Chapter 11

Embracing Poor Outcomes: A Comprehensive Claim Reduction Strategy

Kathryn Wire, Esq.

KeyCite®: Cases and other legal materials listed in KeyCite Scope can be researched through West's KeyCite service on Westlaw®. Use KeyCite to check citations for form, parallel references, prior and later history, and comprehensive citator information, including citations to other decisions and secondary materials.

§ 11:1 Introduction[1]

During the afternoon and evening of February 7, 2003, Dr. James Jaggers transplanted a new heart and lungs into Jesica Santillan at Duke University Hospital. Within an hour, her organs were failing, and he learned from the laboratory that the transplanted organs would probably kill her. After stabilizing her condition as much as possible, he told her family that her new organs came from a donor with an incompatible blood

[Section 11:1]

[1]Ms. Wire appreciates the support of Sisters of Mercy Health System, which provided research facilities required to prepare this chapter.

@MAGNETO/NEPTUNE/AUTOMATE01/V__JUR/HLHB/CH11 SESS: 1 COMP: 07/06/04 PG. POS: 27

type. Despite heroic efforts, including a second transplantation weeks later, Jesica died on February 22, 2003.[2]

In early 2001, toddler Josie King died at Johns Hopkins University's medical center while undergoing treatment for an accidental burn. Over several weeks, her healthcare providers allowed her to dehydrate, and then medicated her with narcotics after a physician ordered that they be stopped. Days later, when caregivers and family knew she would not recover vital function, her family disconnected her life support.[3]

While the legal outcome of the Santillan situation remains unknown, the facts of her situation spread quickly across the national news, and her providers openly discussed the factors leading to her disastrous outcome, leading to changes at Duke and surely in other institutions. Josie King's family initiated an effort in her name to identify and solve the problems that led to her death, and Hopkins' resources devoted to the process have funded an extensive patient safety program. Mrs. King has become an extraordinarily powerful spokesperson for changes in the healthcare process that took her daughter's life.[4] Disclosure of these outcomes and discussion of their causes with the families involved and to the medical establishment have engendered learning which will benefit countless other patients. The families know that their loss will at least lead to prevention of other similar tragedies. What would they feel if instead they had no information about facts leading to the deaths or steps taken to correct the underlying problems?

Attorneys representing healthcare institutions have

---

[2]http://dukemednews.org/news (accessed Oct. 29, 2003).

[3]http://www.josieking.org.

[4]The Josie King website, at http://www.josieking.org, links to a transcript and partial videotape of Mrs. King's October 11, 2002 speech to the Institute for Healthcare Improvement. Anyone who doubts the power of families to impact patient care, or the healing value of such efforts, should view it.

@MAGNETO/NEPTUNE/AUTOMATE01/V__JUR/HLHB/CH11 SESS: 1 COMP: 07/06/04 PG. POS: 28

long juggled potentially conflicting concerns when this sort of gut-wrenching event affects their client. First, a facility must maintain regulatory and/or accreditation compliance. Second, many healthcare professional societies have demanding ethical and moral mandates regarding disclosure of errors. The third concern arises from the statutory and common law protections for privileged investigations, as much peer review and quality improvement information is legally protected from disclosure. Last, and the primary focus of this article, all attorneys strive to protect their clients from unnecessary liability exposure. Newly enacted and proposed laws mandate reporting for adverse outcomes and errors, and yet the aggregation and threatened publication of that information in today's liability climate could create an enormous risk of punitive damage claims based on the facility's "past knowledge" of problems. The reporting requirements for skilled nursing facilities have magnified their liability and the potential conflict between liability defense and regulatory compliance for those providers.[5]

The healthcare community focuses on protecting the confidentiality of reported information and performance improvement processes. While this article does not argue for removal of those protections, perhaps we are betting on the wrong horse. Could the healthcare community better protect itself by incorporating the injured patients and their families into the process? Unfortunately, many attorneys representing healthcare clients have discouraged the open and collaborative conversations that were probably our best tool to reduce the "litigation reflex." Attorneys, so busy worrying about how to defend the suit, forget that a patient has to actively decide to sue in the first place, and they fail to engage the true factors leading to that decision.

In reality, the inconsistency among these interests is much smaller than most lawyers have feared. Within

[5]Marshall B. Kapp, "Resident Safety and Medical Errors in Nursing Homes," 24 J. Leg. Med. 51 (2003).

@MAGNETO/NEPTUNE/AUTOMATE01/V__JUR/HLHB/CH11 SESS: 1 COMP: 07/06/04 PG. POS: 29

the last three years, accepted, peer-reviewed scientific research has clearly established that many of our efforts to avoid litigation have certainly not helped, and may have actually created a climate of distrust which contributes to our patients' litigious responses. In the absence of any countervailing regulatory interest many adverse outcomes were ignored, if not actively buried. As a result, patients and their attorneys alike often perceive that their healthcare providers will not honestly discuss their care and its outcomes. It is entirely possible that this perception causes more litigation than the actual negligent care.

Largely as a result of the perceived conspiracy of silence (and the newfound industry interest in a blameless culture) the JCAHO has determined that all unanticipated outcomes must be disclosed to patients and, if appropriate, their families. This chapter will examine the varied legal considerations surrounding the broad issue of the disclosure of outcomes and their causes from both liability and regulatory/compliance viewpoints.

§ 11:2 Types of adverse outcomes

Four situations can possibly lead to a worrisome outcome. First, there can be a clear error in judgment, technique or oversight. Second, a healthcare system can fail because of its design. Third, communication can fail. Most patients and families would consider all of these events as "errors" justifying apologies and possibly compensation. Traditionally, plaintiff attorneys would only focus on the first category, individual error. More recently, they have used "system errors" as a hook to create institutional liability for hospitals, which usually carry higher insurance limits than individual providers. The fourth category of event arises from biological variation or an unusual but unpreventable consequence of therapy or the patient's disease. This would include idiosyncratic responses to medication, such as Stephens-Johnson syndrome, in which the

@MAGNETO/NEPTUNE/AUTOMATE01/V__JUR/HLHB/CH11 SESS: 1 COMP: 07/06/04 PG. POS: 30

patient sloughs their skin as a very rare and unpredictable side effect of certain medications. It would also include the patient who simply does not respond to treatment, or develops an infection in spite of appropriate infection control processes. These events, though disappointing, do not represent medical "mistakes." They represent a gray area most challenging for those trying to avoid liability, an area that presents the greatest potential for those managing liability losses by preserving the relationship between healthcare providers and the patient.

§ 11:3 Joint Commission concepts

Unanticipated outcome. While this phrase seems fairly clear on its face, one should know the context in which it has gained such fame. The Joint Commission for Accreditation of Healthcare Providers ("JCAHO") enacted the following standard effective in 2001:

> RI.1.2.2 Patients and, when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes.
>
> Intent of RI.1.2.2
>
> The responsible licensed independent practitioner or his or her designee clearly explains the outcome of any treatments or procedures to the patient and, when appropriate, the family, *whenever those outcomes differ significantly from the anticipated outcome.*[1]

There could be better-than-expected unanticipated outcomes (which we would normally divulge anyway because of human nature), or only slightly bad ones, which are not of great concern to the JCAHO. The situations that clearly invoke this standard are the sort of striking errors experienced in the King and Santillan cases.

[Section 11:3]

[1]Comprehensive Accreditation Manual for Hospitals: The Official Handbook, Joint Commission for the Accreditation of Healthcare Organizations, at RI-10 (2002). (RI refers to the section on Patient Rights, Ethics and Institutional Responsibility.) (emphasis added).

Sentinel Event. This definition, also generated by the JCAHO, is significant because a sentinel event requires follow-up performance of a root cause analysis:[2]

> A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.[3]

A couple of interesting points jump out. First, nothing necessarily ties unanticipated outcomes to sentinel events. Second, neither necessarily involves an error. Though rules regarding both sentinel event and outcome disclosure may apply in the same situation, they are entirely different. While sentinel events are unanticipated (they are by definition "unexpected"), an unanticipated outcome need not result from a sentinel event, largely because the definition of sentinel event

---

[2]Comprehensive Accreditation Manual for Hospitals: The Official Handbook (JCAHO, 2002). The following standards are contained in the leadership section:

> LD.4.3.1 Leaders ensure that the processes for identifying and managing sentinel events are defined and implemented.
>
> Intent of LD.4.3.1 When a sentinel event occurs in a healthcare organization, it is necessary that appropriate individuals within the organization be aware of the event, investigate, understand the causes that underlie the event, and make changes in the organization's systems and processes to reduce the probability of such an event in the future. The leaders are responsible for establishing processes for the identification, reporting, analysis, and prevention of sentinel events and for ensuring the consistent and effective implementation of a mechanism to accomplish these activities.

[3]The website of the JCAHO contains useful material on sentinel events, including historical background and definitions, as well as a discussion of the related standards, http://www.jcaho.com/accredited+organizations/hospitals/sentinel+events/se_pp.htm. This article will consciously ignore the uproar over the reporting requirements initially incorporated into the sentinel event standard, as they are consciously ignored by most providers.

@MAGNETO/NEPTUNE/AUTOMATE01/V_JUR/HLHB/CH11 SESS: 1 COMP: 07/06/04 PG. POS: 32

includes near misses. Either can happen without legal negligence. The "unexpected" language in the sentinel event definition indicates that a known risk that comes to pass will not technically constitute a sentinel (*e.g.,* an idiopathic unfavorable reaction to medication), but will clearly qualify as an unanticipated outcome if not discussed in advance with the patient.

The party "surprised" by an event represents one of the primary differences between an unanticipated outcome and a sentinel event. The JCAHO doesn't look to the patient's expectation for defining sentinel events; they are unanticipated to the *providers*, while unanticipated outcomes are most likely defined as unexpected from the *patient's* viewpoint, though it is still an evolving concept.

Root Cause Analysis. The JCAHO requires this process after identification of a sentinel event. Root cause analysis is a brutally invasive process when done properly, almost never accepting stupid human error as the reason for a sentinel event. The concept recognizes, as good risk managers know, that almost all gut-wrenching errors require a convergence of at least two bad decisions and bad luck. Some of the information uncovered in a root cause analysis will have to be disclosed to the patient if an unanticipated outcome discussion is required, but not all of it need be shared.

Clinical examples. Some examples may help clarify these concepts. During oral surgery, a patient's lower jaw is to be broken intentionally into pieces. As sometimes occurs, the patient has a "bad split," resulting in a fracture into more pieces than anticipated, which must be reconstructed. This is not a sentinel event; it is a known complication of the procedure. No root cause analysis is required. In fact, if the occurrence is not disclosed to the patient, she may never know it happened. It will be an unanticipated outcome if the patient did not know to expect it. The same logic applies to greater-than-expected blood loss, unusual anatomy altering a surgical plan or a patient's allergic reaction to a medication. While none of these events

necessarily involves negligence, any one of them could generate either an unanticipated outcome or negligence exposure, depending on the circumstances. None is likely to constitute a sentinel event.

The events described in the introduction to this article illustrate the other end of the spectrum: outcomes which involve clear error and, in all likelihood, negligence. They are unanticipated outcomes and they are sentinel events.

Application of JCAHO concepts. "Patients are informed about the outcomes of care." It seems simple. This standard does NOT:

- Require providers to have a policy, though that is a good idea;
- Mandate a particular disclosure process;
- Require any particular timing for the discussion;
- Necessarily apply to medical *errors*. This standard does not say anything about medical *errors*. It does not apply to errors without adverse outcomes (near misses).

Its very vagueness however, creates a need for some formalized guidance within each facility. The JCAHO surveyors will question hospital leadership about their plan for unanticipated outcomes, and they may follow up with employee questions in the clinical areas. In surveys during 2003, leadership was questioned about the process.[4] Leaders were expected to know how the facility would respond to an unanticipated outcome, and how that process would interface with a sentinel event and root cause analysis, if those requirements applied. Administrators will probably find it helpful to have a policy they can point to as their answer. Since

[4]These events occurred during the system-wide survey of facilities in the Sisters of Mercy Health System, completed before the 2003-2004 redesign of the JCAHO survey process. Though the standard remains in place, the JCAHO's process for assessing compliance is still under development and will differ from Mercy's experience.

@MAGNETO/NEPTUNE/AUTOMATE01/V__JUR/HLHB/CH11 SESS: 1 COMP: 07/06/04 PG. POS: 34

few people are able to think clearly after such a tragic event, a policy will also provide a template for action in the immediate aftermath.

§ 11:4 Long-term care issues[1]

The federal government and many states increasingly require long-term care facilities to report potential adverse events, among other things, as part of the Resident Assessment Instrument, which is part of the Minimum Data Set.[2] While these regulations require facility staff to identify and report potential events, the failure to protect either the information so gathered or the resulting quality-improvement activities has created a very challenging environment for operators. If previous events have been reported, the defendant is arguably liable for extraordinary or exemplary damages for its failure to correct a known problem.

Nursing homes suffer from two other confounding factors: heightened sensitivity among the public to their liability and the fragile condition of most residents. This means events that might not warrant a full disclosure process in the hospital should be addressed with a more extensive disclosure in the long-term care setting. For example, many residents may react poorly or in unexpected ways to the administration of medications, particularly in combinations. While healthcare providers may administer those medications in reasonable amounts and to treat conditions the drugs are designed to address, the frail and elderly may have sig-

---

[Section 11:4]

[1]The primary discussion in this article of applicable regulatory provisions is focused on hospitals. The claim and litigation management concepts apply equally to all heathcare providers, however.

[2]Marshall B. Kapp, "Resident Safety and Medical Errors in Nursing Homes," 24 J. Leg. Med. 51, 59 (2003); Centers for Medicare and Medicaid Services, State Operations Manual, Appendix Resident Assessment Instrument for Long-Term Care Facilities, at http://cms.hhs.gov/manuals/pub07pdf/AP-Q-R.pdf (accessed Nov. 30, 2003).

@MAGNETO/NEPTUNE/AUTOMATE01/V__JUR/HLHB/CH11 SESS: 1 COMP: 07/06/04 PG. POS: 35

nificant undesirable physical responses such as depression or apparent dementia, or loss of balance. When those physical responses lead to injury, both the injury and the primary cause need to be part of the disclosure.

Patients taking no artificial nutrition by choice may develop physical complications, and they present special challenges. The nutritional issue needs to be addressed directly and openly. While force-feeding or tube-feeding may not be appropriate, the patient will suffer the natural and inevitable effects of that choice. Many claims involving the elderly result from inevitable physical deterioration and very reasonable decisions to avoid aggressive medical management. Efforts to educate their families about the expected course can both relieve guilt and avoid later claims. A surrogate should be advised promptly of all falls, including an assessment of any possible prevention factors, such as adjusting medications or the impact of underlying illness. Any implication that the facility is trying to conceal such outcomes or their causes could be disastrous in court.

Family members often display the most hostility to any health care provider when they feel guilty about their own absence at key times for their loved one. Risk managers will confirm that the most difficult family members are often the ones who arrive from out of town at the last minute. This emotional component has even more significance in a long-term care setting, in which family members often feel extraordinary responsibility for placing their elderly or disabled loved one in a nursing home in the first place. Their remorse becomes more intense after an injury. Rather than deal with the emotion directly, they lash out, alleging negligence. Much of this reaction can be neutralized by helping the family understand that the patient has physical conditions that will affect daily living and safety in ANY environment.

§ 11:5 Nuts and bolts of disclosure

Who should disclose? Medical staff member participa-

@MAGNETO/NEPTUNE/AUTOMATE01/V__JUR/HLHB/CH11 SESS: 1 COMP: 07/06/04 PG. POS: 36

tion is essential; the JCAHO standard contemplates that the primary physician will almost always be involved in the disclosure process. The physicians may be very reluctant to participate, but they do not really have a choice. Their participation in the disclosure process will also mitigate their personal liability exposure, as discussed in more detail below. Additionally, if the physician and carrier can resolve the issue before there is a written demand for compensation, the matter need not be reported to the National Practitioner Databank.[1]

Healthcare facilities and medical societies need to develop resources to educate and support the physician-disclosers. Some facilities have found that seminars for the medical staff including representatives of their dominant insurance carriers and the attorneys who often represent them helped overcome objections.[2] The involved professional liability carriers hopefully understand that disclosure is always the better idea, and will encourage and support the concept.[3] A number of professional societies, as well as the National Patient Safety Foundation[4] have videos available on the subject to help train the physicians and make them more comfortable

[Section 11:5]

[1]National Practitioner Databank Guidebook, at http://www.npdb-hipdb.com/npdb.html (accessed Nov. 30, 2003).

[2]Such seminars at several Sisters of Mercy Health System hospitals helped to dispel physician anxieties and also generate discussion between physicians and their carriers before a need to disclose arose.

[3]COPIC, a Colorado physician-owned carrier, has a special program to promote early disclosure and apologies. The events that qualify are handled outside the physician's official claim history, in an effort to encourage early reporting and involvement of the company's "occurrence specialists." *See* Copiscope No. 110, at http://www.copic.com.

[4]http://www.npsf.org.

@MAGNETO/NEPTUNE/AUTOMATE01/V__JUR/HLHB/CH11 SESS: 1 COMP: 07/06/04 PG. POS: 37

with the process. Many medical publications are also addressing the issue.[5]

Much of the physicians' concern arises from significant lack of experience in this area. Education, role-playing and emotional support can be essential. Before physicians can talk to a patient or family about a disturbing outcome, they need to address their own feelings and needs, as well.[6] Many practitioners will not take time before such a discussion to formulate their thoughts and practice what they are going to say, techniques which are often helpful. How many attorneys would deliver a difficult closing argument without practice? The potential downside of a poor performance for the physician with an unanticipated outcome is the same as for the trial attorney. One physician insurance carrier that supports early disclosure and apology advises its member/insureds, "[J]ust as you wouldn't perform a new procedure without the proper preparation, you should not begin the disclosure process without doing your homework."[7] Practice and training are also essential for other staff members (administration or risk management) who may talk to patients with disappointing outcomes.

Facilities and attorneys representing healthcare providers involved in serious events, especially outcomes arising from errors, need to be aware of the emotional and physical needs of those providers. Often, we are so busy complying with regulations and avoiding liability, we neglect them.

Relationship to informed consent. The informed consent process plays an interesting role in the disclosure analysis. Some of the examples above (the bad jaw split, the blood loss) were known possible complications.

---

[5]"Honesty is the Best Policy When Discussing Medical Errors," amednews.com Ethics Forum (Nov. 4, 2002); Mark Crane, "What to Say if You Made a Mistake," 16 Med. Economics 26 (2001).

[6]Lee Taft, "Apology Subverted: The Commodification of Apology," 109 Yale L. J. 1135, 1140 (2000).

[7]Copiscope No. 110 (Nov. 2002), at http://www.copic.com.

If the possibility of such a complication is disclosed to the patient, is the outcome then unanticipated? While one could argue it is not, it is probably better to treat those outcomes as unanticipated and proceed with disclosure because the physician and patient did not commence treatment with that outcome in mind.

If one must discuss the rare but known potential outcome after it occurs, why discuss it before treatment as well? The unanticipated outcome discussion will be much easier if the patient has been educated about how such a thing might happen. And a risk management note: liability exposure as well as the likelihood of an attorney pursuing a claim at all will shrink dramatically if that informed consent discussion has been documented somewhere. The post-event discussion will be the most critical for efforts to prevent attorney involvement in the first place. Patients frequently seek out an attorney to get answers to questions they have not been able to discuss with their providers.[8]

What if the foreseen complication occurs, but there is no visible effect for the patient? Should it still be disclosed? In the bad split example above, the patient did not learn of the actual event, though she had been advised pre-operatively that it could occur. Years later, another surgeon, who happened to be in very heated litigation with the operating surgeon, looked at her x-rays and declared, "What has he done to you?!?!?!?" The ensuing suit would have been much easier to defend (and undoubtedly would not have alleged fraudulent concealment) had she known of the event when it occurred. Even more important, the bad split and treatment related to it is an unanticipated outcome, though not a visible one. It has implications for the patient's long-term situation. Ethically and under JCAHO rules, it needs to be disclosed.

In another example, a patient who receives more

[8]Gerald B. Hickson, et al., "Development of an Early Identification and Response Model of Malpractice Prevention," 60 L. & Contemp. Problems 7 (1997).

@MAGNETO/NEPTUNE/AUTOMATE01/V__JUR/HLHB/CH11 SESS: 1 COMP: 07/06/04 PG. POS: 39

blood than anticipated, requiring donor units in addition to their own collected autologous units, may not have any immediate consequences, but now has an increased potential for antibodies which would make future transfusions more problematic. The patient has thus suffered an unanticipated outcome that will affect future medical care, though perhaps not immediately. This must be disclosed, both under JCAHO standards, and because good medical practice requires education of the patient about a new medical status.

Setting appropriate expectations. Though not technically informed consent, much relationship-based liability control takes place before the patient begins a particular course of treatment. Most patients and their families understand the limitations of healthcare systems IF they have been exposed to them before a bad event occurs. If the attending surgeon will not come in every day over the weekend, explain that and identify who will be covering. If a patient care team in the hospital includes an RN, an LPN and a patient care assistant, patients and their families should be aware of each of those individuals and that each plays an important role in delivering care. Patients and families must understand that in most cases, a hospital or nursing home simply cannot provide around-the-clock monitoring of a patient. If a patient undergoing emergency surgery is diabetic, malnourished and a smoker, the physician should discuss the risk of post-operative infection and healing problems in detail before complications occur, and why the patient's risk factors are exceptional. These discussions accomplish two things. First, they clarify that healthcare has its limits, identifying specific issues for the patient involved, and giving the patient and family a chance to take any special measures necessary under the circumstances (*e.g.,* 24-hour accompaniment or postponing surgery if possible to improve the risk factors). Second, the post-event discussion of underlying causes for the outcome is much easier when the patient and family already know the limits of care provided.

14

Persons involved in disclosure discussion. Should the family members be included in the discussion? Generally, if the patient consents, family involvement saves translation and the associated risk of misunderstanding. Often, the family members become more agitated than the patient about an adverse event. Hearing the explanation initially and having an opportunity to ask questions at the time may curtail their reaction. They will also be able to give the patient emotional support. The final decision must rest on considerations of the relationship between the patient and his/her family as it relates to the patient's well-being. Any disclosure to family requires the consent of the patient or an appropriate surrogate pursuant to local law. The JCAHO suggests including the family if possible. If the patient is unable to participate, then the patient's surrogate should be involved and steps into the patient's shoes.

Who should communicate? Generally, the JCAHO unanticipated outcome standard presumes that the attending physician will communicate the outcome to the patient. Practical considerations also support that expectation. The physician is best poised to discuss the medical implications. However, if there is a serious adverse outcome, others must support the physician in this regard. A hospital representative should accompany the physician if the underlying event substantially involved hospital staff or policies.

Very serious events or events involving presumed physician error may best be handled by a different physician or hospital staff. Research has established that patients prefer to hear about problems from their own physician *unless* there is a serious adverse event. In that case, they prefer to hear from someone else because they will have lost trust in their own physician. Hospitals should also consider a surrogate "discloser" if the patient's physician is a poor communicator. Some doctors just have a hard time communicating due to personality or language issues, and for them, a second person to accompany them and "relate" may help. A

@MAGNETO/NEPTUNE/AUTOMATE01/V__JUR/HLHB/CH11 SESS: 1 COMP: 07/06/04 PG. POS: 41

policy should establish a regular team of hospital staff available to help identify those instances, as well as a good candidate or class of candidates to assist with the disclosure.

A representative of the hospital's ethics committee should have a role in the disclosure process. This establishes a convenient ethical resource for the physician who must communicate to the patient, and also makes sure that the ethics committee will be aware of events as they occur. Pastoral care representatives are often helpful, as well. Both patients and caregivers often need pastoral care support after a bad outcome.

The situation can change in a long-term care facility, where physician involvement is often quite limited.[9] The patient's attending physician may have little or no knowledge of circumstances surrounding the event.[10] While the physician's presence may be helpful to talk about the medical implications and future care for the patient, he or she cannot realistically address the factual issues surrounding an adverse outcome or error. For medical directors covering a number of facilities with hundreds of patients, physician availability for a timely disclosure may be problematic, especially if the discussion has to be scheduled with family members who do not typically visit the patient daily. A knowledgeable and accountable person, preferably a clinical manager, may be the best choice to disclose the factual background and discuss system issues and changes, and have the physician involved in a separate discussion of medical care issues.

Documentation of disclosure. "Communication" also includes documentation of the disclosure process in the medical record. Recordkeepers should be trained to only chart facts and to chart only patient-related items (*not* preparation of an incident report or a meeting of a

---

[9]Marshall B. Kapp, "Resident Safety and Medical Errors in Nursing Homes," 24 J. Leg. Med. 51, 57 (2003).

[10]Marshall B. Kapp, "Resident Safety and Medical Errors in Nursing Homes," 24 J. Leg. Med. 51, 57 (2003).

@MAGNETO/NEPTUNE/AUTOMATE01/V__JUR/HLHB/CH11 SESS: 1 COMP: 07/06/04 PG. POS: 42

disclosure or root cause investigation committee). The facility should develop support for the "discloser" to make sure that the documentation process is carefully planned. The providers will undoubtedly be living with that documentation for a long time.

When to disclose. Patients should learn of an adverse outcome as soon as possible. However, the most extensive investigation usually follows an initial disclosure, so the patient then needs to be advised of both investigative findings and clinical implications of the event when that information becomes available. The American Society for Healthcare Risk Management ("ASHRM") recommends a patient care conference once the providers can answer questions knowledgeably, to make multiple specialties and hospital resources available to the discussion.[11] This could be a very powerful tool, but members of the group should be selected with care and all should participate in advance discussions of the material to be disclosed. No one should ever answer questions "off the cuff."

What to communicate? The substance of any unanticipated outcome discussion must be tailored to the individual clinical facts. However, there are common requirements. First, only the facts should be discussed, with no speculation or guesswork as to cause. If the patient got the wrong medicine, that is a fact. If the medicine was sent correctly from the pharmacy, put in his roommate's medicine storage area and administered to him by the nurse, those are facts, assuming that investigation has established their truth. "The nurse was lazy and didn't look at the name on the dose," is not a fact. Do not assign blame. Disclosers should never guess. They should promise the patient that further information will follow as soon as it is available. The

[11]American Society for Healthcare Risk Management, "Disclosure of Unanticipated Events: The Next Step in Better Communication" (May 2003) and "Disclosure of Unanticipated Events: Creating an Effective Patient Policy" (Nov. 2003), at http://www.ASHRM.org.

@MAGNETO/NEPTUNE/AUTOMATE01/V__JUR/HLHB/CH11 SESS: 1 COMP: 07/06/04 PG. POS: 43

disclosure must include factual information about identified care problems. If the wrong medication was placed on the shelf on the nursing unit, then we need to let the patient know that. If the nurse injected air into an arterial line, the patient needs to be told that fact AS SOON AS IT IS CONFIRMED BY INVESTIGATION, NOT SPECULATION. Clear error should not be disclosed until all affected parties are aware of the findings and have a chance to respond knowledgeably.

Good arguments go both ways as to whether the patient should be told the names of involved staff. Healthcare providers also have an obligation to protect our staff from harassment or inappropriate behavior, and many of these discussions take place while the patient is still in the hospital. There is also a difference of opinion as to whether specific action taken against the staff is a fair topic for disclosure. Generally, the patient should at least be advised that steps have been taken regarding an individual staff member, if that is true, even if not disclosing names or other specifics. If the family was present or involved in the occurrence, there is no point in irritating them by withholding information they know anyway. If you withhold names, tell the patient this is due to a policy on that issue, and be open about other issues. Patients and families often want someone's hide. They do not like to hear that the hospital or physician examined all the relevant processes and made appropriate changes, but no one got fired. However, this blame-free "system" approach to patient safety forms the core of newer programs. This conflict between the new healthcare culture and societal expectations is an ongoing problem, but we must deal with it openly in disclosures.

The discussion must include all available information about the clinical implications for the patient, both short-term and long-term. If the hospital and physician have determined that liability exposure exists and that they will absorb the charges, then the discussion should include that fact. As knowledge of the patient's medical response to the event develops, it needs to be shared.

@MAGNETO/NEPTUNE/AUTOMATE01/V__JUR/HLHB/CH11 SESS: 1 COMP: 07/06/04 PG. POS: 44

The discussion facilitator should not answer questions such as, "Was the hospital negligent?" Generally, they can indicate that negligence is a legal concept. If the patient asks for compensation, then a separate dialog can begin with appropriate risk management, insurance or legal representatives. Generally, this is the best time to address compensation issues, so immediate follow-up on that question is essential. The clinical discussion with the patient and the physician must remain open until all available and appropriate information has been shared, whether or not the patient has asserted a claim for compensation. The JCAHO standard does NOT say "the patient shall be informed unless they have threatened litigation." If the physician is the target of a claim, he/she should discuss the situation with an attorney; a substitute representative may take over the disclosure function if the relationship deteriorates to the point that is necessary. However, the physician should have at least an initial discussion with the patient to express his or her feelings to the patient.

Protecting confidential information. Careful attorneys and risk managers remain exceptionally concerned about disclosures when there are three ongoing investigations, each with different levels of protection from discovery: (1) the risk management/defense investigation; (2) sentinel event/quality analysis; and (3) the investigation for outcome disclosure, which the providers will disclose to the patient. In order to protect quality and peer review information, the pathways each process follows must remain separate, though perhaps occasionally intertwining. While there may be common facts in each, and those FACTS will be disclosed to the patient as needed for appropriate disclosure, the processes and eventual products are very different. Investigative procedures must be carefully designed based on state law to remain separate and protect the confidentiality/privilege for unique information in the defense (attorney work product, attorney-client privilege) and quality improvement investigations. For

@MAGNETO/NEPTUNE/AUTOMATE01/V__JUR/HLHB/CH11 SESS: 1 COMP: 07/06/04 PG. POS: 45

example, the risk management file should not contain the peer review report or root cause committee documents, and the risk manager's report to in-house counsel should not be shared with quality. A defense attorney may need to see a peer review document to determine if it can be discovered, but should not routinely receive them as part of defending an ensuing lawsuit. Accordingly, the various parties must maintain separate files (which may contain some overlapping material), preferably with different individuals in charge of each. Such separation may not be possible in smaller facilities, but the "overlapped" staff needs to be aware at all times of their particular role at any given time. Committees may share members, which would enable those "two-hatted" individuals to share a subset of one group's facts with another group as appropriate. The information shared among the functional groups should be strictly factual. ASHRM's *Perspective on Disclosure of Unanticipated Outcome Information* contains a good discussion of this issue, as do its more recent monographs.[12]

§ 11:6 Liability concerns—Are we giving up the farm?

Shortsighted defense lawyers talk about ways to avoid disclosing any incriminating information to patients. Experienced risk managers know they face NO WORSE defense scenario than a patient learning about relevant adverse facts in discovery, rather than from their own healthcare providers. Before JCAHO enacted its unanticipated outcome standard, hospitals often let the patient's physician make the ultimate determination as to whether the patient would be told of an unanticipated outcome. Now, they don't have that discretion. This change to transparency, if handled

[12]American Society for Healthcare Risk Management, "ASHRM Perspective on Disclosure of Unanticipated Outcome Information" (April 2001), at http://www.ASHRM.org.

properly, should reduce total malpractice outlays and improve the equity of malpractice distributions.

Ethical issues (a standard of care?): There has never been any doubt in the ethical arena whether healthcare providers should disclose facts to their patients. The American Medical Association's Code of Medical Ethics[1] states:

> It is a fundamental ethical requirement that a physician should at all times deal honestly and openly with patients. Patients have a right to know their past and present medical status and to be free of any mistaken beliefs concerning their conditions. Situations occasionally occur in which a patient suffers significant medical complications that may have resulted from the physician's mistake or judgment. In these situations, the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred. Only through full disclosure is a patient able to make informed decisions regarding future medical care.
>
> Ethical responsibility includes informing patients of changes in their diagnoses resulting from retrospective review of test results or any other information. This obligation holds even though the patient's medical treatment or therapeutic options may not be altered by the new information.
>
> Concern regarding legal liability which may result following truthful disclosure should not affect the physician's honesty with the patient.

And the American College of Physicians-American Society of Internal Medicine's Ethics Manual[2] is even more specific:

> [p]hysicians should disclose to patients information about procedural or judgment errors made in the

[Section 11:6]

[1]American Medical Association, Ethical Opinion E-8.12, available on the AMA website at http://www.ama-assn.org/ama/pub/category/8497.html.

[2]128 Annals of Internal Med. 546 (April 1, 1998), at http://www.annals.org/cgi/content/full/128/7/576 (accessed Nov. 30, 2003).

@MAGNETO/NEPTUNE/AUTOMATE01/V__JUR/HLHB/CH11 SESS: 1 COMP: 07/06/04 PG. POS: 47

> course of care if such information is material to the patient's well-being.

The British General Medical Council's guideline "Good Medical Practice" even goes so far as to require "after an adverse event a full and honest explanation and an apology."[3]

Can disclosure and early intervention be WORSE than litigation? Anyone who reads or watches TV news knows that the jury system has not been kind to the medical profession. The linchpin of medical negligence theory, a knowable standard of care in the profession, often doesn't exist, as experts in lawsuits often testify under oath to multiple standards. And juries simply do not interpret the scientific standard the same way physicians do. Research has shown that uninvolved physicians disagree with juries in up to 40% of cases, in cases involving both plaintiff and defense verdicts:

> Perhaps more alarming, neutral physicians reviewing malpractice case scenarios from a clinical perspective disagree substantively with the results of actual jury verdicts. Although it might be thought that such findings result from physicians' acting to protect their colleagues, the physicians within these studies disagreed with case verdicts both for and against the defendant physician. *Such disagreement puts the assumption of an appropriately applied, professional standard of care by the medical liability system into question*.[4]

Even more frightening, studies identifying the eventual recipients of money fed into the malpractice system indicate that more than half goes to the attorneys,

---

[3]General Medical Council. Good medical practice (London: GMC, 1998).

[4]Bryan A. Liang, "The Adverse Event of Unaddressed Medical Error: Identifying and Filling the Holes in the Health-care and Legal Systems," 29 J. L. Med. & Ethics 346, 349 (2001) (emphasis added).

@MAGNETO/NEPTUNE/AUTOMATE01/V__JUR/HLHB/CH11 SESS: 1 COMP: 07/06/04 PG. POS: 48

experts and others supporting the litigation system.[5] The tort system clearly doesn't compensate those wronged by provider errors appropriately, even if the injured were the ones suing. Awards vary widely for the same injuries.[6] And many of the injured never sue.[7] One study found that a patient injured by error has a 4% chance of recovering in the tort system.[8] And much is awarded to individuals who have NOT been harmed by medical error. The Harvard Medical Practice Study found that one-sixth of claims filed involved negligence and an injury.[9] And while tort reform may skew those statistics a bit more toward actual compensation, it will not substantially change the mix of plaintiffs, nor will it eliminate most of the defense costs unless the inappropriate cases are screened out. Most state efforts to impose screening panels as a hurdle to malpractice litigation failed because they couldn't satisfy constitutional guarantees of access to the courts.[10] This raises the question: is there a better way to control what cases reach the courtroom? Can the parties themselves do it better?

---

[5]Tillinghast-Towers Perrin, "U.S. Tort Costs: 2002 Update, Trends and Findings on the Costs of the U.S. Tort System," as cited in Council of Economic Advisors, "Who Pays for Tort Liability Claims? An Economic Analysis of the U.S. Tort Liability System" (April 2002), at http://www.whitehouse.gov/cea/tortliabilitysystem_apr02.pdf.

[6]Jeffrey O'Connell and Andrew S. Boutros, "Treating Medical Malpractice Under a Variant of the Business Judgment Rule," 77 Notre Dame L. Rev. 373, 377 (2002).

[7]Troyen A. Brennan and Michelle M. Mellow, "Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform," 80 Tex. L. Rev. 1595, 1599-1600 (2002).

[8]Troyen A. Brennan and Michelle M. Mellow, "Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform," 80 Tex. L. Rev. 1595, 1618 (2002).

[9]Troyen A. Brennan and Michelle M. Mellow, "Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform," 80 Tex. L. Rev. 1595, 1619 (2002).

[10]See State ex rel. Cardinal Glennon Memorial Hospital for Children v. Gaertner, 583 S.W.2d 107, 110 (Mo. 1979).

@MAGNETO/NEPTUNE/AUTOMATE01/V_JUR/HLHB/CH11 SESS: 1 COMP: 07/06/04 PG. POS: 49

In calculating the costs of our current system, any analysis must include not only a simple count of indemnity payments, but also the percentage of those which go to the plaintiff attorneys, the defense attorney fees, the adjusting fees and the indirect cost to the providers of spending time defending a suit. The direct costs (attorney fees and adjustment expense) average 50% of the total outlays for professional liability. If early discussion and settlement can even match current payments *to patients and families* with a significant reduction in the administrative and legal costs, then the ultimate cost will decrease substantially, releasing resources to compensate the additional truly injured individuals who would be included under a full disclosure program. Ethical plaintiff attorneys who know a provider uses this approach will amend their standard agreements to also encourage their clients to participate in such programs and resolve their cases early.[11]

Will there be more claimants? If providers initiate disclosure discussions early, and if liability and negligence issues remain unclear at the time of the discussions, will the early intervention process result in more or inappropriate payments? Research indicates that the distribution of indemnity payments can hardly be more random or less productive than under the current system. Even expert physicians, whose judgments are used as the basis for determinations of negligence under the medical custom rule, are unreliable in identifying

[11]In my experience, a core group of plaintiff attorneys will in fact alter their behavior and encourage their clients to accept early settlement, if the offers are fair and reasonable. They benefit because they can resolve the case with much less work and expense, and their clients are happy. In small cases, they will actually recommend that the client work with the hospital independently, returning to the attorney if they don't feel they have reached a fair agreement. Some efforts to get local plaintiff trial attorney support for any early settlement arrangements would be beneficial.

@MAGNETO/NEPTUNE/AUTOMATE01/V__JUR/HLHB/CH11 SESS: 1 COMP: 07/06/04 PG. POS: 50

negligence.[12] This lack of clarity suggests that the resources currently allocated to the determination of negligence do not effectively protect providers or allocate payment to the appropriate patients.[13] Query: could those funds be better allocated to early resolution of claims that fall in the gray area in which negligence is unclear?

Brennan and Mellow suggest using market incentives (deterrence) to encourage patient safety initiatives (system improvements), not just malpractice (negligence) prevention, in part through compensating all patients with *avoidable* iatrogenic injury, even if it does not result from negligence. "[T]he concept of *avoidability* invokes the idea of error reduction through changes in *systems* of care, whereas the concept of negligence suggests that errors can be reduced by greater precaution-taking and perseverance by *individuals*."[14] Not only would such an approach arguably deter negligent behavior; it would also further encourage patient safety initiatives that reduce all adverse medical events. To the extent that providers themselves could identify this broader class of events with some certainty, and compensate the patients outside the tort system with early intervention techniques, this process would provide better compensation to those adversely affected by healthcare and encourage process improvement. Early identification of system issues would result from the early investigations, and the financial loss associated more closely with true adverse events would provide stronger and more focused incentives to improve.

---

[12]Troyen A. Brennan and Michelle M. Mellow, "Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform," 80 Tex. L. Rev. 1595, 1624 (2002).

[13]Troyen A. Brennan and Michelle M. Mellow, "Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform," 80 Tex. L. Rev. 1595, 1624 (2002).

[14]Troyen A. Brennan and Michelle M. Mellow, "Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform," 80 Tex. L. Rev. 1595, 1627 (2002).

@MAGNETO/NEPTUNE/AUTOMATE01/V__JUR/HLHB/CH11 SESS: 1 COMP: 07/06/04 PG. POS: 51

Disclosure does not increase overall risk. While scientific research on this issue is sparse, growing anecdotal evidence indicates that facilities and insurance carriers that aggressively disclose and discuss adverse outcomes do not increase their losses. COPIC, a Colorado physician insurance company, encourages its doctors to report incidents of medical injuries or complications, and then offers to pay lost wages and medical expense attributable to the injury. Under the program, which only applies if the patient does not have a lawyer, COPIC will pay up to $30,000. They do not routinely obtain a release, and the patient may go on to file a suit, if they choose. Many events that would have become claims are resolved for a much lower cost with no defense expenses.[15] The Department of Veteran's Affairs in Lexington, KY instituted a similar program that included all claims, even those championed by attorneys. The financial consequences were "moderate. . .comparable to those of similar facilities," though it routinely notifies patients of substandard care and offers help filing claims. Many plaintiff attorneys, after confirming the clinical facts offered by the facility, will negotiate at reasonable levels, forgoing the potential jackpot verdict for a fair and quick resolution.[16]

What about insurers? Physicians and even hospitals with first-dollar coverage or very low deductibles may be limited in their ability to apply early intervention, as their professional liability insurance carrier will control decision-making. They may also be afraid that reporting all patient injuries prior to the assertion of an actual claim may increase their experience rating or make it difficult to find coverage. In some cases, these concerns may be real. Providers with no self-insured or

[15]Julie Appleby, "Insurer, Hospitals Try Apologies for Errors," USA Today (March 5, 2003), at http://www.usatody.com/money/industries/health/2003-03-05-apologize__x.htm.

[16]Steve S. Kraman and Ginny Hamm, "Risk Management: Extreme Honesty May Be the Best Policy," 131 Ann. Internal Med. 963, 966 (1999).

deductible layer must be careful to notify their carriers of disclosure events to avoid any later argument that they tried to conceal it. They should also advise the carrier (in a deductible situation) of their intention to disclose and negotiate.

If a provider discloses an outcome, discusses its true causes and even apologizes, can the carrier deny coverage? No medical malpractice case addresses that issue.[17] However, other cases dealing with automobile accidents provide that public policy prohibits any requirement that the insured disguise or withhold the truth. To the extent that a disclosure and apology simply deal with factual issues and do not assume financial responsibility, insurance should remain intact.[18]

If a patient demands compensation beyond writing off bills at the time of disclosure, then the insured will have to defer that part of the conversation to be addressed by those who bear financial responsibility. ("I will be sure and brief my insurance company about the situation and ask them to contact you.") Similarly, a physician who is not employed by a hospital should not speak on behalf of the hospital regarding compensation or bill adjustment without specific authority to do so. Clinical hospital employees should also not make financial commitments without authority from appropriate risk management staff or the hospital's insurance carrier. Once the provider has undertaken a disclosure relationship with the patient, making appropriate efforts to regain their trust, deferring financial questions to others should not harm that process. However, the clinical and financial camps in that case must tell a consistent story and not directly contradict or conflict with each other on the underlying facts.

Healthcare providers and their attorneys must work

---

[17]Jonathan R. Cohen, "Advising Clients to Apologize," 72 S. Cal. L. Rev. 1009, 1027 (1999).

[18]Jonathan R. Cohen, "Advising Clients to Apologize," 72 S. Cal. L. Rev. 1009, 1027 (1999); *see also* U-Drive-It Car Co. v. Freidman, 153 So. 500, 502 (La. Ct. App., Orleans 1934).

with their carriers and potential carriers to convince them to support early disclosure and intervention. Some already have well-established programs in place to encourage early and fair resolution, such as the COPIC and Veterans Affairs programs described above. As those programs succeed, self-interest of the other more traditional carriers should lead to their adoption of these principles, recognizing the wisdom of Abraham Lincoln's admonition to attorneys: "Discourage litigation. Persuade your neighbors to compromise whenever you can. Point out to them the nominal winner is often the real loser—in fees, expenses and waste of time."[19]

The role of trust: Better relationships, fewer claims. Years of research have been directed at the relationship of trust between healthcare providers and their patients. The patient/physician relationship is intensely personal and founded on trust. We share intimate details with our physicians, and allow them incredible access to our bodies, all because we believe they will use the information so gathered to make us well. Patients also encounter healthcare providers when they are in an exceptionally vulnerable state. Studies indicate that this relationship remains important after an adverse outcome.[20] In fact, a "hallmark of trust is the willingness to forgive mistakes or unfortunate results."[21] But if the relationship ends, so will the trust.

Unfortunately, medical, ethical and legal scholars have ignored this concept of relationship in recent years. The historical model of paternalistic healthcare involved a very unilateral relationship, with what many perceived to be blind and unquestioning faith in

---

[19]Jeffrey O'Connell and Andrew S. Boutros, "Treating Medical Malpractice Under a Variant of the Business Judgment Rule," 77 Notre Dame L. Rev. 373, n.233 (2002).

[20]Steve S. Kraman and Ginny Hamm, "Risk Management: Extreme Honesty May Be the Best Policy," 131 Ann. Internal Med. 963, 966 (1999).

[21]Mark A. Hall, "Law, Medicine and Trust," 55 Stan. L. Rev. 463, 494 (2002).

physicians. When patients rejected the paternalistic model of medicine, medical ethicists and attorneys began to analyze ethics and liability in terms of "patient rights." This demonstrated (though cause and effect are unclear) a significant shift in the perception of the provider/patient bond. Some scholars have observed that scrupulous insistence on observance of one's rights indicates a loss of trust. They suggest instead that we refocus medical ethics on preserving the caregiving relationship providers must have with their patients, but centered on a vision of bilateral communication, not paternalism, as a foundation of trust.[22] In light of some of the research outlined below, one wonders if perhaps our malpractice crisis has roots far outside of either the strictly clinical or legal environment.

What do we do to maintain trust? Studies published in 1996 and 1999 surveyed internal medicine patients in Los Angeles and London.[23] Both groups of authors concluded that patients desire an acknowledgement of even minor errors. Ninety-eight percent of the California patients expected their physician to acknowledge any error; almost none of those patients wanted to talk to a nurse about errors, even minor ones. Unfortunately, many attorneys have advised their clients to do just the opposite, and to avoid any discussion of the event, leaving their patients wondering why they cannot talk to their trusted physician about this healthcare event.[24]

Another unique benefit develops from the preservation of relationships between patients, physicians and

---

[22]Mark A. Hall, "Law, Medicine and Trust," 55 Stan. L. Rev. 463, 494 (2002).

[23]Melanie Hingorani, Tina Wong and Gilli Vafidis, "Patients' and Doctors' Attitudes to Amount of Information Given After Unintended Injury During Treatment: Cross Sectional, Questionnaire Survey," 318 Br. Med. J. 640-41 (1999). Witman AB, Park DM, Hardin SB, "How Do Patients Want Physicians to Handle Mistakes? A Survey of Internal Medicine Patients in an Academic Setting," 156 Archives of Internal Med. 2565-69 (1996).

[24]Jonathan R. Cohen, "Advising Clients to Apologize," 72 S. Cal. L. Rev. 1009, 1011 (1999).

other healthcare providers. Studies by psychologists and physicians have shown that the strongest indications of trust in the physician-patient relationship arise from relationship factors or personality traits, not physician demographics or professional characteristics.[25] In other words, patients trust doctors they like, not necessarily doctors who are good. People generally believe that the motivations of one they trust come from benevolence and caring, making them more willing to overlook a poor outcome if the underlying relationship supports trust.[26]

Psychologists studying trust have identified four dimensions: fidelity, competence, honesty, and confidentiality. In most relationships, trust in one dimension does NOT generate proportionate trust in the others. Someone may have complete faith in their auto mechanic's technical skills, but still believe that he will tell all of his customers any secret shared with him. However, patients who have a strong feeling of trust in their physicians regarding one dimension of trust will carry that over to the other dimensions. So, if a patient strongly believes that his or her physician is honest and will maintain confidentiality or fidelity, they will also trust in the physician's competence.[27]

There are limits, though, to the extent of this trust "carryover." The California study found that patients' specific expectations for continued relationship with their physicians varied with the severity of the outcome. As severity increased, larger numbers of patients would look for a referral to another physician and some compensation, which is not surprising or inappropriate. The patients also had an increase in their desire for a discussion with another physician as the severity of injury increased.

---

[25]Mark A. Hall, "Law, Medicine and Trust," 55 Stan. L. Rev. 463, 494 (2002).

[26]Mark A. Hall, "Law, Medicine and Trust," 55 Stan. L. Rev. 463, 474 (2002).

[27]Mark A. Hall, "Law, Medicine and Trust," 55 Stan. L. Rev. 463, 474 (2002).

These studies confirmed earlier research at Vanderbilt indicating a strong correlation between malpractice litigation and poor personal interaction between patients and physicians.[28] Even if there was not a strong relationship before an adverse outcome, extra effort after the event bears significant potential for improving the liability outcome of a situation. Continuing or developing a relationship with the patient on behalf of all involved providers may argue for at least the option of involving another physician in the disclosure process (and to provide further treatment) if there is a very serious adverse outcome. Risk management should participate in the decisions about these steps, in collaboration with the care providers. Continued trusting relationship with the patient, not strict adherence to a protocol, should be the ultimate determinant of the approach.

The role of trust: Improved medical outcomes. By keeping information from patients, do providers compromise their care? In addition to the practical and legal implications, the failure to discuss poor outcomes, their causes and their medical effect with patients can directly affect the patient's medical condition. When a patient believes that the providers are not open about problems with the care, it will diminish trust. Research has indicated that patients' physical conditions respond favorably to the intervention of a trusted healer, regardless of the technique or capability used by that individual. Some scholars have also postulated that the corollary would hold true as well, that if trust can alter and enhance the treatment outcomes, loss of trust will diminish the effectiveness of even the best healthcare.[29] Could one eventually argue that the *medical standard of care* requires disclosure?

---

[28]Hickson GB, Clayton EW, Githen PB, Sloan FA, "Factors that Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries," 267 JAMA 1359-63 (1992).

[29]Mark A. Hall, "Law, Medicine and Trust," 55 Stan. L. Rev. 463, 483 (2002).

Trust: Barriers to relationship. Hingorani, et al. explored physicians' hypothetical responses to adverse outcomes.[30] Not surprisingly, their attitudes differed from the patients'. In that survey, 81 percent of patients felt that they should always be informed of complications and receive detailed information on possible adverse outcomes from the complication. Only 33% of the physicians (ophthalmologists) agreed with them. Because malpractice liability is not a big factor in England, this study offers some interesting insight into other possible reasons that caregivers might hesitate to disclose and/or discuss adverse outcomes. The authors concluded that paternalism was a significant factor, but also felt that doctors avoid telling patients because it is a time-consuming, difficult and unpleasant task. Given the frequent proclivity of physicians (and everyone else in the world) to avoid time-consuming, difficult and unpleasant tasks, this also provides some useful insight for attorneys or hospital administrators trying to engage a physician in a disclosure process.

§ 11:7 What role apology?

While researchers have long focused on how lawsuits relate to the failure of the physician/patient relationship, only recently have studies focused on the specific role of apology in healing that relationship. If people who are injured often don't sue, and those who do sue more often than not did not suffer any malpractice, what factor can explain the litigation we now face? What is the effect of apology on the relationship, the patient's likelihood to sue and, perhaps more important, on the healthcare provider? Is there any foundation for the terror that the very word instills in many defense attorneys? What if the patient had a bad outcome in spite of appropriate care?

---

[30]Melanie Hingorani, Tina Wong and Gilli Vafidis, "Patients' and Doctors' Attitudes to Amount of Information Given After Unintended Injury During Treatment: Cross Sectional, Questionnaire Survey," 318 Br. Med. J. 640 (1999).

Definitions. The research on apology does not contemplate apology for every bad outcome. Rather, it focuses on adverse events, or injuries caused by medical management and resulting in measurable disability or injury.[1] Three elements typically appear in definitions of the apology itself. The most innocuous of these encompasses an *expression of sympathy* for the pain or difficulty the patient is experiencing. Typically, this "partial" apology would gain the blessing of defense attorneys, though it still made them nervous. Providers were extensively cautioned to avoid the other two elements in any situation: *admitting fault* and *expressing remorse or regret*. Research on the issue describes two types of apology: the full apology, which includes all the elements, and a partial apology, which omits the last two.

Patients and providers: different expectations. In a recent study, Gallagher et al. performed extensive interviews of patients and physicians, apart and together, to determine each of their views on this issue. While all agreed on the surface that a mistake warranted apology, they differed on some issues that could be critical to the effectiveness of apology and early claim intervention, both financially and emotionally. Patients want compassionate disclosure with an apology of a broad category of events. Physicians want truthful, objective and professional disclosure and apology only when an injury results from a deviation in the standard of care. Patients want to know how we will fix the problem; otherwise they believe their own suffering has been in vain. They want "to understand what happened to them and to know [the providers] had learned from the event." The physicians believed they would be better personally with disclosure, but did not believe that it would foreclose claims, which may explain their

---

[Section 11:7]

[1]Thomas H. Gallagher, et al, "Patients' and Physicians' Attitudes Regarding the Disclosure of medical Errors," 289 JAMA 1001 (2003).

hesitance to support broad disclosure and apology, though many said the most difficult thing about medically-caused injuries was forgiving themselves. The authors concluded that the present system "may meet neither the patient's desire for information about errors nor the needs of patients and physicians for emotional support following an error."[2] Or as another author has opined, "surely something is amiss when physicians want to apologize, when patients would appreciate receiving a apologies [sic], but the fear of liability stops physicians from apologizing—which in turn prompts a lawsuit."[3]

Timing of apology. While the provider should not enter an apology discussion without careful consideration and practice, common sense and the general sense of the research indicate that the earlier one offers an apology, the more effective it will be. It need not encompass, and probably should not, the financial component that may well follow. While apologies should reduce one's overall liability, many outcomes will still require financial compensation. The benefit of early apology arises from its ability to help reestablish a trusting relationship and understanding, which will facilitate prompt and economical financial resolution as a follow-up to the apology.[4]

Healthcare providers usually have a distinct advantage over many other alleged tortfeasors: they often have a pre-existing relationship with the potential plaintiff and good information about the injuring event. As a result, they will often know more about their own culpability immediately after they learn of the patient's injury, allowing a prompt decision on disclosure and

---

[2]Thomas H. Gallagher, et al, "Patients' and Physicians' Attitudes Regarding the Disclosure of medical Errors," 289 JAMA 1001, 1004 (2003).

[3]Jonathan R. Cohen, "Advising Clients to Apologize," 72 S. Cal. L. Rev. 1009, 1012 (1999).

[4]Jonathan R. Cohen, "Advising Clients to Apologize," 72 S. Cal. L. Rev. 1009, 1020-21 (1999).

apology. In other situations, such as product liability, the manufacturer only learns of details through discovery. Emergency department providers often have no knowledge of the injury at all until a claim is filed, and they have no relationship to the patient before or after the patient is in the department. They may only garner appropriate information through a formal process. The lack of knowledge often prevents a prompt decision about apology, but this should not preclude consideration of apology and disclosure at the first opportunity.

The attorney's role. If apology (and related disclosure) is good for the injured patient, good for the involved providers and can lead to better financial outcomes, why do attorneys representing providers not suggest it more often? Why do attorneys for patients and families not encourage disclosure and apology as terms of settlement? Most are probably never trained to consider or evaluate it, either in school or their early practice. "The legal system focuses on adjudicating rights, rather than on repairing relationships. An apology is not a legal remedy one can seek in an American court."[5] Part of the answer lies in the role of the attorney, both in the public's perception and their own. They may feel (sometimes with justification) that their clients will perceive them as disloyal if they suggest early resolution and compromise. As the healthcare provider needs a trustful relationship with patients, attorneys should develop such a relationship with clients so that the client will understand the lawyer acts in their best interest, which sometimes requires proposing conclusions and solutions that are difficult for the client to hear. Often clients perceive their attorneys as mercenaries, ready to go to battle at their beck and call. But lawyers also have an obligation to understand and recommend other options if they bear the potential for a better overall result.

---

[5]Jonathan R. Cohen, "Advising Clients to Apologize," 72 S. Cal. L. Rev. 1009, 1043 (1999).

Unfortunately, financial self-interest may also shape the attorney's attitude. An apology and state of mind have no monetary value, and cannot be valued for calculation of a contingency fee. Disputes that resolve prior to litigation do not generate much in the way of hourly fees. "Lawyers derive much income from creating and maintaining litigation. Lawyers generally benefit when disputes escalate. Apologies help bring disputes to an end, and in so doing limit the lawyers' fees."[6] While the vast majority of attorneys would not outright advise against an option of apology and closure when presented, they may passively neglect to discuss that option on their own initiative.

Is this the right case for apology? A number of factors will determine the appropriateness of an apology; attorneys counseling apology should consider them carefully. First, is the true underlying problem a damaged relationship? In medical malpractice, especially physician cases involving long-standing patients, apology may be the *only* thing that can begin a healing process and get the parties to resolution, with or without financial compensation. Second, what is the appropriate scope? A full apology accepting responsibility and expressing regret and remorse is not appropriate for every case with a poor outcome. However, it is probably appropriate when individual negligence or an identifiable system problem (which can be corrected but has not been) causes an injury. Until the cause of injury is clear, though, limit apology. But do keep the lines of communication open and promise open disclosure. Third, when should the apology occur? While some would argue to wait for mediation or other legal protection, the largest benefit both emotionally and financially will come at the earliest time. Lastly, the nature of the presentation itself is important. What *real* message is the purveyor of the apology sending to the injured party? While they should not seem rehearsed, apologies

[6]Jonathan R. Cohen, "Advising Clients to Apologize," 72 S. Cal. L. Rev. 1009, 1046 (1999).

must be sincere and avoid defensive language such as "I am sorry you lost your leg, but . . . ."[7]

Apologies in the courtroom. Some states have enacted provisions that protect expressions of sympathy from admissibility in court.[8] Attorneys in those states should be familiar with their statutory provisions. These provisions only protect "partial apologies," or expressions of sympathy, as opposed to a full statement of remorse and accompanying explanation. Courts have differed on the common law admissibility or effect of an apology. The weight of the case law seems to support admissibility, but denies the plaintiff the ability to use an apology by a healthcare provider to establish either the standard of care or breach of the standard.[9]

Ironically, no one has studied the ultimate effect of apology in medical malpractice cases on the jury. Attorneys have simply assumed that juries would interpret the apology as a sign of guilt on the part of the healthcare provider. Perhaps the opposite could be true. Juries take their own experiences and expectations into their deliberations. To the extent that the general patient population expects disclosure and apology after an adverse outcome, juries may well view an apology as part of the standard of care and consider the providers' other actions in a favorable light for that reason. They may even take the next step and punish the claimant and attorney who want to take advantage of honorable behavior.

§ 11:8 Conclusion

Medical malpractice suits and losses constitute a considerable headache for both healthcare providers and their insurance companies, thus also for the at-

---

[7]Jonathan R. Cohen, "Advising Clients to Apologize," 72 S. Cal. L. Rev. 1009, 1051 (1999).

[8]Jonathan R. Cohen, "Advising Clients to Apologize," 72 S. Cal. L. Rev. 1009, 1030 (1999).

[9]Peter H. Rehm and Denise R. Beatty, "Legal Consequences of Apologizing," 1996 J. Dispute Resolution 115, 119-20 (1996).

torneys who represent those entities. Even more frustrating, the system clearly fails in its two key goals: compensation of the injured and protection of the careful providers from liability. And an extraordinary and completely unacceptable 50% of the cost for the system feeds the system itself, providing no compensation for the injured. Tort reform may stabilize the picture for malpractice carriers by chopping the top end off of the wildly variable pool of verdicts. However, it cannot eliminate the "wrong plaintiff, bad decision on liability" problem that cripples our efforts to effectively compensate those we injure. The tort system also creates evidentiary snake pits that isolate valuable information on clinical risk, limiting the healthcare providers' ability to fix the problem.

Some visionary insurers and providers now treat the patient-provider relationship as the key to the puzzle, working to avoid the tort system and all of its dangers. Their programs' preliminary results can give all of us hope that we can end the frustration and focus appropriate attention on improving healthcare, not on defending lawsuits. Healthcare attorneys must understand the new programs and embrace the potential watershed improvement they can bring to our clients.