Medical Errors and Apologies: Making the Case to a Physician Audience

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Overview

Disclosure of Unanticipated Outcomes

- Professional responsibility
- What the medical literature says
- Process for delivering bad news
- Risk management approach

Unanticipated Outcome

Definition:

"Result that differs significantly from what was anticipated to be the result of a treatment or procedure"

American Society for Healthcare Risk Management (ASHRM), Perspectives on Disclosures of Unanticipated Outcomes, 2001, pg 5.

Professional Responsibility—JCAHO

Standard:

Patients and, when appropriate, their families, are informed about the outcomes of care, including unanticipated outcomes

Professional Responsibility—JCAHO

Intent:

The responsible... practitioner ... 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 outcomes.

Professional Responsibility:
National Patient Safety Foundation

Statement of Principle:

- When a healthcare injury occurs, the patient and the family or representative are entitled to a prompt explanation of how the injury occurred and its short- and long- term effects.
- When an error contributed to the injury, the patient and the family or representative should receive a truthful and compassionate explanation about the error and the remedies available to the patient.
- They should be informed that the factors involved in the injury will be investigated so that steps can be taken to reduce the likelihood of similar injury to other patient.

Approved by the National Patient Safety Foundation Board of Directors on November 14, 2002.

Professional Responsibility: American Medical Association

Principles of Medical Ethics:

"A physician must report an accident, injury or bad result stemming from his or her treatment."

American Medical Association (AMA), Principles of Medical Ethics, 1957, Section 4.

Professional Responsibility
American College of Physicians

Ethics Manual:

"physicians should disclose to patients information about procedures and judgment errors made in the course of care, if such information significantly affects the care of the patient."

American College of Physicians. American College of Physicians Ethics Manual. 3rd ed. Ann Intern Med. 1992, 117:947-60.

Professional Responsibility

Ethical Duty of Physicians to Disclose Errors – 1997

- 150 medical students, house officers and attending physicians
- 70% completed survey of simulated cases
  - 95% would admit error if outcome was minimal
  - 79% would admit error if patient died
  - 17% would disclose if asked directly

Sweet, MP & Bernat, JL. A study of the ethical duty of physicians to disclose errors. J Clin Ethics. 1997, Winter; 8(4): 341-348.

Medication Errors in Pediatric Emergency Department

- Five year period of time
- 33 incident reports dealt w/meds or IV's
  - 42% of reports discussed w/family
  - 36% of reports noted that family was not informed
  - 21% did not document if family was informed

Selbst, SM, Fein, JA, Osterhoudt, K, & Ho W. Medication errors in a pediatric emergency department. Pediatric Emer Care. 1999, 15,(1): 1-4.

Patients' Responses to Physicians' Mistakes*

Patient Response	Minor Mistake (=148)	Moderate Mistake (n=144)	Severe Mistake (n=146)
I would keep seeing my physician if			
Informed of mistake	103 (69%)	90 (41%)	11 (7%)
Not informed of mistake	**19 (13%)**	**11 (8%)**	**4 (3%)**

*Values differ because some surveys were incomplete.

Witman, AB, Park, DM, Hardin, SB. How do patients want physicians to handle mistakes? A survey of internal medicine patients in an academic setting. Arch Intern Med., 1996, 156(22): 2565-9.

Patients' Responses to Physicians' Mistakes*

Patient Response	Minor Mistake (=148)	Moderate Mistake (n=144)	Severe Mistake (n=146)
I would report my physician if			
Informed of mistake	12 (8%)	34 (23%)	102 (69%)
Not informed of mistake	**39 (26%)** (P<.001)	**75 (52%)** (P<.001)	**114 (78%)** (P<.001)

*Values differ because some surveys were incomplete.

Witman, AB, Park, DM, Hardin, SB. How do patients want physicians to handle mistakes? A survey of internal medicine patients in an academic setting. Arch Intern Med., 1996, 156(22):2565-9.

Patients' Responses to Physicians' Mistakes*

Patient Response	Minor Mistake (=148)	Moderate Mistake (n=144)	Severe Mistake (n=146)
I would file a lawsuit if			
Informed of mistake	1(<1%)	17 (12%)	88 (60%)
Not informed of mistake	**6 (4%)** (P>.99)	**29 (20%)** (P<.001)	**111 (76%)** (P<.001)

*Values differ because some surveys were incomplete.

Witman, AB, Park, DM, Hardin, SB. How do patients want physicians to handle mistakes? A survey of internal medicine patients in an academic setting. Arch Intern Med., 1996,156(22): 2565-9.

Question 1

Apologizing for a medical error is a vaccine that prevents lawsuits.

A. True
B. False

Why Families Sue?

Factors that prompted families to file medical malpractice claims following perinatal injuries– 1992

- 368 families in Florida who experienced permanent injuries or deaths
- 127 (35%) completed survey
- Closed cases between 1986-1989

Hickson GB, Clayton EW, Githens PB, Sloan FA. Factors that prompted families to file medical malpractice claims following perinatal injuries. JAMA 1992 Mar 11;267(10): 1359-63.

Why Families Sue?

Reasons for filing:

- 33% advised by acquaintances
- 24% recognized a cover-up
- 24% needed money
- 23% child perceived as having no future
- 20% received inadequate information
- 19% sought revenge/protection from harm

Hickson GB, Clayton EW, Githens PB, Sloan FA. Factors that prompted families to file medical malpractice claims following perinatal injuries. JAMA 1992 Mar 11;267(10): 1359-63.

Why Families Sue?

Families Expressed:

- Dissatisfaction with physician-patient communication
  - 13% believed MDs would not listen
  - 32% would not talk openly
  - 48% attempted to mislead them
  - 70% did not warn about long-term neurodevelopmental problems

Hickson GB, Clayton EW, Githens PB, Sloan FA. Factors that prompted families to file medical malpractice claims following perinatal injuries. JAMA 1992 Mar 11;267(10): 1359-63.

House Officers

Do house officers learn from their mistakes? – 1991

- 254 internal medicine house officers
- 114 (45%) completed questionnaire

Most significant mistake

- 33% error in diagnosis
- 29% error in prescribing
- 21% error in evaluation
- 11% related to procedural complication
- 5% related to communication

Wu, AW, Folkman, S., McPhee, SJ & Lo, B. Do house officers learn from their mistakes? JAMA 1991 Apr 24; 265(16): 2089-94.

House Officers

Do house officers learn from their mistakes – 1991

- 90% of mistakes had serious adverse outcomes
- 31% patient died
  - 54% discussed mistakes with attending
  - 24% told patient or families → 76% did not

Wu, AW, Folkman, S., McPhee, SJ & Lo, B. Do house officers learn from their mistakes? JAMA 1991 Apr 24; 265(16): 2089-94.

Barriers to Disclosure

- Psychological /Personal Issues
- Legal Concerns

Barriers to Disclosure

Psychological /Personal Issues

- Belief that:
  - Disclosure is unnecessary
  - Disclosure is a factual matter not a complex interpersonal conversation
  - Outcome is not related to action on the part of the discloser
  - Outcome would have potentially occurred without error

ASHRM Newsletter, May 2003, Page 6.

Barriers to Disclosure

Psychological /Personal Issues

- Fear of:
  - Retribution from patient/family
  - Retribution from peers
  - Conducting conversation poorly/doing more harm
  - Having to handle emotions

ASHRM Newsletter, May 2003, Page 6.

Barriers: Legal

Concern:

- ? Legal protection for information during disclosure
- ? Legal protection for information in medical record
- ? Necessity for disclosure
- ? “benefit” for disclosure during the claims process → other than perception of honesty

ASHRM Newsletter, May 2003, Page 7.

Barriers: Legal

AMA's Council on Ethical and Judicial Affairs:

"Concern regarding legal liability which might result following truthful disclosure should not affect the physician's honesty with a patient."

American Medical Association(AMA) Council on Ethical and Judicial Affairs and Southern Illinois University School of Law. Code of Medical Ethics, Annotated Current Opinions. Chicago, Ill: American Medical Association; 1994.

Is Disclosure the Best Defense?

Albert W. Wu, MD, MPH:

- Less than 20% of medical malpractice involve negligence
  - Nearly all involved breakdown in MD-patient communication
- Almost 50% of perinatal injury lawsuits are motivated by suspicion of a cover-up revenge
- PCPs less likely to be sued if
  - Patients told what to expect, encouraged to talk, used humor and spent more time
- 75% of all medical malpractice cases involve inpatient and education

Wu, AW. Handling hospital errors: Is disclosure the best defense? Annals of Internal Medicine 1999; 131(12): 970-972

Models for Managing Process

- One person alone (“lone-ranger”)
- Team (“kumbya”)
  - Small
  - Large
- Just–in–Time Coaching (“we’re here to help”)

Also,

- Delegate up the chain, not down!

Risk Management
Extreme Honesty – 1999

VA Medical Center, Lexington, KY

- Suggests (<u>but does not prove</u>) financial superiority of a full disclosure policy.
- Honest and forthright risk management
  - puts patient's interests first
  - may be relatively inexpensive
    - avoids lawsuit preparation
    - litigation
    - court judgments
    - settlements at trial

Kraman, SS & Hamm, G. Risk Management: Extreme Honesty May Be the Best Policy. Annals of Internal Medicine. 1999, 131(12) 963-967.

Risk Management
Extreme Honesty – 1999

VA Medical Center, Lexington, KY

- In place since 1987
- Has not caused an onslaught of litigation
  - Compared to 35 other VAs
    - Average workload
    - Top quartile for claims filed
    - Bottom quartile for payments

Kraman, SS & Hamm, G. Risk Management: Extreme Honesty May Be the Best Policy. Annals of Internal Medicine. 1999, 131(12), 963-967.

Disclosure Process

- Guiding Principles
  - Recognize that all caregivers have the patient's best interest in mind.
  - Recognize that the physician is ultimately responsible for treatment decisions.
  - Recognize that physicians (and the organization) are responsible for providing quality patient care.
  - Recognize that performance improvement and patient safety are continuous tasks. Therefore, we continually seek to identify, develop, and share best practices.

Delivering Bad News

- Timing
  - As soon as practicable after immediate health care needs are addressed
- Focus
  - Keep patient and family needs in forefront
- Approach
  - Avoid jargon
  - Don’t make excuses
  - Don’t minimize family’s concerns

What to say

- Explain the patient's status now. Discuss only pertinent clinical facts.
- Explain the plan of action.
- Explain the current prognosis
- Explain the updated plan of care.
- Explain that you (and the hospital) have taken appropriate steps to reduce the risk of recurrence, including an internal review of the situation.
- If the cause is clear, it should be discussed. Usually, the cause will not be clear at the time of the discussion. State that the cause is unclear and do not speculate!

Apology/Regret

- **Begin by stating that you "regret this has occurred."**
  - **"I have something difficult and important to tell you. I regret to say that there was a problem with…."**
- **Express personal regret and apologize (<u>different schools of thought</u>)**
  - **"I am sorry that you…" or "I am sorry for…" -- <u>versus</u> --**
  - **"I am devastated by what's happened, and can only tell you how sorry I am."**
- **Elicit questions and concerns**
  - **" I am sure this comes as a great shock to you…can I answer any questions?"**

PA Association for Health Care Risk Management, August 2001, page 1.

Wu AW. When things go wrong: Clinical, ethical, human relations considerations. PASHRM. Sept 28, 2000.

Disclosure Process

- Medical Record Documentation:
  - Facts – clinical facts without speculation or assignment of blame (Joe Friday approach)
    - **Who – Who was present during the discussion**
    - **What – What did the team tell the patient/family. Be specific. Do not generalize.**
    - **Where – Where was the discussion held (be specific)**
    - **When – date and time of discussion**
    - **Why – Only discuss "why" if causation is clear and there is no room for speculation.**
  - Response – Response of the patient/family, including competence and verbalized understanding.
  - Follow-up – Changes to plan of care, other services/resources offered

What to avoid

- Subjective information
- Speculation or conjecture
- Confidential information from peer review process
- Role/responsibility of other health care team members
  - Inform patient that you can only comment on your own care
  - Team discussion about who discloses information about other providers' care or system issues

Pennsylvania Experience: Act 13

Patient Safety Requirements

Certain incidents must be reported to the Department of Health, others to the Patient Safety Authority, and some to patients *in writing*

- Not an acknowledgement or admission of liability

Pennsylvania Experience: Act 13

- Health Care Worker Reporting
  - If a worker reasonably believes a Serious Event or Incident has occurred, he/she must report this belief to facility within 24 hours unless worker knows that a report has already been made
  - If worker does not report
    - Facility can take disciplinary action
    - Facility must report workers who do not comply to the relevant licensing authority

Texas: TCPR 18.061

Communications of Sympathy:

(a) A court in a civil action may not admit a communication that:

(1) expresses sympathy or a general sense of benevolence relating to the pain, suffering, or death of an individual involved in an accident;
(2) is made to the individual or a person related to the individual within the second degree by consanguinity or affinity, as determined under Subchapter B, Chapter 573, Government Code; and
(3) is offered to prove liability of the communicator in relation to the
individual.

Texas: TCPR 18.061

Communications of Sympathy:

(b) In this section, "communication" means:

(1) a statement;

(2) a writing; or

(3) a gesture that conveys a sense of compassion or commiseration emanating from humane impulses.

(c) Notwithstanding the provisions of Subsections (a) and (b), a communication:

including an **excited utterance** (Rule 803(2)) which also includes statements concerning negligence or culpable conduct pertaining to an accident or event, is admissible to prove liability of the communicator.

Texas Experience

- No mandate in Texas requiring a physician or other health care provider to disclose or report a serious or sentinel event to a patient or family member.
- Expressions of sympathy are not admissible to show negligence.
  - If those expressions of sympathy are followed up with "I messed up" "I took out the wrong lung," etc., those statements would be admissible to show negligence.
- "I am sorry this has happened" or words to that effect are acceptable alternatives.

Question 2

Disclosing a medical error and apologizing, the physician will:

A. Avoid being sued
B. Definitely be sued
C. Potentially change the jury's discussion about punitive damage if a court case resulted.

Texas Experience

Bottom line:

- "I am sorry" is not admissible,
- "I am sorry I messed up" is admissible.

Attorney's Perspective on Disclosure

In over 25 years of representing both physicians and patients, it became apparent that a large percentage of patient dissatisfaction was generated by physician attitude and denial, rather than the negligence itself. In fact, my experience has been that close to half of the malpractice cases could have been avoided through disclosure or apology but instead were relegated to litigation. What the majority of patients really wanted was simply an honest explanation of what happened, and if appropriate, an apology. Unfortunately when they were not only offered neither but were rejected as well, they felt doubly wronged and then sought legal counsel.

Wu AW. Handling hospital errors: Is disclosure the best defense? Annals of Internal Medicine 1999; 131(12): 970-972.

Conclusion

- Disclosure, when done appropriately, makes sense from:
  - Ethical standpoint
  - Professional obligation
  - Risk management perspective
  - Regulatory/licensure compliance
  - Legal perspective

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ASHRM Newsletter, May 2003.

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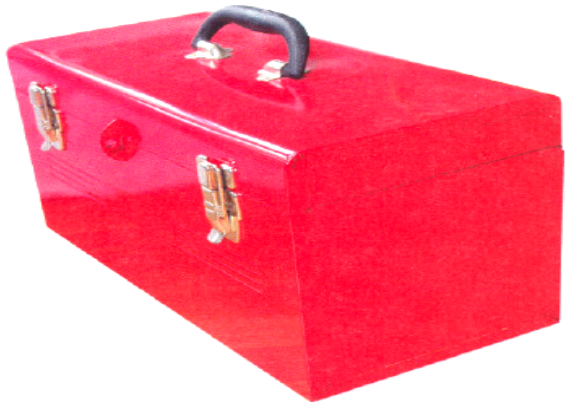
Wu, AW. When things go wrong: Clinical, ethical, human relations considerations. PASHRM. Sept 28, 2000.

Tool Kit

Looking for More Information about
Disclosure and Apologies for Medical Errors?

Look No Further!



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