

Lead Report

Medical Errors

Hospitals With Unexpected Outcomes Explore Alternatives to 'Deny and Defend'

Hospitals are exploring new ways to deal with patients harmed by medical errors and other bad outcomes. Some use ombudsmen to resolve potentially litigious situations early and some encourage physicians to apologize. Department of Health and Human Services health clinics ask patients to name the price of their satisfaction.

Most of the programs are designed to defuse patient anger and address the reasons most patients or their families sue—to assert their dignity, exact retribution, and get information about what happened to them, according to Aaron Lazare, dean of the University of Massachusetts medical school and author of the book *On Apology*. The voluntary "Early Offers" program at HHS is somewhat different, asking an independent third party to compare offers submitted by each side. If the amount HHS offers is more than or equal to what the patient will accept, HHS pays the requested amount.

Beyond the 'Benevolent Gesture.'

U.S. lawmakers, too, have weighed in, seeking to protect physicians who admit fault from having their words used against them. In April 2003, Colorado became the first state to prohibit a health care provider's apology to an injured patient from being used as evidence in a damages suit. Many states have "benevolent gesture" laws that exclude providers' expressions of sympathy from use in malpractice suits. Colorado, however, was the first also to exclude actual admissions of fault. Since then, at least three states—Ohio, Oregon, and Wyoming—have followed suit and many others, including Massachusetts, New Hampshire, and North Carolina, are considering amending their evidence rules to allow health care providers to admit responsibility for bad medical outcomes without risking legal liability.

But does apologizing to a patient who suffers an unexpected medical outcome or who is injured by malpractice risk too much? Leaders of some of the nation's most prominent hospitals tell BNA that, on the contrary, they are convinced such policies reduce the number of lawsuits filed as well as any settlement amounts. But they also tell BNA that a big obstacle to introducing such policies is physician reluctance. One of the biggest obstacles to change is physicians' fear of being sued, several experts told BNA.

"There's been a culture of nondisclosure in the medical community for a variety of reasons, not just fear of legal liability," according to the University of Florida's Jonathan R. Cohen with the Institute for Dispute Resolution in Gainesville. While "deny and defend" owes much to the traditional role of defense counsel and risk managers, "simple shame around admitting errors can be difficult for people as well."

Cohen sees legislative changes weakening the tendency to circle the wagons, but says a larger cultural shift also is occurring. Many medical organizations are saying, "We should admit the mistake and face it squarely," Cohen said, a necessity, experts agree, if providers are to improve patient safety by sharing what they learn from medical errors (11 HLR 965,

7/4/02). But "it is a real abuse to play a con game with apologies," Cohen warned. They must be accompanied by offers of fair compensation, he said.

Risk manager Kathleen Roman with GE Insurance Solutions in Greenfield, Ind., told BNA she believes many doctors are afraid to apologize mainly because they haven't been trained how and when to do so. A doctor might say, "I'm sorry; I just don't know what happened," and the family hears the doctor admitting a mistake, she said. Even comforting statements can be misconstrued. "It will be okay; we're going to take care of you" can be taken to mean "we're going to take care of you financially," she said.

"What's really needed is training that enables providers to discern which comments are likely to be misinterpreted," Roman said. Without such training, risk managers, hospital administrators, and defense attorneys are going to be cautious about letting doctors engage in those discussions, she said. "We do not want hospitals shoving doctors out to the end of that diving board."

Growing Phenomenon

Despite these concerns, apologies increasingly are part of modern dispute resolution. The Veterans' Administration Medical Center in Lexington, Ky., often is cited as leading the way in the United States. In the 1980s, it instituted a program of "extreme honesty" regarding medical errors after two lawsuits cost the center some \$1.5 million in damages. A 1999 report in the *Annals of Internal Medicine* said the program reduced the hospital's average annual settlement costs to just \$190,000. The VA program, however, is not an early resolution program (patients are handed a claim form as part of the disclosure meeting) and does not include apologies by treating physicians (hospital administrators make the disclosure and also apologize to injured patients when warranted). Furthermore, it was not the first to institutionalize apologies. GE's professional liability insurer Medical Protective has had such a policy for more than 100 years, Roman said.

Among acute health care facilities, it was the Organizational/Ombudsman/Mediator Program at the National Naval Medical Center in Bethesda, Md., that first used the services of a designated neutral to resolve health care disputes/issues at the lowest level and earliest opportunity prior to claims' being filed. Three criteria define success, according to Barbara Moidel, the NNMC's current ombudsman/mediator: 1) honesty and information-sharing in real time, 2) acknowledgment of the patient's injury or situation, with an apology by the treating provider if warranted, and 3) assurances that patient safety will improve and that what happened to the patient will not happen to someone else.

The Bethesda system—slated for expansion also to Naval medical centers in San Diego and Portsmouth, Va.—addresses patient care issues including unexpected outcomes, delayed diagnoses, medical errors, sentinel events, and expected and unexpected deaths. The system also helps improve care quality using feedback from patients, family members, and providers, and making upper level administrators aware of system problems. In every case, "early referral is the key to success," Moidel told BNA.

For more than two years the NNMC has had a policy of full and frank disclosure of all unanticipated outcomes and errors, so training staff providers in disclosure techniques is a critical function, she said. Provider disclosure begins as soon as practical after the event, and is not just a single conversation or encounter. Early on the patient and family "don't have all their questions and we don't have all the answers, so we follow up as we get additional information," she said.

Participants retain all their legal rights. The process is not patient advocacy and not a legal venue. Lawyers are not involved and do not sit in on the mediation sessions, Moidel said. While the 30 percent of NNMC's patients who are active military personnel may not sue for malpractice, the remainder can sue under the Federal Tort Claims Act. Nonetheless, "the focus is on doing the right thing, not on preventing claims," she said. Her job is to ensure the process is fair for the patient, family, providers, and medical center, Moidel said. Indications

are that the program it is a success. By sharing information and reducing miscommunication, the process has improved patient satisfaction, quality of care, and safety, she said. Resolutions are effected using ombuds and mediation techniques, including shuttle diplomacy, informal fact-finding, facilitating discussions between patients and providers, and assisting parties in creating their own resolution options. Even though the statute of limitations has not expired on a number of cases, data thus far suggests progression to legal claims has been "very minimal," she said.

Kaiser Permanente sent representatives to the NNMC in 2003 to learn how to set up its own ombuds program. Bruce Merl, Kaiser's director of medical-legal affairs, told BNA Kaiser discovered that what injured patients want is "an apology, particularly if there has been a medical error, acknowledgement of their suffering, and an understanding of all the facts. The other thing they often want to know is what you will do to stop it from happening again." To address these concerns, Kaiser "openly discusses errors and communicates with patients about what happened to them."

Kaiser also is devising a system to assess program results objectively. "We started with a very rudimentary data base and now are merging patient encounter numbers with data on how long it takes to close a case and other measures," Merl said. "We don't yet have a good way of evaluating satisfaction with the process, and we are looking at ways to survey people connected with it." At a January meeting with some 20 physicians who supervise the process at Kaiser facilities in northern California, however, "everyone thought it was the greatest thing we've ever done," Merl said.

Apologies 'Get All the Attention.'

The University of Michigan Health System (UMHS) revised its patient safety system in 2001. Apologies are only a part of the program, spokeswoman Kara Gavin said, "but it is the apologies that get all the attention." In addition to saying "sorry" when appropriate, Michigan's approach uses "communication, full disclosure, and learning from our experiences in a blame-free environment," Gavin told BNA. She summarized the program as: "Apologize and learn when we're wrong, explain and vigorously defend when we're right, and view court as a last resort."

Because of the time it takes a claim to work its way through the legal system, final data are not available, but indications are the program is very successful, Gavin said. Numbers of claims and lawsuits appear to be down dramatically, claims' severity is rising more slowly than national averages, average legal expenses per case are about a third lower, closing times for claims are dramatically shorter, and malpractice premiums are "practically level, despite increases in our clinical business." Program feedback also has led to many system improvements in clinical care, she said.

Undoubtedly contributing to the program's success is a state mandated "cooling off" period for malpractice litigation. After notice of suit is filed, parties have six months to consider their cases before going to court. UMHS uses that period to investigate and to establish a dialogue with its patients, often eliminating the desire to sue, Gavin said.

Apology Versus Mere Disclosure

According to Carole Houk with Resolve Advisors LLC in Alexandria, Va., many health care institutions—including all those in the Department of Defense—aim to have disclosure policies in place for their next accreditation surveys to satisfy new Joint Commission on Accreditation of Healthcare Organizations Standard RI.2.90. "But disclosure is not the same as an apology," Houk said. Disclosure merely describes the unanticipated outcome, with no analysis whether the cause was human failure, system failure, or a combination, she said.

One institution trying to go beyond simple disclosure in resolving medical disputes outside the legal system is Harvard's School of Public Health in Boston, where noted patient safety expert Lucian Leape heads the exploratory committee. Committee member Robert Hanscom

with Harvard's Risk Management Foundation (RMF) told BNA, "We are very supportive of these programs, including apologies, and firmly believe they reduce and moderate adversarial actions." Analysis of RMF's own cases shows "a lot of patients sue almost solely because they were not given an apology or felt they were not treated well following an adverse event," Hanscom said.

Information on Michigan's patient safety program is available at <http://www.med.umich.edu/opm/newspage/2004/patientsafety.htm>. A description of the HHS "Early Offers" program is at <http://www.hhs.gov/news/press/2004pres/20040921b.html>.

By Susan K. Carhart

Contact customer relations at: customercare@bna.com or 1-800-372-1033
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