MIEC

SPECIAL REPORT

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How do I say I'm sorry? Let me count the ways

INSIDE

Special Report Claims Alert
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Confused about recent discussions related to disclosure of unexpected adverse outcomes, apology v. sympathy, early resolution of injury-related complaints, and how to avoid unnecessary liability risks? You're not alone. Here is some advice for handling potentially difficult circumstances with compassion, truthfulness and candor.

What does "I'm sorry" mean?

In the lifetime of a practice, a physician experiences a multitude of opportunities to offer an expression of sympathy, condolence, regret, or apology. Saying "I'm sorry," the most common representation of these sentiments, can convey a variety of messages depending on the context in which it's expressed. Defense attorneys historically counseled physicians to avoid saying "I'm sorry," assuming that a plaintiff's attorney would argue that the words were an admission of guilt. Dr. Lucien Leape, Professor of Health Policy at Harvard Medical School, has this to say about that assumption: "For decades, lawyers and risk managers have claimed that admitting responsibility and apologizing will increase the likelihood of a patient filing a malpractice suit and be used against a doctor in court if they sue. However, this assertion, which seems reasonable, has no basis in fact. There is to my knowledge not a shred of evidence to support it. It is a myth."

Despite the admonitions, physicians have an ethical duty to inform their patient about what happened during a treatment or surgery. In 2001, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) established a standard that requires hospitals to ensure that unexpected adverse outcomes are fully disclosed to patients. Until recently, no one championed the cause of physicians who want to apologize to patients—and no one helped them to do so in a way that avoids putting the physician needlessly in legal jeopardy.

***SITUATION:** You appropriately prescribed Tegretol and your patient developed Stevens-Johnson syndrome.*

***SUGGESTION:** You say, "Mrs. Bee, this is one of those unlikely but possible—side-effects we discussed when I prescribed the medication, and I am so sorry that you were one of the people who experienced it! We will do everything possible to take care of your symptoms and look for another solution to your original problem."*

Sometimes it is appropriate—even essential—to say "I'm sorry." Even in those instances, some physicians hesitate, fearful that an apology will be held against them if the patient brings a lawsuit against them. On the other hand, a more damaging situation could unfold: consider the effect it would have on a jury if a physician was on the witness stand and the plaintiff's attorney asked, "Doctor, did you ever tell my injured client that you were sorry this happened?" and the physician had not.

"I'm sorry" legislation

Legislators in many states have passed laws in recent years to protect physicians who express empathy, compassion, and condolence to injured patients. In California, physicians'expressions of sympathy for patients' untoward outcomes are protected from being used in a civil action as an admission of liability; however, if the physician orally admits liability, the confession of fault is admissible.

SITUATION: *Your patient says that your medical assistant was too rough as she changed his dressing.*

SUGGESTION: *You say, "Gosh, Mr. Ali, I am so sorry it hurt. Although I know she's usually as gentle as she can possibly be, I'll ask her what was going on that might have made her movements more abrupt this time. I hope she apologized as it happened. She did? Great, but I'm going to remind her, too, how important it is to keep you as comfortable as possible."*

Idaho recently enacted legislation to make physicians' expressions of apology, condolence and sympathy, and their accompanying explanation of what happened, inadmissible as evidence of liability. Statements of fault, however, are admissible, so care must be taken to make sure that an expression of apology or an accompanying explanation do not also contain an admission of fault. Nineteen other states currently have similar laws, and other states, including Hawaii, have introduced similar bills for consideration. As of the date of this publication, Alaska has remained silent on the subject.

What's a physician to do?!

Defense attorneys, professional liability carriers, risk managers, and physician consultants have long known why patients bring lawsuits against their physicians. First, those patients have been or believe they were injured. Second, they are angry. They are angry—about not having their questions answered, about being given too little information about their condition and treatment, because they were treated coldly or dismissively, and for other real or imagined slights during the course of treatment.

The first step a physician must take to ensure that he or she can successfully communicate about an untoward outcome is to establish comfortable, solid rapport and trust with patients from the outset of the doctor-patient relationship. To facilitate the best decision-making about whether or how to express sympathy, condolence, regret, or apology, the physician must anticipate and prepare for such an event.

It is not possible to offer physicians specific advice for every possible circumstance and related contingency. Inevitably, there will be situations which require rapid judgment and action with far-reaching consequences. Every physician must consider the possibilities, be comfortable with the responsibility for patients, and rely on his or her moral compass for decision-making. In all other situations, a framework of practical recommendations and a common sense application of them will cover most contingencies.

SITUATION: *Your 93-year-old patient suffered a heart attack the day after her last visit to your office. Her youngest son, also your patient, is beside himself with grief and asks, "Why didn't you save her, Doc?"*

SUGGESTION: *You say, "I am so sorry for your loss, Mr. Chow. You know we were right there together to the end, trying everything that might have helped her, but your mom's heart was just too fragile and couldn't be fixed. I'm honored that I was able to participate in the care of such a well-loved and long-lived patient as your mother."*

Recommendations

What to do BEFORE you are confronted with an unexpected adverse outcome: Anticipation and preparation

- ✓ Establish and maintain a warm and communicative **rapport with patients**.
- ✓ Introduce new patients to you, your staff and your policies by giving them a "Patient Information Brochure" (*Ask the Loss Prevention Department for sample brochures*).
- ✓ Ensure that your staff is well-trained to welcome patients to your practice and convey interest in their well-being, both on the phone and in person. Hire staff who will convey warmth and reassurance to patients.
- ✓ Ensure that your staff knows how to respond to patient complaints to avoid escalation of perceived problems (*See Managing Your Practice, Advisory No. 3, Patient complaints: how to stop them before they start*).
- ✓ **Educate patients** about their disease, condition, general health, medication, or other treatments. Give them written information about these topics and your advice. Tell them to read what you've given them and invite them to ask questions if they have any. Document that you've done so.
- ✓ Lay the groundwork for future discussions by having a **thorough informed consent discussion** prior to invasive procedures or other risk-inherent treatment. Remember that informed consent is a process, not a form. Obtaining informed consent is an opportunity to educate patients, answer patients' questions, reassure patients, strengthen the doctor-patient relationship, and to realistically establish patients' expectations. (*See MIEC Loss Prevention Claims Alert, No. 17, Informed Consent Revisited: What is Expected of Physicians*).
- ✓ Thoroughly **document your care**; justification for medical decisions; patient education efforts; plus, informed consent and informed refusal discussions (*see MIEC's Medical Record Documentation for Patient Safety and Physician Defensibility*).
- ✓ Find and **participate in training programs** to assist you to sharpen your skills in the art of disclosure of unanticipated outcomes, expressing compassion and sympathy in treatment settings, and communicating in potentially conflictual doctor-patient situations. (Local hospital risk managers and education departments may be a resource for such training programs.)
- ✓ Consider in advance, informally (with trusted colleagues) and formally (in appropriate committees or groups for that purpose), what you might do if faced with a situation in which a patient suffers an unexpected, adverse outcome in which you played a role. These discussions needn't involve actual cases that might be discoverable, but hypothetical circumstances of the kind physicians are likely to face. Include consideration in advance of what you might do if you were faced with such a situation and lacked the opportunity to call MIEC for advice about how to proceed.

SITUATION: *Despite your utmost care in the examination of your 6-month-old cardiology patient with osteogenesis imperfecta, you realize you've fractured his arm.*

SUGGESTION: *You say, "Mr. and Mrs. Dillon, I'm so sorry, but I believe that Donnie's arm is broken. It's even possible that my examination contributed, as gentle as I tried to be; his bones are so very fragile, as you know. I'd like to take him right over to the emergency department for evaluation and treatment. I'll stay with all of you until he's been treated and we know everything that needs to be done has been done." (As soon as possible, you call MIEC's Claims Department to report the situation) [***Note***: The parents in this real circumstance did not sue the doctor.]*

What to do if you are involved in, believe you have contributed to, or are implicated in an unexpected adverse outcome:

✓ **Call MIEC's Claims Department <u>as soon as possible</u>!** The Claims Representative will discuss with you the relevant facts of the circumstances and your role in them, and will advise you of the most prudent and appropriate course of action. If necessary, the Claims Representative will obtain the services of an attorney to participate in the discussion and subsequent decisions on your behalf. As the Claims staff is not available "24-7," in some instances it will be necessary to express sincere sympathy (but not liability), and call MIEC after the fact to determine how to proceed. Attorneys caution against making statements of liability because some physicians may be so overwhelmed by an outcome that they are prematurely self-critical, when in fact they did **not** contribute to an injury and their care turns out to be entirely defensible.

✓ Be aware that when patients are injured (or believe they've been injured) they want three things: 1) Sincere sympathy and/or an apology; 2) A show of concern; and, 3) If they were injured by an untoward event, a commitment to ensuring that no one else is injured in the same way in the future. Many patients also want an explanation for what happened and why; physicians can advise the patient or family member that every effort will be made to understand the circumstances of the event. It is important to then follow through with that promise, with the advice of the Claims department.

✓ Know your hospitals' disclosure policies, especially the specific steps to take in the face of an unanticipated adverse outcome in the hospital (*see MIEC's Special Report, MIEC Claims Alert, No. 33, Disclosure of unanticipated outcomes*).

✓ With the help of the Claims Representative, determine what events and details will be disclosed, if any. Determine when disclosure will take place, who should be present, who will conduct the discussion, what should be said and to whom, who will say it, and where the meeting will be held (in a private setting, for instance).

✓ With the help of the Claims Representative, determine whether you will offer an apology, an expression of sympathy, an accurate and objective explanation, a promise for an investigation, or some other demonstration of your sincere response to the situation. [In some instances, if the situation is hospital-based, it may be appropriate to work cooperatively with the hospital risk manager—again, with the advice of the Claims representative.]

SITUATION: *When your patient called at 3:00 a.m., you suggested he go to the emergency room to be evaluated and after initially agreeing, he said he wasn't that ill. You urged him to go because you want to make certain that nothing serious is missed. You make a note to that effect. The next day his wife calls to tell you that the patient collapsed and died at home at 11:00 a.m.*

SUGGESTION: *You say, "Oh, Mrs. Eddy, I am so very sorry to hear that! Is there anything I can do to be of assistance to you?" [As soon as possible, you call MIEC's Claims Department to report the situation. DO NOT make changes to the patient's chart.]*

✓ If you offer an apology or an expression of sympathy and an accompanying explanation, be sure to have a colleague, nurse or other person present to observe and listen. In the event you

SITUATION: *The results of the PSA you ordered was filed in the patient's chart without your review and you didn't see it until 18-months later. It is acutely elevated, and given the patient's general health, you know that this result indicates a further compromise of his health.*

SUGGESTION: *First, you call MIEC's Claims Department to discuss how to proceed. You and the Claims Rep review the patient's chart and the pertinent details and decide when and how you will contact the patient, and what you will say. You will discuss possible ways to take care of the patient's immediate and long-term needs related to this obvious lapse in care.*

are accused of admitting liability and not "just" apologizing and explaining, a witness to the conversation will be helpful.

SITUATION: *Your 15-year-old appendectomy patient developed post-surgical peritonitis; you supervised and assisted the surgical resident who did the surgery. Upon returning her to the OR, you discover that you nicked her bowel. You're aware that her recovery is likely to be slow and complicated.*

SUGGESTION: *You spoke briefly to the Claims Representative prior to taking the patient to surgery the second time because you suspected the cause of the patient's distress. Upon meeting with the parents after successful surgery to repair the tear, you say, "Mr. and Mrs. Goodman, it appears that a slight problem arose from the original surgery and that somehow we may have nicked Jessica's bowel, causing the contents to contaminate her belly. As you recall from our discussion prior to her appendectomy, this is one of the common surgical risks, and we're so sorry that it happened. Dr. Berry and I will go back over the original surgery to determine exactly when and how this might have happened, and we'll tell you what our conclusion is. In the meantime, we are taking good care of her, and we'll keep you informed of her progress every step of the way. Her recovery will take longer than we initially discussed, but please let us know if we can answer your questions, or assist you as Jessica recovers."*

- ✓ If you will be involved in lengthy discussions about sensitive issues with the patient or family, respect the patient's cultural frame of reference, ability or disability, cognitive skill level, education, language, religion, or any other factor that may influence how you communicate. (See *References* below)
- ✓ If an investigation will be forthcoming, determine what will be done and by whom (policyholder, hospital, internal review committee, MIEC, other professional liability carrier), and what will be done with the investigative results. If the patient or patient's family is to be informed of the findings, determine who will be responsible for conveying the information, and whether it will include details about accountability, personal responsibility, and/or resultant policy changes.
- ✓ DO NOT change anything in the patient's chart. If you believe that something is in error or requires an amendment, call MIEC to discuss how to proceed.
- ✓ Avoid casually placing blame and finding fault. (These actions are distinctly separate from assigning or taking personal responsibility when it is appropriate to do so.)
- ✓ Focus on the patient's experience, which may prevent the conversation from becoming adversarial and help you avoid the possibility you will become defensive.
- ✓ Do not discuss offering assistance or compensation with anyone without first consulting and obtaining the approval of MIEC's Claims Representative. If you have questions about such matters, ask the Claims Representative what should be offered to the patients and/or family, if anything, and if so, of what nature and how much.
- ✓ Document accurately, specifically and objectively all discussions you have with the patient and/or the patient's family about the subject event, including what you said and the patient's response, and contributions by others present—in the patient's chart. DO NOT document privileged discussions with the Claims Representative or your defense attorney, if you have one, in the patient's chart.
- ✓ If it is possible, recommend, organize or participate in a program designed to provide emotional support to physicians who have had to admit to a patient or patient's family an error that caused a patient injury. Although the process of making an apology to a patient is frequently a healing experience for patient and physician alike, it is not without consequence to either. Many physicians, following closure with the patient or patient's family, benefit from a "debriefing" process in which they experience closure with

their internal critic as well. Prior to establishing such a group, consult the Claims or Loss Prevention Departments, local or state medical society, or defense attorney to ensure that the group does not discuss discoverable events, but focuses on the emotional impact of having experienced a sensitive patient interaction that involved saying "I'm sorry."

SUGGESTION: *Train yourself and your staff on the arts of clear communication and thorough documentation by ordering and reviewing MIEC's do-it-yourself loss prevention survey on CD ROM. Or, request an on-site loss prevention survey tailored to your practice and staff. MIEC's loss prevention CD, literature, and surveys are offered free of charge to MIEC's policyholders.*

Part of your premium dollars goes towards having MIEC's Claims, Underwriting, and Loss Prevention Departments' experts available to answer your questions and provide advice when you are faced with uncomfortable and challenging liability-related issues in your practice of medicine. MIEC's policyholders own MIEC. We're here to help you. Call us.

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