

Medical Mistakes Happen; They Don't Have Anything to Do with Social Injustice Really?

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Abstract

Medical mistakes are often experienced as single and highly personal events that just should not have happened and that could have been prevented by another course of action. Some of the many ways of how mistakes are entangled with social injustice are discussed in this paper, that is, in what ways medical mistakes belong to the many faces of social injustice and, vice versa, how social injustice contributes to medical errors.

Keywords: medical mistakes, social injustice

Introduction

On first sight, medical mistakes do not seem to have much to do with social injustice: mistakes happen during one's encounter with the healthcare system and social injustice seems to be the result of a failure to justly distribute resources. This paper, though, attempts to show some of the ways medical mistakes and social injustice are interlinked. The method to approach the problem is based in applied philosophy, influenced by a phenomenological approach to the notion of injustice, and necessarily interdisciplinary. Why this particular focus? From time to time, media headlines highlight the chilling fact that more people in the U.S. die of preventable medical errors, mainly hospital errors, than from AIDS, car accidents, breast cancer and plane crashes. Annual mortality statistics normally do not make mention of medical mistakes but one in five U.S. Americans can tell a story about the serious harm that was caused either to themselves or a family member (AHRQ, 2015; Allen, 2013; James, 2013; McMains, 2016). The high medical error rate is one of the factors that make healthcare in the U.S. costly, not just because of insurance, "repair," and restitution expenditures but also because of the economic and social extra-costs. Another of these cost factors is the continued existence of access and quality gaps (health disparities) for members of minority groups. In order to drive these costs down and enhance population health, a system of accountability and quality assurance and safety has been introduced and reporting mandated, especially for hospitals and clinics (AHRQ = U.S. Agency for Healthcare, Research, and Quality). To these measures belong a more patient-centered approach, patient, family, and community engagement, error disclosures, and greater equity, especially through health insurance expansion (ACA) ("Healthy People: 2010, 2020").

As a result both population health outcomes and equity of the system improved and any ACA repeal that creates new enrollment barriers will negatively impact health outcomes. It is also a fact, that the error rate remained high and health gaps between groups that have been historically marginalized or neglected and whites continue to exist, as do other disparities ("Healthy People: 2010, 2020;" "Transforming Healthcare," 2013). According to the Agency for Healthcare Research and Quality, over 60 percent of health care disparities in quality have stayed the same or worsened for Blacks, Asians and poor populations, whereas nearly 60 percent of the disparities have stayed the same or worsened for Hispanics ("Healthy People: 2010, 2020"). Health disparities, that is, population specific differences in the presence of disease, health outcomes, and access to health care (treatment and health management options) that are associated with wealth, class, socioeconomic status and/or geographic location (esp. regions and states), are often also termed inequities (Freeman, 2015, 31-32) and researched as social (in)justice and (un)fairness issues (Levy & Sidel, 2005). Other inequities are simply differences, for instance, when a particular minority population is significantly younger and, therefore, do not utilize the health care system to the degree the white majority population does to which it is compared.

So health care reporting, research and health policies connect both mistakes and inequities as cost and quality influences. Moreover, analyses of the factors that impact the error rate or inequities point to a number of determinants that are the same for the reduction of both: individualization and personalization of health care, standardization of treatment (best practices), feedback loops, improved communication, access opportunities (including insurance and location) in general, and specifically regarding the level of healthcare that is needed, as well as low income and educational differences. Health Disparity Reports with focus on access to and utilization of tests, health education, and different levels of care, therefore, provide some insights into the probability of higher exposure of minorities to medical errors. The picture, though, is incomplete. First, there is no universal or U.S.-wide shared definition of medical mistakes. The definitions of errors, e.g., that are used for quality reporting, have been developed with measurability in mind. Second, there is no rubric for deaths or serious bodily harm that result from mistakes. Third, the numbers that the press reported are extrapolations and approximations of available data, mostly from hospitals. The majority of interactions between persons in need of care and care and treatment providers, however, takes place in primary care and, increasingly, nursing homes and other health care related institutions. Fourth, different methods of defining, measuring, and interpreting disparities additionally complicate the picture. And, as mentioned above, not all of what is listed as disparity is per se an issue of social injustice and/or unfair.

If the focus is on quantifiability, outcomes, and relatively easily enforceable changes, only those mistakes that fit the model in case are documented; what is outside the chosen parameters stays unnoticed. What is also missed is that both injustices and mistakes are phenomena that are happening, that is, processes and, more so, processes that can overlap. Additionally, when the focus is on objectified outcomes, how these processes are experienced still remains underexposed. As the etymology of the words *injustice*, *mistake*, and *errors* shows, these words exist in a linguistic field with “harm,” “injury,” “moral wrong,” “unfit,” and “transgression,” which, too, point to the often underestimated experiential aspect of these phenomena. There exist long-standing philosophical discussions on the appropriateness of responses to wrongdoing and wrongdoers in the form of social-cultural (rejection, disrespect, shaming, bans, and apologies) and legal punishments (retribution, retaliation, and revenge) and on emotional reactions (e.g., shame, guilt, anger, resentment, aggression, feelings of betrayal and broken trust). More recently - under the umbrellas of moral repair, apology laws, the need for empathetic professionals, and debating the embodied experience of illness and injustice as well as the situatedness of the experiencer – phenomena, such as, disability, moral injuries, and the human costs of injustices and medical mistakes have been given more attention (Carel, 2014; Halpern, 2001; Lindeman, Verkerk, & Walker, 2008; Shklar, 1990, Dickenson, 2003; Rubin, & Zoloth, 2000, Levy, & Sidel, 2005). Theoretically, this turn has been based on naturalized, new materialist, and/or phenomenological approaches to ethics, epistemology, and political and social philosophy.

The following research has to be seen in this tradition. It will not only take a look at how medical mistakes and health disparities are interlinked (systemic level) but also bring embodied experience and the experiencer into the picture. It takes into consideration that, although mistakes can happen to anyone, medical mistakes are perceived (by patients, their friends and families, or guardians) as single, almost unbelievable events that should not have happened and that could have been prevented with a different course of action or better thinking or communication (individual level).

To discuss how medical mistakes and social injustices feed on each other also requires to consider

(1) what mistakes are, how they come about, and how they are experienced (directly or indirectly) and portrayed, (2) under what economic, financial, political, and geographic conditions the health care sector/health care industry operates, (3) how injustice is directly or indirectly experienced, portrayed, and can influence medical mistakes as well as (4) how the fundamental bio-ethical principles of no harm, beneficence, autonomy, and justice weigh in. Although both mistakes and injustices are linked to misfortunes and bad luck and reactions of acceptance and/or blame and the desire to “right” what has happened, a discussion of apology, punitive measures, and healing from exposure to these events will not be the primary objective of this paper.

How are medical mistakes and social justice entangled?

1. What are medical mistakes/errors?

Although the definitions and taxonomies of medical mistakes differ, there exists a widely shared understanding that mistakes are knowledge, skills, and competency dependent (Runciman, Merry, & Walton, 10, 112-123) and, also, influenced by expectations.

Within the framework of quality measurement, improvement of health care, and litigation avoidance, mistakes are generally understood as unintentional actions while performing a routine task or wrong, delayed, or incomplete diagnosis and/or wrong/delayed or inadequate treatment or wrongly exercised treatment after a correct diagnosis (“Preventable Medical Errors, 2013;” James, 2013; Surbone& Rowe, 2015, 1; Sharpe, 2004, 61-62). In other words, medical mistakes (or errors) are distinguished from intentional acts that have harm as their purpose. They are considered deviations from good judgment, or digressions from or violations of reasonable treatment and “best practices” and standards of good care (Munson, 2012, 890-904). These deviations can lead to adverse effects for the patient, which can be immediate, delayed, cumulative, or long-term (James, 2013).

Narrative bioethics and virtue ethics approaches as well as graphic medicine added another facet, the aspect of experience, to this mainly biomedical and litigation-related understanding. With it, the interactions in the patient/families/friends/guardians – health caregiver relationship and the complexity of the moral, social, and economic values that are guiding the expectations and behaviors of these actors are brought into the picture. Concepts, such as, *shared decision-making*, *truthfulness*, *apology*, and *forgiveness* attest to it; they recognize that decision-making happens in engendered, socio- and ethnic culturally, racially, religiously, language and power-shaped environments (Halpern, 2001, 106, 132-133; Walker, 2006; Berlinger, 2008; 2005). Moreover, these notions do not only reflect the participatory aspect of the patient/families/friends/guardians – health caregiver relationship but also the factors that influence the levels of trust and distrust in this relationship (Elwyn, Edwards, Kinnersley&Grol, 2000). For example, expectations regarding how care should happen and what good care and appropriate treatment are, impact the level of collaboration as well as the evaluation of what is considered errant/mistaken behavior. Cultural beliefs and mass/social media – influenced expectations also affect the decision whether and how to utilize the health care system. Following this train of thought, right implementation of the standards of “due care” should be oriented in evidence-based “best practices” and result from negotiations with the patient and/or their advocates. Treating patients as an autonomous being requires honoring their wishes and/or maintaining or restoring (if possible) their decision-making capability, so that they can participate in the healing or health management processes.

Consequently, the necessity to explore and openly debate genuine treatment/testing/care options arises. This, in turn, brings the patient’s, advocate’s, or healthcare workers’ knowledge levels, cultural and religious beliefs, considerations for others who might be impacted by the decision, and economic and financial considerations into play. With it, the justice principle becomes part of the decision-making process, which demands to treat similar cases alike, that is, race, gender, ethnicity, or income should not determine a patient’s eligibility for treatment and/or care. The welfare of the patient has priority, that is, differences in treatment of the same condition should never be arbitrary or totally irrational (Ridley, 1998, 51-54); the merits of each and any case should be considered, although guided by guidelines concerning “good practices” and “reasonable” resource utilization. Following this train of thought, medical mistakes can be seen as events that, even if they did not result in serious harm or harm at all or do not have a legally responsible originator, happen in an environment in which the person being cared for trusts the caregiver with his/her life and respective health condition and expects and negotiates professional support in the management of this condition, under the stipulation of being exposed to as less harm as possible (physical, psychological, and financially). Taking an experiential approach to the same processes, what is perceived as mistakes and adequate treatment are “suffered through,” they are bodily experienced (often inscribed into the body) and affectively memorized, that is, they are interpretatively remembered. They become parts of different narratives that can be full of hurt, frustration, anger, disappointment, blame and self-accusations, and the feeling of having been wronged or having caused suffering, needing “revenge,” and the desire to not let anything like that happen again (Halpern; Berlinger, 2005; Vannatta & Vannatta, 2013, 35-44).

Breaches of the non-maleficence principle then deserve an explanation, an apology, and remediation. In this model, beneficence and respect for autonomy are definitely weighted in. The justice principle, though, is often given less consideration because of the understanding of medical mistakes mentioned above. Pragmatic approaches to error reduction might, instead of weighing these principles, prioritize them but also with the justice principle being considered last or as an “extra” (Berlinger, 2005; Sharpe, 2015). Focusing on social injustices, though, might show that the justice principle, especially when centering on avoidance of possible injustices, deserves more attention in order to reduce errors and improve the quality of care.

2. What does or does not make mistakes direct or indirect acts of social injustice?

In order to discuss the relationship between medical mistakes and social injustice, first, the concept of injustice that is applied to this discussion will have to be given attention, second, the relationship between mistakes and injustice, and, third, what it is that can make mistakes direct or indirect acts or contributors to social injustice. Generally speaking, injustice refers to the quality of unfairness or undeserved outcomes. In her seminal text on injustice, Shklar added a number of important specifications, such as, the distinctions between:

- (1) Active and passive injustice. The latter refers to indifference or the refusal of individuals to prevent acts of wrongdoing when they could and should do so; it represents a civic attitude (1990, 5, 39-41);
- (2) Immediate and latent injustice; the latter can also be cumulative;
- (3) Invalidated or validated injustice because of rule-governed prohibitions (7);
- (4) Legally recognized and remedied injustices and those who do not show up in official inventories, although they might become part of social memories;
- (5) Injustice because of broken rules, promises, and trust, and disappointed hopes and expectations. Negative expectations that have been met also belong to this category (10-11, 37-39). They can happen to both individuals and groups and arouse feelings of having been denied a promised benefit or having been rejected as expected because one was seen as belonging to a particular social, racial, or ethnic group. It comes with the feeling of victimization and undeserved treatment by others, rather than being considered a misfortune, and it calls for change (40-66, 83-84);
- (6) Injustice because of systemic or individual failures or resulting from systems that are pre-programmed to be unjust. One could also add injustices that occur because of the complexity of systems and/or contradictory systemic rules (AP).

Inherent to all these variants is that they are “lived,” experienced injustices, with the experience depending on how individuals or groups are framing the event – influenced by others, the media, fact-checking efforts, and their own background valuations. This means, whether something is called an injustice depends on an individual’s or group’s perception of unfair treatment and sense of injustice, which itself is shaped also by their understanding of the role of government (social contract expectations). In that sense, injustice doesn’t concern a “sheer fact” but complex meanings that are remembered by individuals and groups or tried to be forgotten. These meanings are emotionally charged, open to interpretation and historical change, and can have a more or less long afterlife, way beyond the original event (Kregel, 2009; Kohn, M., 2009).

If these injustices are based on rules that discriminate against individuals who belong to particular groups because of race, ethnicity, poverty/wealth, class, socioeconomic status and/or geographic location so that their access to social services is unduly limited, in our case to healthcare, treatment, and health management options, they become social injustices. This applies also to the, sometimes cumulative, affects of individual and/or group experiences with healthcare provision. The reason is that these experiences are interpreted as discriminatory and retained as such in social memory. If and how they are remembered influences individual and group expectations and behaviors toward the health care system and its representatives. That the effects of past discrimination and social inequality in form of socially inflicted trauma, substance abuse, exposure to toxic substances, and food insecurity have been “incorporated” into the body of those who experienced it, adds to it. It shows in health disparities statistics in the form of presence of diseases and health outcomes (Hardimon, 2013, 16-17).

Now, how does the above relate to medical mistakes? Like injustices, medical mistakes occur on an individual level, that is, as a result of the personal interaction of care/treatment provider and patient/guardian as well as on a system level, that is, resulting from the complexity of interactions of compound agents within the process of caring/treating a patient. They also happen because of the possibility of conflicting rules, responsibilities and background valuations (e.g., civic, moral, and financial) that influence the personal interaction. The doctor/patient/guardian relationship, even when technologies are involved, takes place within systems of rules and regulations but is always a personal encounter. The following will therefore take a look at the intersection of individual and system levels in the case of “good professional judgment” and deviations from “best practices” and “good care.” Taken as directly or indirectly perceived deviations from evidenced standards of “good professional judgment,” “good care,” and “average” professional skills, medical mistakes meet the definition of injustice in that they are “wrong” acts that violate the right(s) of another to not experience unnecessary harm.

Acts to which a “reasonable” patient has properly given informed consent and which lead to unfavorable outcomes, although they are non-negligently performed, are cases of bad luck and grounds for regret that the procedure has been done on both sides, as Dickenson has convincingly argued. In these cases, doctors/care givers are neither legally responsible nor ethically blameworthy (2003, 65-66). Although expectations were disappointing, promises were not broken. Another group of cases in which no blame is doled out concerns disagreements between the care-giver and the “well-informed” and “reasonable” cared-for with regard to what plan of action should be taken. The caregiver might perceive a plan as – at least – partially wrong when it is not in line with what he/she considers standards of good care and/or causes harm to the patient, although the harm deems the patient acceptable. The patient simply does not consider that act as blameworthy and a personal injustice because his/her expectations and understanding of a “wrong path of action” differs, as informed by different value interpretations and/or priorities. The picture changes, however, when the path taken by the health care person diverges from or collides with the patient’s/guardian’s wishes and expectations, that is, when the latter feels ignored, misunderstood, or unfairly and biasedly treated. If the patient/guardian links the discrepancy to his/her belonging to a particular racial, ethnic-cultural or language and, or income group (poverty), the wrong turns into the perception of a social injustice.

The link between unsuccessful or distorted communication and adverse events that reach from physiological reactions (Hardimon, 16) to medical mistakes is even more pronounced in cases of biased communication, acts that are based on prejudices and biases and/or a lack of so-called “cultural competence” on the side of the health care provider. Low education level, language barriers, ethnic and cultural differences in value interpretations, and circumstantial conditions, such as a patient’s nervousness and/or pain, influence what is and how it is explained and understood. This, in turn, has repercussions for the plan of action and the level of cooperation.

Error analyses also document that prejudices and biases against patients/guardians, even if subtle or unconscious, raise the possibility of mistakes and deviations from best practices (Surbone & Rowe, 116-121; DeVoe et al, 2007; Sabin, Nosek, Greenwald & Rivara, 2009). The resulting mistakes, then, as in the previous case, can be seen not just as personal wrongs but also as acts of commission of social injustice. More so, these acts can become part of latent and cumulative social injustice: Mistakes are embodied and can show in bodily mutilation and/or additional stress and suffering. The “body of evidence” can serve as a more or less constant reminder of that to the victim as well as his/her friends or acquaintances and carry the mark of an unwanted and underserved act that is linked to one’s “membership” in a particular group that is negatively valued. Whether taken with resignation or indignation, the event will enter collective memory and might add to an already existing history of injustice, harms and humiliating acts that have been committed by others, such as police forces, government bureaucrats, or border patrol agents. With it, the embodied mistake functions as individual and collective memory location and can contribute to the buildup of other forms of biases, this time in the victim, his/her communication partners, and underprivileged groups. By retelling, stories change and get mixed with other first- or second-hand experiences and, also, with hopes, expectations, and expressions of emotional states, such as fear, anger, and resentment. Thus, these stories can contribute to a collective identity of victimhood and neglect, which, in turn, can influence decisions on whether to utilize the help of these agencies, among them the health care system. As an example of the above mentioned, news reports about Baltimore-West point out that for African Americans in the area, memories of the Tuskegee experiments and of the story of Henrietta Lacks mix with personal perceptions of medical maltreatment, stories of past and recent police encounters and negative experiences with city administrators, in particular within the poor Baltimore neighborhoods. The negative collective memory has functioned as a reason for caution and hesitance to seek medical help in local hospitals or clinics when needed (often too late or not at all). Although the quality of care has improved, people often seek help too late or not at all. In the words of a doctor, “*But to the frustration of hospital officials who say they deserve better, Bon Secours is still known across West Baltimore as "Bon Se-Killer"*” (Hancock, 2016) Negative experiences with border patrol, insecurities because of their immigration status, poverty, and language barriers can have similar effects for Hispanics. In both cases, the fact of not having gotten needed medical attention shows in data about health disparities and error rates (Walker, Williams & Egede, 2016; Garfield, Majerol, Damico & Foutz, 2016; Cancer leading cause of death, 2012). Prolonged time without necessary medical intervention often contributes more to a complex clinical picture, which makes diagnosing harder and raises the need for more procedures and more coordination. With the possibility of more interactions and more complicated cases, the probability of unforeseeable adverse events rises.

So, in conjunction with social memory, both the direct or indirect experience of latent or cumulative injustice and/or medical mistakes can feed on each other and have measurable short- and long-term effects. Although medical personnel and care providers are directly only responsible for the individual patient and not populations, indirectly, their actions have broader implications for the experience of social injustice. Moreover, the socio-cultural, political, economic, geographic, and environmental as well as social media context in which health care takes place, influences who will and can access what level of care and when as well as how the care is delivered. This links health care delivery directly to latent social injustices and higher risks. Living in rural, poor, medically underserved areas and/or being African American and Hispanic, significantly increases one's likelihood of being exposed to non-standard treatment and errors (2014 National Healthcare Quality and Disparities Report; Molina, Silva, & Rauscher, 2015; Freeman, 2015; DeVoe et al.; Heiman & Artiga, 2016). The same is true for the elderly (Dilworth-Anderson, Pierre, & Hilliard, 2013; Hasnain-Wynia, et al., 2007).

Treatment differences between people with insurance and people who do not have insurance or are underinsured should not cause lower testing and cancer survival rates for the latter (Andrews, 2016) and late testing or under-treatment for HIV ("Black Americans," 2017). Shklar calls the resulting sense of social injustice appropriately *righteous indignation* and a form of unwarranted social deprivation (84). However, not being treated in accordance with best practices ironically can sometimes be of advantage, as the current controversies over efficiency and necessity of mammograms, breast and colon cancer tests, or over beta-blocker efficiency for post-myocardial infarction indicate. Again, deviation from best practices is not per se a mistake or leads to a social injustice, even if it might be perceived as such. The problem is that best practices are not necessarily based on "best" but on available evidence and enforceability and linked to financial-economic and other considerations of political decision-makers (e.g., debate on mammograms and colon cancer tests; Molina, Silva, & Rauscher, 2015; Liverani, Hawkins & Parkhurst, 2013; Lin, 2016; Bloomberg, 2012; Surbone & Rowe, 52-55, 128-129). Best practices recommendations with regard to treatments and diagnostic tests are way too often and, to a degree understandably so, based on the "average patient." Many of the data that we have is derived from "a" patient that looks more like an insured, at least high school educated, middle-aged, 155-pound white male - despite improvements in trial participation of women, the elderly, and ethnic racial minorities (Williams, 2004, 3-4; "The Center for Information," 2005). It is also the case that some treatments become the norm not because they are better but because the evidence is better or easier attainable (Dickenson, 116-117). Many research projects focus rather on acute than on chronic conditions, on severe versus less severe conditions, on rare diseases versus common ones, or on younger patients instead of older patients and young kids (Williams, 2004; Tricoci, Allen, Kramer, Califf & Smith, 2009; The Center for Information, 2005; Prasad, 2013).

So as helpful a tool the rules are as standardization of treatment is concerned, some of them are also inherently biased towards certain groups. If recommended tests or treatments are not specific enough, not getting them does not necessarily constitute harm or an act of discrimination but can save from unnecessary risks (e.g., mammograms, some colon cancer tests, and use of beta-blocker efficiency for post-myocardial infarction). On the other hand, singling out certain groups and providing special tests and/or access to differing treatment based on genetic lineage/area of origin, as is in case of, e.g., Tay Sacks or more aggressive breast cancer in African Americans, could, if background knowledge is missing, be perceived as discriminative on the side of the respective patient. Other patients or insurance companies might raise the question whether the extra costs are worth spending. A brief commentary on this will follow later; now back to the influence of expectations, fears, and hopes on the configuration of mistakes and/or injustice.

These experiences are pre-mediated. Health and health policies have become constant features of news coverage and social media debates. New treatments and technologies are sensationalized, illnesses stigmatized, others are found not "newsworthy." Often, new techniques and technologies and alternative treatments seem to promise sensational new healing and treatment options. The aggrandized reporting can easily raise unrealistic expectations and exaggerated hopes in people, leading them to assume that they, too, deserve this new and promising chance and make unrealistic demands, even via legal means. The surgeon Nuland called this very pointedly the "tyranny of unrealistic expectations for both the sick and the well" (2008). In short, what is perceived as "normal," over, or under-diagnosing and good care is influenced by what and how risks and chances are communicated and how the media, including social media posts, frame what happens. Also of influence are what and what quality information is when available or not, to whom it is available and whether people take the time to research.

This, in turn, impacts what is perceived as medical mistakes and social injustice (National Survey, 2004; Vasterman, Yzermans & Dirkzwager, 2005; Media hypes, 2015) As mentioned above, that health care is administered for a price needs to also be taken into consideration when discussing direct or indirect and immediate or latent or cumulative injustices and their links to medical mistakes. Best practices recommendations, for instance, are also influenced by the need to flatten the cost curve (Surbone& Rowe, 52-55 128-129). So insurance types and availability of different levels of treatment and kinds of diagnoses impact if, when, and what quality of care is available to the patient. This, in turn, influences their perception of disappointed hopes, met negative expectations, and rejection by “the system.”

Another variant of individually experienced systemic latent injustice that is coupled to mistakes is linked to the serious value conflicts that medical doctors experience because of the cost factor. Does it count as a mistake when an expensive drug is prescribed to a patient who cannot afford the medication for a prolonged time and might, therefore, stop the treatment or will not buy the medication in the first place? Would the doctor contribute to a social injustice? What if a cheaper alternative was available? Wouldn't the doctor have to have knowledge about the patient's financial situation – just asking might raise feelings of discrimination and embarrassment – and about alternative treatments and the many medications that belong to certain classes of medications, their differences and price ranges? Furthermore, even if the doctor had all this information, he/she would have to skillfully maneuver through a precarious conversation, which could take up quite some time. How would this fit into his/her schedule and the time constraints the doctors are under? What would be “good practice” in dealing with patients to not make them feel unheard, rejected, or humiliated?

The value conflict for both doctor and patient is even more pronounced when one takes into consideration that the price of medications depends on what the pharma industry can charge, on agreements with insurers, on the government, on investment in research and other factors. Outcomes are not included in the pricing, cure or not (Wapner, 2011; Hawley, 2016). As a result, life-saving meds (e.g., EPI kits) or those, that can cure and/or for which almost no alternative exists, can be sold at high prices (e.g., EPI kits, chronic Hepatitis C meds). This can put doctors who see uninsured, underinsured patients or “just” poor patients into a dilemma; they know that a cure is available for a disease that will, if not medicated, end in death but the cure is very often out of reach for the patient. This is, for example, the case with Hep C meds, which have an estimated 95% probability to cure the patient but come with a very high price tag attached (\$100,000 and more) (Treating HepC, 2017). If the doctor cannot put the patient into a discounted trial group that makes the meds available to an acceptable price, he/she will have to resort to watching over a patient's deteriorating situation that can also lead to cirrhosis or cancer of the liver. Instead of being cured (against the beneficence principle), patients who are still in relatively good condition and would probably most benefit from the meds, will be exposed to more and unnecessary “necessary” risks and suffering (against the non-maleficence principle), a choice that is taken away, and the experience of social injustice because of a lack in finances (against both the autonomy and the justice principles). The doctor can console him/herself that this is the best he/she can do under the circumstances: “It's out of my hands, just a case of bad luck.” To do more about it would then be a matter of civic responsibility and engagement. Expecting the patient and his/her family to go into bankruptcy for health purposes does not seem fair either. And saying that the patient should have positioned him/herself better for such eventualities corresponds to what people normally want to do, that is, blame the person who took upon herself a deliberate gamble. But the blame is doled out after the fact, looking back. It is impossible to foresee and prepare for all kinds of eventualities in one's life; this would require God's omniscience. More so, following this logic, smokers, overeaters, drinkers, people who do extreme sports deserve blame, too. But they get treatment and receive no blame.

Saying, You should have worked harder to position yourself better, makes one's economic success the basis for the chance for a healthy life and, per se, excludes the poor. That limits future chances for a healthy and prosperous society. If one blamed sexual practices or past drug use for the exposure to viral Hep C, one tells the victim that it is his/her fault and, again, accuses him/her for not anticipating future health problems. Moreover, this argument actually differentiates between risky behaviors that are excusable (drinking, smoking, etc.) and inexcusable ones, for which one is fully to blame. Such an approach works only under the condition of background valuations that single out certain behaviors as sinful and bad and identify the person itself with the behavior. As with poverty, this turns persons into moral failures. And the moral judge is acting on bias towards sinful behaviors and groups of people, in this case homosexuals, as was the case with the advent of HIV in the 1970s. What is forgotten is that the disease can be a result of other causes as well, such as, blood transfusions.

More so, such judgments or just the suspicion of being judged can make the patient who has to live with a ticking time bomb (his/her body) despise his/her own body. Because they know that the illness will further and further restrict their options to live life, they are much more likely to accept the verdict of being a “loser.” Furthermore, part of their humanity is taken away; they are not just living social injustice but are tortured instead of healed. – One could call this a social failure in civic responsibility...

One last remark: Another indicator of the connection between poverty, social injustice, and medical mistakes are malpractice lawsuits and restitution for harm. Tort law reforms have made the process of attaining evidence more complicated and expensive and drastically capped the amount of money. For a poor person it has become extremely difficult to afford and go through a lawsuit. It is the plaintiff’s expert who has to provide the key evidence and the amount of money that can be granted might even be insufficient (Baker, 2005; Goguen, 2017).

Conclusions

Reporting and apology laws, together with health care quality assurance and improvement programs, as important as they are to lower the occurrence of medical mistakes, are not enough to tackle the problem. Errors and social injustice are interlinked and a reduction in social injustice contributes to error reduction and vice versa. Consequently, individualized patient-centered care and a higher degree of availability and affordability of insurance, care, and medications are necessary as well as a review of the levels of cultural competence that communities accept. Medical error rates and health disparities will react to new health care policies. How exactly, will have to be researched. It is foreseeable, though, that (1) any reduction in health insurance coverage or access to the needed level of care to an affordable price, (2) price increases with regard to tests, treatment, care and medications and (3) across the board deregulation to allow “medical businesses” to flourish that is not based on best available evidence concerning quality improvement will show in increased mistakes and a growing sense of social injustice. The impact of the latter will not just be momentary but very likely long lasting, that is, reach across generations.

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