. Our approach recognizes that what may seem like private conversations between physicians and patients do not operate in a vacuum. They are most obviously embedded in, and structured by, social and cultural forces. But another significant force shaping such communication is the legal regime that governs medical errors. By regulating those instances of medical care that constitute malpractice, the law has in effect shaped the entire spectrum of doctor-patient relations. The law is present and has an impact even where formal legal arrangements are missing, and the law's effect is indirect and intangible. If we wish to allow open, mutual and effective communication to take place in the medical arena, the law must recognize that "to err is human," and cultivate an environment that allows for learning to take place.