



Photo courtesy of Jupiter/Images 2008

APOLOGY and DISCLOSURE

HOW A MEDICAL
OMBUDS CAN
HELP BRING A
POLICY TO LIFE

By Carole S. Houk, JD, LLM;
Leigh Ana Amerson, BA;
and Lauren M. Edelstein

In the March/April issue of *Patient Safety & Quality Healthcare*, the article “Conflict Management from the Heart: A Day in the Life of a Medical Ombuds/Mediator” presented a fictional yet representative case of a medical error involving the unexpected death of a young cardiac patient. In the first installment, the surgeon contacted the medical ombuds to ask for help in preparing for his first meeting with the grieving family while causative factors were still unknown. In this installment, the patient’s death has been attributed to a medical error, and the surgeon again seeks the assistance of the ombuds to help prepare for the disclosure meeting.

I know who it is as soon as he says hello. It is impossible to ignore the heaviness in his voice and I instinctively know that Dr. Greene is calling to share additional information regarding Joey Frank’s death. Although it has been several weeks since the young boy died during cardiac surgery, I have been anticipating this call. From our earliest conversations, there had been the slender yet real possibility that the child’s death might have been the result of a medical error. As I hear Dr. Greene say, “Joey’s death was caused by an anesthesia error that could have been prevented,” the questions that I know the family will have, and that Dr. Greene must have as well, begin to formulate in my mind. “What are my next steps,” he asks. Understandably, Dr. Greene wonders whether he should involve the anesthesiologist, apologize directly, or bring in legal counsel. We both agree that the next step is for us to meet the next morning to prepare for the disclosure conversation with Mr. and Mrs. Franks. Before saying goodbye, I remind him that by building a good foundation with Joey’s parents, we have worked together to establish trust following the devastating loss of their son. This does not mean that the disclosure conversation will not be extremely difficult for everyone, and there certainly will be many difficult conversations that follow. By continuing to share information and keep all lines of communication open and honest with the Franks, Dr. Greene and the hospital will show a commitment to the assurances given to the Franks the day Joey died that they would always be told the truth and that ‘walls’ would not go up.

In preparation for my meeting with Dr. Greene, I reflect back on what Mr. and Mrs. Franks said when they received the shocking news of Joey’s death. They wanted to know why it happened and if there was anything that could have been done to prevent their son’s death. In order to continue to meet the expectations of the Franks, I need to assist Dr. Greene in preparing to address these and other questions during the disclosure conversation. Any inability to address their concerns could be perceived by the Franks as ‘hiding’ something or evidence a lack of compassion, openness, and honesty in discussing the facts regarding Joey’s death, halting further communication and breaking the fragile trust existing between Dr. Greene and the Franks.

I prepare a list of questions to discuss with Dr. Greene: What are the facts that we know for certain surrounding Joey’s death? Who do you feel should be involved in the disclosure conversation? What should be disclosed? Who discloses the error? Where

should the meeting be held? If an apology is appropriate, who should apologize? What does an appropriate apology look like to you? How may I assist during the meeting with the Franks?

I know that here will be two separate components to the meeting: disclosing the medical error and an appropriate apology. Without properly framing the information the Franks will need to receive regarding their son’s death, future discussions surrounding what could have been done and what the physicians and hospital are doing to prevent something like this from happening again will not occur. Therefore, it is critical that each component holds equal importance, and adequate consideration and preparation need to occur prior to the meeting. Once we determine who should be involved in the disclosure conversation, I will need to reach out to each individual and offer to meet separately and collectively as we prepare to meet with the Franks.

Dr. Greene arrives at my office a few minutes early. He shares with me the clinical facts he is prepared to disclose to the Franks regarding the medical error and asks for assistance in framing the disclosure. As a designated neutral, I stress the importance in only sharing the facts, without speculation, to avoid future misunderstandings. I also realize that this is extremely difficult for Dr. Greene, as Joey’s death is a distressing loss for him as well as the parents. Having to sit across from Mr. and Mrs. Frank and share with them that their son’s death might have been prevented seems unbearable to Dr. Greene, and I know it will take an emotional toll on him and everyone involved.

We pause to talk about Joey. As Dr. Greene begins, his compassion and caring for his patient is clear. I realize that what I am seeing is what the parents need to see, that the tragic death of Joey Franks is shared by everyone involved in his clinical care. The physicians and hospital share in the Franks’ need to understand what happened, why it happened, and—most importantly—what can be done to prevent it from ever happening again. As I wrap up my meeting with Dr. Greene, I assure him that I will reach out to the Franks and share with them that there is additional information and arrange for a meeting. I advise Dr. Greene that I will be offering assistance to the Franks in preparation for the meeting and explain that the Franks will need an understanding of the purpose of the meeting and who will be attending, as well as an opportunity to prepare any additional questions they may have. Dr.

Greene agrees to contact me if there is any additional information, and I assure him I will notify him once I speak with the Franks.

Mrs. Franks is out when I call their home. I ask Mr. Franks if he would like me to call back when they are both available, and he says he will let Mrs. Franks know that I called. I inquire how they are both doing and if he has a moment to speak with me. "It is still extremely difficult, and we have so many questions; we still don't understand why Joey died," he says sadly. Without prolonging Mr. Frank's uncertainty that they may never receive answers to their questions, I explain that I have met with Dr. Greene and would like to arrange a meeting in order to discuss additional information. He is quiet for several seconds and then very softly says, "Oh." Deafening silence. "I see." A short pause, and then he says, "When would Dr. Greene like to meet with us?" I say that I would like to arrange a time that would be convenient for both he and his wife and ask if I could offer assistance in helping prepare questions they may have. We agree that I will call back the next evening to arrange a time for the three of us to speak and allow me the opportunity to assist in understanding what to expect at the meeting.

When I call the next evening, Mrs. Frank answers on the first ring and asks her husband to pick up the extension. They are anxious to hear any news regarding their son's death. I tell them that Dr. Greene has additional information and would like to meet, and he would like to obtain their permission to include any other physicians that might provide additional information and insight. I do not share any of the facts and advise that my role is to assist in helping prepare for and to facilitate the meeting itself. Mrs. Franks is quick to admit that she has an extensive list of questions and asks if I would share them all with Dr. Greene so he can address them when they meet. We set up a time to review the list, and I acknowledge how difficult this time must be for them, again offering my services if there is anything else I can do to be of assistance.

My separate meetings with Dr. Greene, Chief of Anesthesia Dr. Miller, and the Franks, were challenging yet fruitful. On the day of the scheduled joint meeting, I arrive early to prepare the room and greet everyone. As expected, emotions are high and tears are close to the surface. It is the first time the Franks have seen Dr. Greene since Joey's funeral. They stand across from each other, and it appears as if they don't know whether to shake hands or hug one another. Dr. Greene extends his hand to the Franks and quietly says, "Hello," before we move into the meeting room. Once seated, I thank everyone for their willingness to meet today and introduce everyone, including Dr. Miller. I explain that Dr. Greene has asked Dr. Miller to meet with us today since he will be able to answer questions relating to the anesthesia services Joey received during surgery. As Dr. Miller offers his sincere condolences for their loss, Mrs. Frank pauses briefly, reaches into her purse and pulls something out. As tears begin to slowly roll down her cheeks, she gently caresses the picture in the silver frame as she touches her fingers to her lips and places a kiss on the picture of Joey. "It is one of our last pictures of him. He hated that outfit, but I thought he looked handsome in it." She hands the photo to Dr. Miller as she whispers, "This is my son, Joey."

Dr. Greene looks at me for encouragement and I nod slightly. In prior discussions held with both physicians in preparation for this

meeting, we made the decision that in light of the lengthy relationship Dr. Greene had established providing Joey's medical care, he would be the one to disclose the facts surrounding the medical error. Dr. Greene begins by thanking Mr. and Mrs. Frank for their willingness to meet with him and Dr. Miller. "I reviewed the questions you prepared and would like to address each one individually. Please stop me at any time if you have any questions about what I am saying or if I need to provide more information." The Franks agree and express their eagerness to know what happened.

Dr. Greene starts the dialogue at the beginning of the admission and slowly, patiently, and compassionately begins to outline each step of the care provided to Joey prior to the surgery. He pauses to check for their understanding and continues when the Franks nod that they understand and it is all right to continue. Dr. Greene glances at Dr. Miller before going further, as he is about to share with the Franks the events leading up to the anesthesia error, which ultimately led to Joey's death. As Dr. Greene shares the facts, he pauses several times to allow the Franks time to process the information being shared with them and then asks if they have any questions that either he or Dr. Miller could answer. At first, the Franks are silent. As the realization of what has been shared with them begins to show on their faces, the questions begin to flow. As Dr. Greene promised, he answers each question the Franks have honestly and compassionately. When Mrs. Franks asks Dr. Miller a question he does not have an answer for, he offers assurances that he will investigate further and asks permission to provide them with the information as it becomes available.

As my eyes are drawn to the picture of Joey, I sense the exhaustion of everyone in the room. The physicians have just shared with the Franks that their son's death was caused by a preventable error. The Franks have received a sincere apology accepting responsibility for what has happened. Questions have been asked by the Franks and they now need time to process all the information they have received. The room is quiet. Realizing that the disclosure of the error and the apology offered by Dr. Greene and Dr. Miller is only the beginning of what will be the focus of many future conversations, I take advantage of the pause in the conversation to ask if it would be OK if I 'checked in' with everyone over the next few days. I offer the suggestion that Mr. and Mrs. Frank might want to take some time to process what has been shared with them and to possibly meet again for further discussions as needed. As Mr. and Mrs. Frank rise to leave, they thank Dr. Greene and Dr. Miller for their honesty and concern. Mrs. Franks closes by saying, "We now know what happened and how it happened—I'd like to learn what could have been done to prevent such a mistake, and what you and the hospital will do to prevent it from happening to anyone else's little boy." Dr. Miller responds by explaining the root cause analysis process that is currently being conducted by the hospital's risk management department as well as the peer review process that is looking into the medical error. "As we discover more about what happened, we will share with you what we can, and want you to know that we are committed to providing a safe environment for all our patients. We know that mistakes have been made. We also know that transparency and a critical examination of what is not working well is necessary to assure patient safety in the future."

Medical ombuds are often asked *why* a caregiver should be open and honest in disclosing the truth about a medical error to a patient and family. Simply put, disclosure is the *right thing to do* when a patient has been harmed. When a patient and his or her family endure harmful medical errors, both ethical and practical considerations suggest that their doctors should tell them the truth about what has happened. Ethically, doctors have a duty to be honest with their patients stemming from fiduciary responsibilities within the physician-patient relationship (Levinson & Gallagher, 2007). Practically, informing patients about medical errors is critical to ensure informed decision-making about subsequent treatment (Levinson & Gallagher, 2007); to allow patients and families to begin a process of grieving and healing (Gallagher, 2003; Leape, 2005); and to foster trust between patients and providers (Leape, 2005; Massachusetts Coalition, 2006). Further, through disclosure of information about failures, errors, and adverse events, a hospital will develop the data to make the institutional insights necessary to reduce the likelihood of repeating the same mistakes in the future (Joint Commission, 2005; Roberts, 2007).

When disclosure of medical errors is accompanied by an apology, the aftermath can be a positive and restorative experience for patients and their doctors. This kind of healing experience, regrettably, takes place infrequently. Even though many physicians and members of the public report errors in their own or a family member's care, neither group sees medical errors as a key problem in the healthcare system (Blendon et al. 2002). While on one hand, medical errors are not seen as being of critical importance, public survey data cited in the Institute of Medicine's report *To Err Is Human*, found that an astounding 44,000 to 98,000 Americans die annually as a consequence of preventable medical errors, costing an estimated \$17 to \$29 billion annually (Kohn, 2000). Apologies and disclosure of errors reduce both the financial cost and human toll of medical errors.

An Example from Manufacturing

The case of the Toro Company, a lawn mower manufacturer, serves as a notable example for the healthcare industry of how an expensive, litigious system can transform into one that reduces costs and fosters trust, openness, and relationship building. Toro shifted its management of product liability claims away from a litigation-based system to a compensation and settlement approach. When a person is injured by a Toro mower, representatives of Toro visit him or her to acknowledge suffering, express sympathy and regret for the accident, answer any questions about the product, and offer monetary compensation to those harmed (Jones, 2004). This strategy for handling claims, according to Toro, has been a very positive business and customer relations experience. The change in claims management has saved the company \$100 million in litigation costs between 1991 and 2005 (Jones, 2004). The average expenditure on an injury claim has dropped from \$115,000 to \$35,000, a decrease of almost 70% (Jones, 2004). By some estimates, other lawn mower manufacturers typically spend \$200,000 to \$300,000 per claim on legal expenses alone (Jones, 2004). Toro's

When disclosure of medical errors is accompanied by an apology, the aftermath can be a positive and restorative experience for patients and their doctors.

settlement program has also improved the relationships between the company and its customers, leading even those who have been harmed to walk away from an incident with healed relationships and good-will toward Toro (Jones, 2004). Healthcare organizations have the power to make similarly transformative system changes to better manage medical errors.

Physician Training and Support

For a physician to walk into a room and sit down beside a frightened, angry, and anxious family and apologize for injuring or killing a loved one as a result of a medical error is an act that the vast majority of physicians today are wholly untrained for and uncomfortable performing. And yet, data shows that when a party responsible for harm to another offers a full and sincere apology, the chances that the harmed party will remain angry and sue decreased significantly (Robbennolt, 2003; Massachusetts Coalition, 2006). The ability to engage in open, compassionate conversations with patients and families about medical conditions and care, to be honest about problems that may have arisen, to take responsibility for harm to a patient, and to offer heartfelt apologies are characteristics of a trustworthy physician, a good caregiver, and the kind of person who contributes to improving public trust in the healthcare system. This also happens to be the profile of a physician who is likely to face fewer malpractice claims than his or her colleagues (Levinson & Roter et al., 1997; Leape, 2005; Ambady et al, 2002).

Opening the lines of truthful communication can be a very powerful and cathartic experience for patients, families, and caregivers. It can foster trust in the medical system, reduce litigation costs, and even reduce the occurrence of medical errors. The question becomes: How do we equip physicians with the support they require to converse compassionately and sincerely with their patients and families?

One answer to this question is legal reform to reduce the risk that apologies will be used against caregivers in court. Steps have been taken in 11 states to protect certain apologies from being used as evidence in a trial (Leibman & Hyman, 2005). However, since this represents only about 1 in 5 states, and many of the existing laws do not protect against full apologies but only partial ones, some lawyers and risk managers may

continue to fear the potential negative consequences of these kinds of admissions (Leibman & Hyman, 2005). Continued reform in this area can help incentivize apology. However, legal reform by itself cannot provide caregivers with the tools necessary to use apologies and disclosure effectively.

In order to equip physicians to speak freely and openly, education and training are of the utmost importance. The Association of American Medical Colleges in the 2000-2001 calendar year reported that a mere 12 out of 125 medical schools in the United States had a required communication skills course for their students (Leibman & Hyman, 2005). If caregivers are to become the trustworthy and honest physicians that patients deserve, they must be trained in how to conduct difficult conversations, how to admit fault and weakness, and how to show compassion to those they have harmed. These skills are not innate. To teach caregivers how to disclose and communicate effectively, they will need to learn to take a step outside their own comfort zones and recognize the human connection between themselves and their patients. They will need to start thinking about what it would feel like to be in their patient's or family's position and realize that their patients want to be treated with honesty and compassion (Leape, 2005; Massachusetts Coalition, 2006). Meeting these needs demands that physicians be trained in how to disclose and how to apologize after a medical error has taken place. Within healthcare organizations, services such as the medical ombuds/mediator program can serve as an example of what may be possible. In the case of Dr. Greene and the Franks, through disclosure and apology training; coaching; and support offered by the in-house medical ombuds, Dr. Greene had the support he needed to engage in difficult conversations with a distraught family about the medical error that led to their son's death. The support he received from the ombuds permitted him to maintain confidence in his ability, not be overcome by fear, and to accept responsibility. The ombuds can provide critical support to a physician fearing the worst: being sued, losing his reputation as a good doctor, and experiencing guilt and anxiety for harming a patient (Gallagher, 2003). The communications between Dr. Greene and the grieving parents sitting before him also fulfilled deep seated needs of the family to know the truth about the circumstances surrounding their son's death and to be apologized to sincerely (Leape, 2005; Gallagher, 2003). It is how we would want to be treated if the unexpected outcome occurred to a family member or ourselves. Our patients deserve no less. **IPSQH**

Carole Houk is an attorney and conflict management systems designer based in Washington, D.C. Her firm, Carole Houk International LLC (CHI), specializes in the design of integrated conflict management systems for organizations, with a particular focus on the healthcare industry. She co-developed the concept and designed the operating protocols and training for the first Medical Ombuds/Mediator Program for the early resolution of patient-provider disputes within acute care hospitals in the United States. This innovative program has shown impressive results in its first seven years of operation at the National Naval Medical Center in Bethesda, Maryland, as well as at dozens of Kaiser Permanente medical centers. Houk has been an adjunct professor at the Georgetown University

Law Center, Hamline University School of Law, and Pepperdine Law School's Straus Institute of Dispute Resolution. She may be contacted at chouk@chi-resolutions.com.

Leigh Ana Amerson is an experienced medical ombuds/mediator, having served as one of 29 pioneering healthcare ombudsman/mediators (HCOM) for Kaiser Permanente in their Mid Atlantic States Region. Prior to her role as an HCOM, she worked for Kaiser Permanente as a consultant in compliance, HIPAA, and customer service. In 2006, Amerson was selected to present the HCOM program at the jointly sponsored Kaiser Permanente - Harvard conference 'Seize the Moment' - Reaching Excellence in Patient Safety. She currently works as a healthcare consultant with Carole Houk International and can be reached at lamerson@chi-resolutions.com.

Lauren Edelstein is a second year master's degree candidate in conflict resolution at Georgetown University where she is studying conflict management, communication, and process design in healthcare and bioethics. She is currently interning with CHI.

REFERENCES

- Ambady, N., LaPlante, D., et al. (2002). Surgeons' tone of voice: A clue to malpractice history. *Surgery*, 132(1), 5-9.
- Blendon, R. J., DeRoches, C. M., et al. (2002). Views of practicing physicians and the public on medical errors. *New England Journal of Medicine*, 347(24), 1933-1940.
- Gallagher, T. H., Waterman, A. D., Ebers, A. G., Fraser, V. J., & Levinson, W. (2003). Patients' and physicians' attitudes regarding the disclosure of medical errors. *JAMA*, 289, 1001, 1005.
- Joint Commission on the Accreditation of Healthcare Organizations. (2005). *Health care at the crossroads: Strategies for improving the medical liability system and preventing patient injury*. Joint Commission Resources, 4-16.
- Jones, A. (2004). Product liability: House calls. *Corporate Counsel*, 4(10), 88.
- Kohn, L., Corrigan, J., & Donaldson, M. (Eds.). (2000). *To err is human: Building a safer health system*. Report of the Committee on Quality of Health Care in America, Institute of Medicine. Washington, D.C.: National Academy Press. Also available at http://www.nap.edu/catalog.php?record_id=9728#toc.
- Leape, L. L. (2005). Understanding the power of apology: How saying "I'm sorry" helps health patients and caregivers. *Focus on Patient Safety*, 8(4), 2-8.
- Levinson, W. & Gallagher, T. H. (2007). Disclosing medical errors to patients: a status report in 2007. *CMAJ*, 177(3), 265-267.
- Levinson, W., Roter, D., et al. (1997). Physician-patient communication: The relationship with malpractice claims among primary care physicians and surgeons. *JAMA*, 277(7), 553-559.
- Liebman, C. B. & Hyman C. S. (2005). Medical error disclosure, mediation skills, and malpractice litigation: A demonstration project in Pennsylvania. *The Pew Project on Medical Liability in Pennsylvania*. <http://www.medliabilitypa.org>: 9.
- Massachusetts Coalition for the Prevention of Medical Errors. (2006). *When things go wrong*. Boston, MA: Author 8-20.
- Robbenolt, J. K. (2003). Apologies and legal settlement: An empirical examination, *Michigan Law Review*, 102, 460-516.
- Roberts, R. G. (2007). The art of apology: When and how to seek forgiveness. *Family Practice Management*, 14(7), 44-49.