

Some thoughts on the malpractice crisis

by Richard Moskowitz

Malpractice as a subset of medical risk

The legal term 'malpractice' applies only to those cases of patient injury for which individual or group liability can be attributed to specific acts or failures to act, i.e. mistakes or human error ranging from negligence to incompetence, poor judgement, or simple inattention on the part of physicians and often hospitals and other health professionals as well.

A verdict of malpractice further implies that certain standards of reasonable and acceptable care exist for the procedures and situations in question, that they are generally well known and adhered to by the profession, and that they were violated in the particular instance.

Malpractice tends to be very difficult to prove in court, partly because medicine remains to a large extent an art, with standards that must be innately adaptable to each new situation and therefore can seldom be formulated rigorously or agreed upon in advance. But the principal reason is simply that in many cases no definite mistake can be found, because the patient fell victim to a drug or procedure that is inherently dangerous even when used appropriately.

Unfortunately, the injured patient has no available redress other than this difficult, prolonged, and expensive legal action, which attempts to assign specific liability for damages to the doctor(s) and the hospital and any other professionals involved. The patient or plaintiff must therefore assume an enormous burden of proof, while the defendants need only establish that they acted pretty much under similar circumstances, such that the patient's suffering or disability becomes simply a misfortune in which nobody was at fault and for which nobody can be held responsible.

This old and cumbersome legal machinery is also stacked against the patient in another important sense. Like all other legal proceedings, malpractice cases are highly ritualized controversies in which the roles and arguments of both sides are more or less predetermined and the whole substance of their disagreement is effectively reduced to two technical questions:

- 1 whether malpractice actually occurred in the particular instance, and, if so,
- 2 how much compensation should be awarded to the victim.

The litigation process offers no relief whatsoever to those who cannot or may not even want to prove malpractice within this restricted format but are nevertheless genuine victims of the medical system with a need and a right to be heard.

Consider a few common examples. If a gynaecologist performs a hysterectomy and leaves a sponge or haemostat in the abdomen or inadvertently severs an artery, a finding of malpractice is virtually assured, and the woman will at least collect her damages if she survives

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and can still afford an attorney. But if the surgery is performed competently and the patient dies of an allergic reaction to the anaesthetic or becomes chronically disabled from thrombophlebitis or a pelvic infection acquired later during her hospital stay, the culpability of her doctors and nurses and even of the hospital may be far from clear. Such cases often never make it to trial or are dismissed or settled in favour of the defendants, in which case the victims receive no compensation at all, and the doctors, the hospital, and the medical system as a whole will never be called on to take responsibility for what happened.

Many other cases fall somewhere between these two prototypes. A skilful attorney can often raise serious and legitimate doubts in the minds of a jury regarding the notorious laxness of many doctors in such important matters as informed consent, careful record-keeping, or simple caring and attentiveness in the face of a busy schedule or a paternalistic attitude. Under such circumstances, insurance companies may elect to settle out of court even if their clients appear to be innocent rather than incur the trouble and expense of further litigation.

The principal cause of the malpractice crisis thus cannot be malpractice, because this term excludes these other far more numerous types of injury. Doctors who blame skyrocketing malpractice premiums on unscrupulous attorneys looking for work fall equally wide of the mark. For a malpractice case could not even be brought to trial, let alone settled, without some serious harm having been inflicted on a patient, whether anybody was specifically at fault or not; and the vast majority of patients so injured never even attempt to sue. Nor can it be the fault of the patients if the only way for them to redress their grievances is to enter the great malpractice 'sweepstakes' or forever hold their peace.

However expensive malpractice insurance may be, it continues to buy for physicians the privileged assurance that most lawsuits brought against them will prove unsuccessful and that the few exceptions will be settled without further loss of income or serious disciplinary action, so that business will continue more or less as usual and the basic features of medical practice will be protected from outside scrutiny or change.

But in return for these guarantees, the present malpractice system has had a chilling effect on how medicine is actually practised and on the doctor-patient relationship. It greatly over-emphasizes the risk of injury due to human error, which is often sensational but to a large extent unavoidable; and it neglects to consider the more fundamental and correctable risks posed by modern science as a system, i.e. when it is practised conscientiously, with reasonable skill, and with genuinely informed consent.

The nature and extent of iatrogenic illness was investigated in 1981 by Knight Steel, *et al*, who followed 815 consecutive admissions to a university hospital medical service over a five month period.¹ The authors found that 36% of those admitted to the 80-bed unit suffered at least one iatrogenic complication during their stay, and that fully one-fourth of this group, or 9% of the total, developed complications that were seriously disabling or potentially fatal.² Indeed, 2% actually died at least in part as a result of such complications while still in the unit. Furthermore, the authors point out that these figures are a lot lower than they would have been had that included:

- 1 iatrogenic events suffered by the same patients during the same time period but before their admission or transfer to the unit or after their discharge or transfer out of it;
- and
- 2 other episodes not attributable to any specific procedure, such

as seizures or falls in heavily medicated patients, which were dismissed as 'incident reports' even though the medication clearly made such events much more likely.³

But they nevertheless proved quite adequately that modern medicine, purely as a system and quite apart from the personnel who happen to administer it, is inherently dangerous to everybody who seeks its help, ie, to everybody.

In the second part of the study, the authors showed that the risk of serious or fatal complications had much less to do with which diagnostic tests were ordered, drugs prescribed, or surgical procedures performed than with how many, ie, with the total number of transactions with the medical system, regardless of their nature or specific content.⁴ In other words, patients are endangered less by how well or badly medicine is practised than by how much it is practised.

The principal sources of medical risk

Modern medicine is essentially a methodology, a body of rules for generating measurable and verifiable information about human diseases and techniques for controlling them. We of today are so familiar with its accomplishments that we often fail to consider how fundamental a shift in thought and practice was required to bring them about.

Consider the following passage, written and sounding almost quaint today:

The physician's high and only mission is to restore the sick to health, to cure, as it is termed. The highest ideal of cure is rapid, gentle, and permanent restoration of health, in the shortest, most reliable, and most harmless way, on easily comprehensible principles.⁵

These are the opening sentences of Hahnemann's *Organon of Medicine*, the original homœopathic text, which was considered quite a radical and innovative work in its time. Now compare them with another passage, written only a few decades later, and already we are in another world, much like our own:

What we call immediate cause of a phenomenon is nothing but the physical and material conditions in which it exists or appears. The object of the experimental method and the limit of every scientific research is therefore the same for living as for inanimate bodies. It consists in finding the relations which connect every phenomenon with its immediate cause, or, putting it differently, in defining the conditions necessary for the appearance of the phenomenon. When the experimenter succeeds in learning the necessary causes of a phenomenon, he is in some sense its master. He can predict its course and appearance; he can promote or prevent it at will.

As a corollary to the above, neither physiologists nor physicians must imagine it their task to seek the cause of life or the essence of disease. That would be entirely wasting one's time in pursuing a phantom. The words 'life' and 'death' and 'health' and 'disease' have no objective reality. Only the vital phenomenon exists, with its material conditions. That is the one thing that they can study and know.⁶

In place of the absolute unity of the 'vital force' or the existential unity of the living patient, modern medicine substitutes the defective but measurable unity of the disease process (e.g. TB, cancer, hypertension), which can be defined purely technically on the basis of demonstrable abnormalities (tubercle bacilli, cancer cells, elevated blood pressure) and therefore studied in the abstract as a composite of interrelated mechanisms, quite independently of any particular patient who happens to exhibit them. The various disease 'entities' can then be used to group and even explain the clinical signs and

symptoms insofar as the corresponding abnormalities would naturally tend to produce them (cough or haemoptysis in TB, headache and focal neurological deficits in brain tumour, heart disease and stroke in hypertension).

The goal of medicine is thus no longer solely or primarily to 'heal the sick,' but rather to achieve effective dominion or technical mastery over every identifiable aspect of the life process. What the great Claude Bernard so clearly envisioned, and what modern medicine now routinely seeks to accomplish, is essentially to acquire the knowledge and devise the means to regulate biological phenomena artificially and more or less at will.

The experimental method as Claude Bernard applied it to human biology consists of the following elementary steps:

- 1 to characterize the phenomenon to be studied;
- 2 to identify its component parts and isolate its physico-chemical 'causes';
and
- 3 to develop appropriate technologies for manipulating them with as little disturbance as possible to the remainder of the organism.

Anything that cannot be subdivided or objectified in this way need not and should not be studied, because it cannot as yet be defined rigorously or therefore understood in any practical or useful sense.

But this technological imperative is inherently dangerous to the patient, not only because it makes human error much more likely and much more serious, or even because it must frequently fail, but especially when its particular objectives are successfully attained. For the mere attempt to control life processes by force, for whatever reason and whatever the outcome, creates insoluble theoretical and practical dilemmas for the profession that encompass a large part of what the present medical crisis is all about.

In the first place, the diagnostic process of assigning living patients to abstract pathological categories tends to ignore or distort how people actually feel and even how they objectively function in relation to their own personal criteria (e.g. job record, ability to cope with stress, etc.), rather than the mere average or norm assigned to them. Thus patients with spinal films showing advanced osteoporosis or degenerative arthritis may have no pain or stiffness and no functional impairment, while others may have severe impairment with no pathology, or anything in between. Yet crucial life decisions continue to be made largely on the basis of what biopsied cells look like under the microscope, despite the inconsistent correlation between any test and how well or badly any given patient feels or functions, then or later.

Whether or not the test or its interpretation is accurate is therefore less important than its tendency in either case to push the patient further in the direction of still more diagnostic and treatment procedures, and thus to help bring about the reality or the interpretation (or at least the fear) that ultimately justifies the intervention. The obsessive reliance on diagnostic testing, always in the name of precision, thus often generates still more confusion, uncertainty, and fear in doctor and patient alike and greatly and non-specifically multiplies the probability and the risk of still further interventions within the system.

A closely related problem is the theoretical and practical need of modern medical science to edit out or actually defeat the primitive self-healing capacity of the patient, which seems too crude to define or measure and too unpredictable to control. That is why diseases are diagnosed on the basis of objective abnormalities (physical signs, structural 'lesions', or simple deviations from statistical norms or

averages, such as blood pressure), while older terms like 'health', 'illness', and 'healing' depend on subjective and otherwise ambiguous criteria such as pain or 'well being' and are therefore allowed or encouraged to fall through the cracks and drop out of sight.

The theory of the disease process thus reduces the actual experience of illness to a mere automatism, a self-propelling chain of necessary causes pre-programmed to worsen, simply by editing out the equally definitive and powerful tendency of every illness in every patient to recover. In life, as in physics, even a 'necessary' cause can never be quite sufficient to guarantee that the predicted effect will actually follow. But once the disease process is accepted as somehow 'given', such that both doctor and patient surrender themselves to what they suppose to be its laws, they are likely to forget that every illness must also be received by and somehow recreated in the image of the patient and that the same idiomatic reasons that helped him to fall ill in the past will just as likely help him recover in the future.

But the *coup de grace*, the final overthrow of the natural healing capacity, is reserved for the famous 'double blind' experiment, in which the causal effectiveness of some drug or procedure is matched against the simple desire and hope of all patients to recover and of their doctors to help them recover. This 'placebo effect', which is simply the starved and tattered remnant of the self-healing capacity in action, is further handicapped by keeping both doctor and patient ignorant of whether the test drug or procedure was actually used, or only some passable imitation.

Much as in a bullfight, the superior technical resources of modern civilization are thus ritualistically pitted against the primitive forces of nature in a carefully staged and absurdly unequal contest in which the latter is almost always defeated. The double irony of the double-blind experiment, so precise and useful in so many other respects, is that it obliges modern medicine to resurrect the self-healing capacity for a brief moment, solely in order to kill and surpass it again and again, and that in doing so it eliminates precisely that which most needs to be studied. For if they do not ultimately help sick people to heal themselves, then even the most powerful technologies must remain doubly blinded forever, with the blind leading the blind along a definitely sightless path.

Finally, the theory of the disease process distorts and trivializes prognosis and case management by reducing the whole art of treatment to merely correcting the abnormalities used to define them (killing the tubercle bacilli, destroying the tumour, normalizing the blood pressure). These drastic over-simplifications create a dangerous ambiguity in the evaluation of 'improvement' and 'worsening' and even in the classification of disease itself, since a 'cured' cancer patient with cachexia and aplastic anaemia may be at least as sick as before, and patients who develop severe or intractable illness soon after effective suppression of another illness pose a basic dilemma that cannot be resolved within the existing theoretical structure.

For if we say that these conditions are simply unrelated diseases in the same individual, then there is no meaningful way to address the individual patient as a unified system over time; and conversely, even if they are related, the patient will still require diagnosis and treatment for each of them. Either way, the net effect of modern medicine as a thought form is always to multiply the number of technical interventions within the system, by virtue of its tremendous analytical power of subdividing the living patient into an infinity of identifiable and potentially controllable phenomena.

A fitting epilogue is simply the profound curiosity of patients in the face of such knowledge and power, their desire and need and endless fascination, often in the face of considerable fear and hesita-

tion, to match up their own unique, experimental world with the independent and profoundly alien version of the body as a machine, so blissfully or horribly anonymous and neutral.

Each one of these risks pertaining to diagnosis, research, and case management is then augmented and completed in the sphere of treatment, where something more or less drastic is done to the patient and its stated purpose virtually guarantees that potentially destructive force will be required to achieve it.

This is most clearly apparent in the case of surgery, the supreme example of technical mastery in medicine, its epitome as a thought form and often advancing most rapidly in its practical development as well. For all of modern surgery is predicated on its ability to control pain, bleeding, and infection by purely technical means, and above all on the systematic and precise identification of the structure and function of the parts of the body, a truly magnificent achievement. Without great skill and precision and effective moment-to-moment control at every point, surgical patients would regularly die or suffer crippling impairment.

But the technology of control as epitomized by surgery is not dangerous solely or primarily because there are so many more and costlier ways in which it may fail. Surgery seems almost irresistibly attractive as an option just to the extent that is technically possible, because it promises immediate and permanent relief – because wounds tend to heal automatically, whereas diseases often have to be slowly and painfully cured. By converting diseases into wounds, surgery thus ironically obliges its patients to heal themselves, to activate their optimal self-healing capacity just in order to survive. Indeed, in some emergency cases, such as a ruptured spleen or gall bladder or a tubal pregnancy or overwhelming pelvic infection, surgical intervention may be the only way to save life.

But in the process of cutting into the living body, something momentous and irreversible has been done – some part of the body has been removed or bypassed, repaired or replaced, the continuity of the bioenergetic field has been interrupted, jammed, or interfered with, and the subsequent experience and functioning of the patient has been more or less permanently disfigured or altered in some way that requires a very artful decision in each case, and the long-term consequences of which can never be precisely foreseen.

As a way of assisting the natural healing process, of repairing the body when it is already broken or removing a part that is already dead, modern surgery is thus unquestionably one of the supreme technical achievements in all of human history. But as a method of curing disease, and above all as a model for the biochemical endeavour in general, it is a shameful travesty, a military decision to cut and burn in lieu of gentler, safer, and more effective ways to restore health to part or whole. The immense burden of post-operative suffering and disability cheerfully borne by our 'cured' patients thus stands as a terrible indictment of a system that knows and wants to know nothing better, an indictment that never shows up in the statistics.

Exactly the same calculus applies to pharmaceutical drugs, which are similarly designed and used primarily to correct specific abnormalities, as defined above. Physicians certainly hope and even assume that hypersensitive patients, for example, will feel better, live longer, and suffer fewer heart attacks and strokes as a result of the treatment. But its primary goal remains simply to normalize the blood pressure on the comforting assumption that these further derivative goals will likely follow.

In like manner, modern doctors are trained to use antibiotics to kill pathogenic bacteria, cytotoxic drugs to destroy cancer cells, anticonvulsants to control seizure activity, cortico-steroids to sup-

press the inflammatory process, bronchodilators to open constricted air passages, diuretics to force the kidneys to excrete more urine, insulin to substitute for the diabetic pancreas, and so on. In some advanced cases, these drugs can give miraculous relief or at least buy valuable time and may represent the best that can be done under the circumstances.

But the fact remains that each of these abnormalities represents only a small fraction of the total pathophysiological response of the patients, who are trying as hard as they can to overcome whatever they are trying to overcome, trying, in short, to heal themselves. The effectiveness of drugs in counteracting particular abnormalities therefore always tends to weaken the total healing capacity in some manner, to greater or lesser degree, and especially to bypass or override whatever unique or individualizing factors are at work in each case. For that purpose, comparatively large doses will usually be required, and the 'margin of safety' between the therapeutic and the toxic dose will be correspondingly small or non-existent. Indeed, the art of medicine today has largely reduced itself to skilfully walking this tightrope.

That is why, as with surgery, the risk of iatrogenic disease is just as serious when the treatment 'succeeds' as when it fails. For drugs that are simply ineffective or that produce serious 'side effects' or toxicity elsewhere in the patient will ordinarily be found out and discontinued sooner or later. Moreover, a reasonably skilful and attentive physician will usually suspect if and when the prescribed dose proves insufficient or excessive for any given patient and will usually make the proper adjustment.

But when the drug 'works' to suppress or counteract the abnormality in question, the latter will either disappear entirely, in which case some even deeper and more serious condition will often supervene in its place, or the original abnormality will reappear with equal or greater force as soon as the drug 'wears off'. Using drugs in this quasi-military fashion thus presupposes, first of all, the readiness to continue using them for long periods of time, often permanently, with the expectation that the original complaint or worse will reappear as soon as they are discontinued.

This is precisely the technical definition of 'addiction', a deep-seated chemical dependence by no means limited to narcotics; and addiction follows regularly and inescapably from the standard practice of using drugs to control abnormalities rather than to assist the total healing capacity of the patient. It is also the fitting conclusion to the dire prophecy already contained in the theory of the disease process, namely, that chronic diseases are incurable anyway and therefore have to be either medicated indefinitely, surgically removed, or borne in silence.

In this way, what may have begun as an episodic ailment, idiomatically programmed, gradually becomes a chronic and indeed eventually incurable process, chemically programmed, by trading off temporary palliation of symptoms or technical correction of abnormalities for long-term perpetuation of the original energy dysfunction.

One further complication is that all drugs tend to be less and less effective over time, which means that still larger doses will be required and the already slim margin of safety may be eliminated altogether. Finally, as we have seen, complete or prolonged suppression of symptoms or abnormalities may lead to an even more serious and apparently unrelated ailment in the future (e.g. asthma following suppression of eczema or hay fever, endometriosis or ovarian cysts after birth control pills or aggressive treatment of dysmenorrhea, ulcerative colitis in the wake of functional bowel disease), a problem which cannot even be meaningfully stated until we break out of the

theory of the disease process and begin to look at the individual as an evolving bioenergetic system over time.

Thus it is not our deviant youth but the mainstream of society that gives the truest measure of its underlying 'drug problem'. Without those tens of millions of people who are more or less successfully maintained for years on their ever more numerous and sophisticated drug dependencies, it is impossible to give true weight and measure to all the mistakes, overdoses, side effects, and allergic, idiosyncratic, and toxic reactions that inevitably follow in their wake.

Modern medicine has thus given us formidable biological weapons with the power to kill or maim at least to keep patients effectively trapped within their orbit. Furthermore, the mere existence of these techniques makes it seem possible and even convenient to dispense with the natural healing capacity and the practical understanding of life that alone could guide or restrain us in their use. The ultimate danger of the present medical system is therefore not solely or primarily its sophisticated methods of diagnosis and treatment, in themselves capable of much good as well as harm, but the idolatrous worship of biotechnology for its own sake and its mindless but immensely profitable substitution of technical imperatives for authentic human problems requiring art and caring and individualized attention.

Healing the doctor-patient relationship

These abstract risks and probabilities are ultimately realized, dispelled, or perpetuated through the medium of actual relationships with physicians and other professionals, where they cannot readily be distinguished from the risk of the illness itself or that impending sense of danger that prompted them to seek or avoid professional help in the first place.

The enormous power for good or ill vested in the doctor-patient relationship originates in the attempt to comprehend the mystery of illness within the familiar setting of a personal encounter. It compromises a request for help, an opportunity to investigate, and a strategy for change, all rendered fragile and poignant by the nearness of suffering. Under these charged circumstances, a relationship based on mutual trust and respect can help even the most grievously ill patients to find the necessary courage to complete the work of healing and to accept what cannot be changed, just as a breakdown in communication can transform even a trivial illness into a nightmare of anguish and betrayal. The acknowledged prominence and high estate of physicians in society must therefore be earned not only by skill and training but also by a willingness to serve.

An effective alliance between doctor and patient also makes it possible to brave and overcome the risk of any drug or procedure, if both parties implicitly or explicitly agree to make all decisions jointly and thus share responsibility for both the process and the outcome. Then both are simply working together, doing the best they can, with no guarantee or expectation of cure or benefit and death or failure to recover as inherent possibilities, in themselves no cause for blame or implication of failure on either side.

But the unrestricted growth of the biomedical enterprise has massively substituted built-in technical priorities for the give-and-take of actual human relationships and threatens to dissolve the infrastructure of the doctor-patient alliance, the human 'glue' which cannot itself be measured but which holds the system together at every point and makes it work.

This change is attributable in part to the fact that the goods and services of the health care 'industry' – the diagnostic equipment, pharmaceutical drugs, surgical instruments, and techniques and poli-

cies governing their use are controlled by the companies that produce them, the hospitals and research and training institutions that keep and maintain them, and the physicians and other professionals who prescribe and dispense them. As major industrial commodities, they may be sold to the patient for profit or made available on some other basis, but in any case on terms dictated primarily by their 'owners' in accordance with their respective corporate, institutional, or professional criteria and having at most secondarily to do with the felt needs or expressed wishes of the patient.

The increasing specialization of health care further obliges the patient to maintain relationships with an ever-enlarging network of physicians and allied health professionals, whose various roles and jurisdictions are likewise governed by institutional, guild, or team criteria seldom responsive to criticism or negotiation from outside.

Finally, just as the act of making the diagnosis threatens to reduce the patient to a mere specimen of the disease category, conventional medicine or surgical treatment attempts to isolate the diseased parts or chief symptoms and to reverse or actually remove them from the patient's body. The patient thus easily becomes the passive recipient of these procedures, with nominal power to give or withhold consent but little opportunity to negotiate diagnostic or treatment plans, much less to alter or modify them once begun.

The patient in this sense stands quite alone, isolated, and virtually defenceless before the entire medical system, with compelling reasons to fear it, no effective check against it, and no clear alternative but to submit to at least some of its directives and bring a malpractice suit after the fact for actual damages done. The so-called 'malpractice crisis' has thus escalated far beyond the specialized legal question of malpractice into the spontaneous insurrection of the patients against the impositions of the medical system as a whole. By far the most dangerous of these is the pervasive sense of fear, rage, powerlessness, and distrust that their doctors share with them and that poisons their ability to work together by twisting the common experience of illness into an obsessional neurosis of calculated risks and deeper meanings.

The adversarial relationship now prevailing between doctors and patients is therefore no accident and cannot be ascribed simply to prejudice on either side: it follows quite easily from the dominant conception of disease as a sequence of abnormal mechanisms programmed to worsen and therefore always in need of artificial correction.

The idea of malpractice insurance likewise seems compelling to the extent that physicians are allowed to take effective responsibility for birth and death and health and illness away from patients, who have come to suppose that their physicians understand their needs better than they do themselves. Under these conditions, it does realistically fall to the physician to decide how and if they live or die, recover or fail to recover. The incalculable risk to which malpractice insurance does in fact address itself is this additional liability that doctors incur by assuming that infinite responsibility, such that death and worsening do indeed resemble failure in the endless quest for purely mechanical solutions to disease and all other human problems.

Because no amount of insurance could ever adequately cover such a liability, it still looks like an incredible bargain for physicians, no matter what it costs. It protects them against sudden or catastrophic loss of income in the event of a successful claim against them. It is also a profitable investment in its own right, because the initial outlay, however steep, is soon made up many times over by the much greater volume of diagnostic and treatment procedures and hospitalizations that it generates and the much higher fees that can be commanded for

them. With the newer physician-owned companies, the combined premiums themselves constitute in effect a tax-free mutual fund that could generate considerable new income if the claims against it could be kept sufficiently small.

On the other hand, by deciding which doctors to insure and how much to charge them, which practices to defend and which to settle out of court for, the insurance companies have effectively substituted technical, actuarial, and conformist or 'herd' criteria for the independent and artful clinical judgement of the practising physician, based on the unique variables at work in each individual patient.

Thus a physician consulted for what appears to be a simple tension headache could easily decide to hospitalize the patient, consult a neurologist, and obtain a CAT scan just to make sure, without any reason to suspect a brain tumour, simply because we have the technical capacity to find it and therefore a potential legal liability for not finding it. The physician limits his own liability by sharing it liberally with his colleagues, while the patient is made to incur a tremendous expense and receives no useful information and a prescription for analgesic drugs that merely palliate the symptoms temporarily. In this fashion, the total or cumulative risk of (and hence also the physician's liability for) even this routine dysfunction is actually amortized or compounded many times over for a long period of time, rather like a home mortgage loan.

Similarly, gynaecologists today often advocate hysterectomy for uterine fibroids even in the absence of serious pain or bleeding and even though the chances of malignancy are negligibly small, because that is what gynaecologists know how to do superbly well, and the insurance company can more easily defend a recognized procedure, even one that is ineffective or unsafe, than doing nothing, i.e. admitting that we do not understand the tumour process well enough to heal it in a natural and timely fashion.

In this way, even though the medical system is in reality a heterogeneous collection of techniques with only a certain methodology to unite them, the breakdown of the doctor-patient alliance and the ever-present threat of litigation exert powerful pressure on physicians to practise more or less in conformity with the real or imagined standards of their insurers. These standards in turn amount to little more than the lowest common denominator or composite average of what our least imaginative colleagues are doing, and above all to doing something, filling the space with some definite action or procedure, whatever the outcome, rather than leaving some possible diagnosis unmade or some possibly corrective treatment untried. The malpractice system thus effectively teaches doctors to fear their patients and even to sacrifice their own personal enjoyment of and fulfilment in their work, rather than risk following the intuitive or creative impulse of the moment, so likely to seem meaningless or even indefensible outside of that unique and never-to-be-repeated situation.

Likewise, when a doctor is actually sued, the underwriters have good reasons to settle out of court even when no mistake was made or secure an acquittal for wrongs that actually were committed, purely on the basis of their own corporate needs. Malpractice insurance ultimately protects individual physicians and hospitals only to the extent that they are willing to follow the rules of high-cost, high-tech, high-risk medicine.

Finally, the argument that malpractice insurance also protects the patient cannot measure up against the fact that victims of medical malpractice are patients who have already been maimed or killed by their doctors: the only kind of protection they needed was the kind they didn't get. By multiplying the total number of medical interventions and by helping to create the atmosphere of suspicion and fear

surrounding them, malpractice insurance and the system of tort law that it underwrites must itself be accounted as a medical risk of formidable proportions. In addition, by singling out a few egregious mistakes, the business of the medical system is allowed to continue essentially as before, with its radical distortion of health and illness unexamined and unchanged. Far from protecting the patient, the malpractice system remains the principal reason why the vast majority of medically injured patients will never have to be compensated or even heard.

It follows that no system of malpractice insurance can ever solve or even meaningfully address the present health care crisis, any more than the growing army of mutilated, drugged, and embittered victims can adequately speak for it. The first priority is to rebuild the doctor-patient alliance itself, the mutual sense of good faith without which useful collaboration is impossible. This task will obviously require a major commitment to reconciliation on both sides and indeed may no longer be possible.

Its chief goal must be the empowerment of the patient as a full and equal partner in all health decisions and will probably need to be affirmed as a fundamental political and legal right, namely, that birth, death, health, and illness are inalienable life experiences belonging wholly to the people undergoing them, and that nobody else has the right to manipulate or control them or any part of the body involved in them without their explicit request or that of somebody else duly authorized by them to act on their behalf.

For physicians, that means, first of all, serving patients by being available and attentive and willing to listen to them. It also means enlisting their active participation by asking what they want or don't want, making no decisions without their prior approval, and ultimately being ready and willing to learn from them and their unrivalled expertise about themselves. Above all, it means a serious and ongoing commitment to the alliance itself, to the quality of attention to and awareness of the relationship as the most precious of all healing resources, and to cultivating and protecting it as the core of what healing work is all about.

These minimal requirements actually correspond fairly closely to what patients are asking for, e.g. in two recent bulletins from prominent consumer organizations.⁷ A sign of good faith might therefore be for physicians to acknowledge these rules and practices, or something like them, as general duties and responsibilities owed to patients, or rights that the latter are entitled to expect from their doctors. Thus patients could easily be allowed to invite a friend or relative to attend the consultation, to bear witness and serve as advocate or intermediary if necessary. Patients should also be supported and encouraged to come together to form organizations to represent them, to uphold their interests in negotiating with doctors, hospitals, legislative bodies, and governmental agencies, and to appear in court on their behalf.

Commitment to these elementary patient rights not only does not limit physicians' freedom of action but gives them the right to expect corresponding duties and responsibilities from their patients in return.⁸ Thus patients can and should be expected to learn as much as possible about their illness and what they themselves can do to assist in their own healing work; to know and observe all rules and policies; and to honour and carry out all agreements freely entered into. Above all, patients will have to take responsibility for making their needs and wishes clearly and explicitly known and for giving feedback and constructive criticism when they feel unheard or dissatisfied.

Even if these guidelines are followed out to the letter, the problems of malpractice and iatrogenic illness will obviously not

vanish. Misunderstandings are bound to occur, patients will continue to be injured by what doctors do or fail to do, and some way will still have to be found for society as a whole to underwrite the large majority of instances where no individuals were specifically at fault.

But the fact remains that doctors who are attentive to their patients, respectful of their wishes, and sensitive to changes in their relationship are much less likely to be sued. The doctor-patient alliance remains by far the best possible insurance for doctor and patient alike, and ultimately there need be and can be no other.

Healing the medical system

Rebuilding the doctor-patient alliance is only a starting point. Of itself it cannot solve the problems of malpractice and iatrogenic injury, which are deeply rooted in our basic assumptions about health and illness and in how physicians are trained to diagnose and treat their patients.

The most effective way to make the practice of medicine less dangerous is therefore to provide comprehensive health education to the general public, beginning in elementary school and continuing throughout life. Such a programme would also teach doctors and patients alike to recognize and promote good health as more than the absence or prevention of diagnosable disease or detectable abnormality, as a fundamental energetic property of all biological systems, including the capacity to maintain and repair themselves that is evident in all spontaneous recovery from illness and in all effective healing work.

The idea of the natural healing capacity, the *vis medicatrix naturae*, is already prominent in Hippocratic medicine, and receives its classical formulation in the writings of Paracelsus, the great Renaissance physician:

The art of healing comes from nature, not the physician. Every illness has its own remedy within itself. A man could not be born alive and healthy were there not already a physician hidden in him.⁹

At the level of basic health education in the schools, such an orientation might emphasize training in physical fitness, nutrition, and simple spiritual practice to assist every student in understanding and coping with ordinary life stress and to provide safe and effective techniques for maintaining health that are accessible to everyone and applicable throughout life. A new type of paraprofessional or community health worker could then emerge, roughly analogous to the Chinese 'barefoot doctor' who after completing a brief but rigorous training programme would be qualified to teach and supervise others in the general area of self-care (health maintenance, triage, and first aid of injuries and simple domestic ailments).

At the level of licensed health professionals (nurses, physician assistants, nurse-practitioners, midwives, primary care physicians), the program would include comprehensive graded and certified programs in nutrition, yoga, acupuncture, homœopathy, herbalism, midwifery, counselling, meditation, and the like, to assist the natural healing capacity in cases of largely functional or curable illness in which fixed anatomical lesions and irreversible organic changes or tissue damage are minimal or insignificant. Such practitioners could provide safe and effective services inexpensively to millions of people, helping to restore them to improved health and well-being with minimal risk while maintaining the finest medical and surgical facilities in readiness for those cases where they are required.

Even at the level of speciality and subspeciality care, the same orientation could teach surgeons and cardiologists to go beyond the diagnosis by paying more attention to those unique and idiomatic

features of the case that often help to explain each patient's illness as well as it can ever be explained. It could then assist in the healing of it by investigating the gentler methods first and resorting to the more drastic ones only if all others fail or in urgent or desperate cases where nothing else will serve.

Such an orientation would insert new priorities at every level of the system, by keeping people sane and fit and scaling down the need for costly and dangerous medical procedures of every type. It would evaluate various non-invasive methods of diagnosis and treatment and provide research and training facilities for teaching and practising them. It would develop new research protocols to go beyond the limited perspective of diagnosable diseases and detectable abnormalities and study the living patient as a unified bioenergetic system over time.

These changes in emphasis would undoubtedly stimulate the creation of a new experimental health technology of a more advanced and sensitive type, as presently envisioned by Kirlian photography, electro-acupuncture, radionics, and the like. They would teach physician and patient alike the primary helping roles of educator, counselor, advocate, comforter, healer, and midwife, defined less by what they do to their clients than by how to be there for them, to help them plan and carry out their own healing work in whatever way is most useful to them. Sick people might then have reason to trust that they will always be cared for and can therefore leave the hardest decisions for when the time comes to make them.

In a system of this type, the risks of iatrogenic injury and medical malpractice would certainly be reduced to tiny fractions of what they are now, such that medically injured patients could easily be reimbursed out of the same insurance plan that would cover their regular health and medical expenses, which would also be considerably lower than they are at present.

One simple scenario would be for a government insurance plan to pay all primary-care physicians and health providers directly and generously for those services which the public directs them to provide, such as health and wellness services as above, simple triage and diagnostic work, and whatever speciality or emergency care would be authorized by referral at the time. All of this could be reimbursed to the patient or the physician out of something like Medicare or Social Security, which would in effect become a huge home for basic health services with the whole population as subscribers. The same fund could also reimburse subscribers for injuries sustained by them at the hands of participating physicians.

Whatever the plan did not cover, such as elective surgery or speciality care not authorized by referral, could still be available but would have to be paid for privately; and any injuries sustained by the patient outside the plan would require legal action for redress, much as they do now. The plan could thus be designed to provide as much preventive and wellness care as possible and to keep the high-cost, high-tech, high-risk private sector competitive and generally unnecessary. Private insurance could still be available and even required for these 'big-ticket' items and for those doctors and patients who still wanted to use them oftener than the regular plan would provide.

If this reasoning is correct, then the diagnostic and treatment services of the health care system would indeed become less and less necessary as its educational programmes become more and more popular. Can doctors merit higher praise than that their patients heal themselves without needing their help and continue not to need it in the future? In the words of the great Chinese sage:

A leader is best when people barely know he exists
Not so good when they obey and acclaim him

Worst when they despise him
Of a good leader
When his work is done and his aim fulfilled
The people will say, 'We did this ourselves.'¹⁰

- 1 Seel, K, *et al*, *Iatrogenic Illness in a General Medical Service at a University Hospital*, *New England Journal of Medicine* 304: 638, 12 march 1981
- 2 *Ibid*, p 638
- 3 *Ibid*, pp 638-639
- 4 *Ibid*, pp 640-641
- 5 Hahnemann, S, *Organon of Medicine*, 6th Edition, transl. William Boericke, M.D., Boericke and Tafel, Philadelphia, 1935, paras 1 and 2.
- 6 Bernard, C, *An Introduction to the Study of Experimental Medicine*, transl H.C. Greene, Dover, New York, 1957, pp 65-67, *passim*.
- 7 Cf. *Code of Practice*, People's Medical Society, Emmaus, PA, and Doris Haire, *The Pregnant Patient's Bill of Rights* ICEA, Minneapolis, MN.
- 8 Cf. *The Pregnant Patient's Responsibilities*, ICEA, Minneapolis.
- 9 Paracelsus, *Selected Writings*, transl. N. Guterman, ed. J. Jacobi, Bollingen Series XXVII, Pantheon, New York, 1958, pp 50,76.
- 10 Lao Tse, *The Way of Life*, transl. W. Bynner, Putman, New York, 1944, pp 34-35

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