Disclosure:

The Other Side of Apology

By Victor R. Cotton, MD, JD

Disclosing medical errors to affected patients and apologizing for those errors has recently emerged as a potential solution to the medical professional liability (MPL) problem. The approach is built on the premise that patients who receive honest explanations and apologies are less likely to sue, and it has gained considerable acceptance in the risk management community. However, the idea that seriously injured patients, many of whom face major financial burdens, will simply forgive and forget about the errors that crippled them is counterintuitive. And, most clinicians remain skeptical, if not fearful, of the practice.

This article will evaluate the scientific literature behind disclosing errors, analyze the situations where it has allegedly been successful, and then examine why more physicians are not implementing this practice.

The ideal world

If we lived in an ideal world where the legal system functioned perfectly, every person who had been injured by medical negligence would file a lawsuit and be guaranteed to receive proper compensation. In addition, because the system was perfect, persons who had not been injured by negligence would never sue, and there would be no frivolous or non-meritorious lawsuits. In this ideal world, every injured patient would sue, and every lawsuit would have merit.

In such a world, apologizing for medical errors might be a viable strategy: If every injured patient is 100% likely to sue and equally certain to receive an equitable compensation, there is little to lose by asking for forgiveness. And, if even a few patients decide to forgive and forget, the savings could be substantial.

Victor R. Cotton MD, JD, *is President of Law & Medicine, an ACCME-accredited organization based in Hershey, Pennsylvania, and is licensed to practice both law and medicine in the Commonwealth of Pennsylvania.*

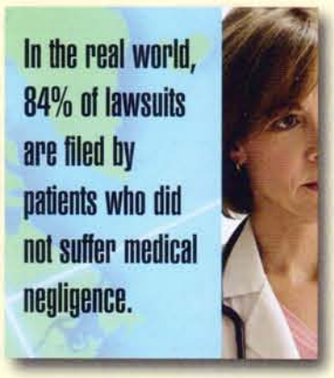
An Alternative Perspective

The real world

While this "ideal world" scenario is intriguing, most physicians practice medicine in the "real world." And, in the real world, 84% of lawsuits are filed by patients who did not suffer medical negligence.[1,2] Because these persons were not victims of medical errors, they would not be targeted for disclosure or apology (since there is no error to disclose, and therefore nothing for which to apologize), and their decision to file a lawsuit would therefore be unaffected.

The other 16% of litigants (who actually did suffer errors) could be targeted for an apology. And, if we assume that half of them subsequently decide to not sue (an optimistic assumption), the total number of lawsuits would fall by 8% (one-half of 16%). Compared with the dramatic decrease in lawsuits that often results from legislative tort reform (40% to 60%), this is a relatively minor reduction.

Of course, one could argue that the apologies eliminated half of the meritorious, and therefore more costly, lawsuits. While this argument is theoretically true, our legal system does not function with such precision. Brennan found that the likelihood of a plaintiff receiving money, along with the amount of money that he receives, is dependent only upon his degree of injury, and not whether he actually suffered medical negligence.[3] So, in this scenario, the 8% of lawsuits eliminated would reduce the overall cost by only a proportionate 8%. And, to achieve even this result, half of the injured patients must agree to forgive and forget.



The significant risk

In contrast to its limited potential benefit, the disclosure-and-apology strategy carries with it a significant number of risks. In the "ideal world" example, 100% of patients who were injured by medical negligence filed lawsuits. However, in the real world, only 2% of these patients do so.[1,2] This means that the vast majority of patients who are injured by medical negligence do not presently sue. While it is likely that there are multiple reasons for this phenomenon, a primary one is that most of these patients are unaware that they suffered an error, and therefore do not know that they have a viable claim for medical malpractice.[4]

Because there is no established method for distinguishing the 2% of injured patients who will sue from the 98% who will not, apologies would have to be given to all of them. This would be a very labor-intensive and precarious undertaking. To be successful in reducing the number of lawsuits, the approach would have to persuade the 2% not to sue, without triggering an appreciable number of the other 98% to sue.

The improbability of succeeding against these odds has been demonstrated in simulated scenarios, where 27%–44% of patients who were told of a medical error indicated that they would sue (compared with the 2% who do so now).[5,6] And, despite the hope that injured patients will forgive and forget, Wu found that, once aware of an error, neither expressions of empathy or apology had *any* effect on the patient's desire to sue.[5]

The net result is that full implementation of disclosure and apology can be projected to increase the number of injured patients who file lawsuits by more than tenfold (from 2% to 27%–44%). In addition, because the errors will have been admitted, few of these cases will be defensible. The resulting financial impact would be devastating. Even with optimistic assumptions, a Harvard study concluded that the question was not whether disclosing errors would increase MPL costs, but rather, how great the increase would be.[6]

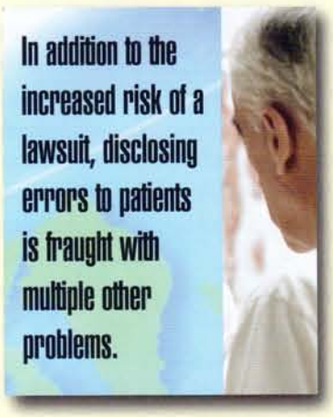
The alleged success stories

Despite the improbable math, it is frequently said that apology programs have been proven to reduce the number of lawsuits at the VA hospital in Lexington, Kentucky, and at the University of Michigan. However, these statements are not consistent with the study results that were published in the scientific literature.

According to the paper originally published in the *Annals of Internal Medicine*, beginning in 1987, the Lexington VA investigated every bad outcome (of which it was made aware) and informed the patient of the result.[7] In the event of a medical error, the involved persons would apologize and explain what was being done to fix the problem. Over the next 12 years, the policy resulted in an increase in the number of legal cases, and the facility rose to the top quartile among its VA peers (even though it was one of the smaller facilities). But, the facility was able to negotiate reasonable settlements in most cases and realized a slight overall savings, primarily because of a decrease in attorney hours.

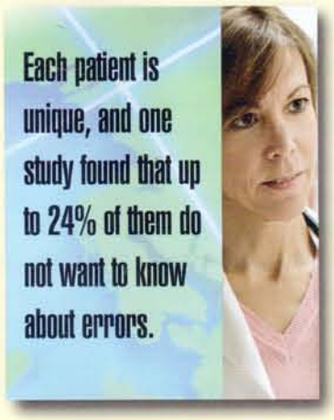
Disclosure: An Alternative Perspective

Unfortunately, there are some essentials for a rigorous study that the authors did not report: a standardized methodology for the apology, the number of cases in which the strategy was employed, or the results of those particular cases. And, there was no control group. In addition, the results were favorably influenced by several phenomena that are unique to the VA system. The VA patient population consists mostly of older men of limited means, who have finite expectations, deep ties to the Armed Services, and low levels of litigiousness.[8] The level of legal exposure is further reduced by the Federal Tort Claims Act, which protects government physicians from personal liability and mandates that a patient first proceed through an administrative process before he can gain the right to sue.[9] But, even with this unique patient population and extensive legal protection, the number of claims increased.



Many proponents of apologies cite the University of Michigan as another success in the apology movement. However, a recent analysis of the University's data (also published in the *Annals of Internal Medicine*) revealed that in fact the number of lawsuits there began to drop after the State of Michigan enacted extensive tort reform. The University then capitalized on tort reform and further reduced the number of lawsuits by changing the way it handled pending legal claims (settling many of them before a lawsuit could be filed). Finally, several years into the process, the University implemented an apology program. Given the many variables in play, the *Annals* paper concluded that a causal relationship between the apology program and the decrease in lawsuits could not be established.[10] In addition, like the Lexington VA, the University did not report a standardized methodology for the apology, the number of cases in which apologies were given, or the outcomes of those cases. And, there was no control group.

The absence of control groups is particularly problematic when studying MPL, because the incidence of lawsuits is highly cyclical. Since the last peak in 2003, the national incidence has fallen by approximately 50%. Without control groups to factor out the inherently cyclical nature of the problem, one could mistake correlation for causation, and conclude that every strategy implemented since 2003 has been "successful" in reducing the number of lawsuits. This conclusion would be scientifically invalid.



Additional concerns

In addition to the increase risk of a lawsuit, disclosing errors to patients is fraught with multiple other problems. Spokesmen for the apology movement claim that patients "want to know" about medical errors, but this is an overly general statement, which assumes that all patients have the same desire. In fact, each patient is unique, and one study found that up to 24% of them do not want to know about errors.[11] To override these patients' wishes by informing them anyway directly violates the tenets of "patient-centered care" upon which disclosure and apology is supposedly based.

In addition, forcing this information on unwilling patients has potentially serious health consequences. A patient's mental outlook has been shown to affect his clinical outcome; optimistic patients have better outcomes.[12] As a result, to the extent that it compromises the patient's outlook and confidence, informing patients of errors may also compromise his prognosis.

Disclosing errors outside of protected settings (e.g., patient safety organizations, peer-review proceedings) also poses significant risks for the clinician. In addition to the risk of being sued for malpractice, physicians who commit errors are regularly disciplined by state boards of medicine and sanctioned by hospitals. They also face the risk of criminal prosecution; this happened recently to a Wisconsin nurse, after her error caused a patient's death.[13] Although most states have passed some version of a medical apology law, most of these laws cover only expressions of sympathy (and not admissions of fault), and provide no protection in an administrative (board of medicine) or criminal proceeding.[14]

In addition to the legal and professional

risks, disclosing errors also poses a remote but nevertheless real safety concern for clinicians. In 2010, a surgeon at The Johns Hopkins Hospital was shot by a patient's family member who was distraught by bad news about his mother's condition. A *JAMA* article several months later outlined the significant problem of patient violence against healthcare providers.[15]

Although this risk receives little attention from apology advocates, it is very real for physicians, many of whom have hospital security with them when they are breaking bad news to certain patients. Disclosing that a healthcare provider may have been responsible for the bad outcome will increase the inherent risk in these situations and inevitably put physicians and nurses in harm's way. This isn't just ethically problematic; it will also likely result in liability for those who create these situations.

The outside influences

Because the vast majority of patients who suffer medical errors are not aware of the mistake and thus do not know that they have a viable legal claim, trial lawyers have repeatedly advocated for the disclosure of medical errors. During the legislative battle over tort reform in 2005, then-Senator Obama proposed the National Medical Error Disclosure and Compensation ("MEDiC") Act, a bill that championed disclosure and apology for medical errors as an alternative to the Republican calls for limits on non-economic damages.[16]

Although that initiative failed, most of the Affordable Care Act money that was earmarked for studying MPL subsequently went to disclosure and apology programs. And, in Pennsylvania, trial lawyers were successful in obtaining legislation that requires hospitals to provide written notice to any patient who experiences an unanticipated outcome.[17]

In contrast to trial lawyers, those who practice medicine are anchored by the principle of *primum non nocere* ("first, do no harm"). This principle demands that any change in the interaction between doctor and patient must first be proven to offer more benefit than risk. Unfortunately, because it poses a substantial risk to both doctor and patient, and offers little to no established benefit (other than to trial lawyers), disclosure and apology are not properly within the practice of medicine.

Conclusion

The concept of disclosure and apology purports to reduce legal risk by improving the interaction between doctor and patient in the wake of a medical error. However, only 2% of patients who suffer medical errors eventually file a claim, which suggests that there is actually little room for improvement. How physicians have managed to produce this phenomenal record has not been established. However, it is likely related to the lessons learned during 4,000 years of empathizing with the sick and comforting the dying. And, physicians are understandably reluctant to transform the nature of these interactions simply to conform to a counterintuitive and unproven idea. PIAA

Caveat: I would like to emphasize, however, that I fully support reporting medical errors to Patient Safety Organizations and other peer-review groups, in a location where the facts of the case can be discussed beyond the reach of trial lawyers.

References

1. Localio AR, Lawthers AG, Brennan TA. Relation between malpractice claims and adverse events due to negligence—results of the Harvard Medical Practice Study III. N Engl J Med 1991;325:245-251.
2. Studdert DM, Thomas EJ, Burstin HR, Zbar BI, Orav EJ, Brennan TA. Negligent care and malpractice claiming behavior in Utah and Colorado. Med Care. 2000;38:250-260.
3. Brennan TA, Sox MC, Burstin HR. Relation between negligent adverse Events and the outcomes of medical-malpractice litigation. New Engl J Med 1996;335:1963-1967.
4. Studdert DM, Mello MM, Gawande AA, Brennan TA, Wang YC. Disclosure of medical injury to patients: an improbable risk management strategy. Health Aff. 2007;26:215-226.
5. Wu AW, Huang IC, Stokes S, Pronovost PJ. Disclosing medical errors to patients: it's not what you say, it's what they hear. J Gen Intern Med. 2009 24:1012-1017. Epub 2009 Jul 4.
6. Helmchen LA, Richards MR, McDonald TB. How does routine disclosure of medical error affect patients' propensity to sue and their assessment of provider quality? Evidence from survey data. Med Care 2010;48:955-61.
7. Kraman SS, Hamm G. Risk management: extreme honesty may be the best policy. Ann Intern Med. 1999;131:963-967.
8. Wu AW. Handling hospital errors: is disclosure the best defense? Ann Intern Med 1999;131:970-972.
9. FTCA 28 U.S.C. §1346(b), §1402(b), §2401(b), and §§2671-2680.
10. Kachalia A, Kaufman SR, Boothman R, Anderson S, Welch K, Saint S, Rogers MA. Liability claims and costs before and after implementation of a medical error disclosure program. Ann Intern Med. 2010;153:213-221.
11. Hobgood C, Peck CR, Gilbert B, Chappell K, Zuo B. Medical errors what and when: What do patients want to know? Acad Emer Med 2002;9:1156-61.
12. Harkaaa K, Jarvikoski A, Estlander AM. Health optimism and control beliefs as predictors for treatment outcomes of a multimodal back treatment program. Psych and Health 1996;12:123-134.
13. http://www.wha.org/legalAndRegulatory/DOJcriminalcomplaint11-2-06.pdf. (accessed July 10, 2011).
14. Matroianni, AC. The flaws in state 'apology' and 'disclosure' laws dilute their intended impact on malpractice suits. Health Aff 2010;9:1611-1619.
15. Kelen GD, Catlett CL. Violence in the healthcare setting. JAMA 2010;304:2530-2531.
16. Clinton HR, Obama B. Making patient safety the centerpiece of medical liability reform. N Engl J Med. 2006;354:2205-2208.
17. 40 Pa. Cons. Stat. Ann. § 1303.308.