CRICO RMF

Protecting providers.
Promoting safety.

Disclosure and Apology: The Human *and Legal* Perspectives

Robert Hanscom JD
Jessica Bradley MPH
CRICO/RMF

February 8, 2007

Background

- 2001: JCAHO issued its disclosure standard (narrowed in ’02)
  - Sentinel events
  - Disclosure of unanticipated outcomes
  - Responsible licensed independent practitioner or designee
  - An institutional policy
  - No requirement to: (a) disclose “near misses”; (b) admit error or fault; or (c) document the details of the disclosure discussion

… but silent on apology…

Apology has gained momentum

- Disclosure without an apology = feels hollow
- Numerous organizations experienced problematic scenarios that highlighted the need to apologize
- … but no guidance on how to do this in a balanced fashion

The Insurer's Perspective

Concerns:

- If done inappropriately, can increase litigation and therefore lead to greater malpractice costs
- No evidence yet as to whether an apology actually prevents lawsuits
- Most scenarios are not clear cut

…. *rather, they are shaded in deep gray*

The Insurer's Perspective

However, **apologies – *if done correctly* – should occur**

- *First and foremost*, it is the right thing to do
- *Second*, it may be critical to preserving the doctor-patient relationship
- *Third*, a balanced, empathetic apology may do much to defuse negative situations

The Benevolent Gesture Statute

Mass. G.L. c.233, Sec. 23D

"… Statements, writings or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering, or death of a person involved in an accident and made to such person or to the family of such person shall be inadmissible as evidence of an admission of liability in a civil action…"

The Benevolent Gesture Statute

Caveats:

- Initially written for automobile accident scenarios
- Does not prevent a plaintiff's attorney from introducing an apology into evidence
- Apologies need to be limited to expressions of sympathy or empathy
  - If they go beyond that and infer causation, they may be construed *as admissions of liability*

“The Wrongs”

An apology is clearly appropriate when the “wrong” is clear cut.

Examples:

- Wrong patient
- Wrong digit, limb, organ
- Wrong drug, dose, method of administration
- Wrong procedure

… but most scenarios are "gray"

- Situations where there is obvious error are rare events
- Most scenarios:
  - Patient experiences a poor outcome – *unhappy patient or family, but no negligence or causation*
  - Negligence is suspected, *but causation is unclear*
  - Negligence and causation are present, *but no damages* (other than "emotional distress")

The Balanced Disclosure

- Take care of the patient
- Contact institutional resources
- Disclose as immediately as possible
- Do not speculate about causation
- Convey compassion for patient's pain and suffering
- Take responsibility (for what needs to follow)
- Assign accountability for follow-up
- Preserve evidence
- Report incident

“Take care of the patient”

- Don’t abandon the patient or the patient’s family
- Make every attempt to preserve the relationship between patient and doctor, and/or between patient institution
- Restore the patient’s trust
- Consult specialists (if necessary)
- Communicate identity of everyone who is there to “fix” what happened

“Contact institutional resources”

- Institutional risk manager should be alerted immediately
- At discretion of physician, there can be an informed decision as to who should be present when the disclosure takes place
- Risk manager *may* be in the best position to assess what has happened
- Risk manager can also coach, instruct, and refresh a physician before he /she talks to the patient

"Disclose as immediately as possible"

- The more time that goes by, the greater the chance that the patient's trust will be eroded
- Best person to communicate with the patient: *the physician*
  - … this is true even if the physician had nothing to do with the actual adverse event
  - Can also be a nurse manager, or somebody who is clearly the designee of the patient's primary caregiver

“Do not speculate about causation”

- Communicate only what is known
  - Do not conjecture about possibilities
  - Separate fact from opinion
  - Avoid being subjective
- Avoid attribution of blame
  - … e.g., “the lab always does this”

"Convey compassion for patient's pain and suffering"

- This is the apology
- "I am sorry for what you are experiencing"
  - Show empathy *and mean it!*
  - Do not say words such as *"I am sorry we did this to you"* or *"I apologize for my mistake"* [unless it's clear that one of the "wrongs" has occurred]

“Take responsibility (for what needs to follow)”

- Our version of Aaron Lazare’s “apology + taking responsibility”
- Take responsibility for everything that needs to happen (particularly clinically) in getting patient whole
- If patients say, “I just want to make sure this doesn’t happen to anyone else”, *give that statement full faith and credit*

"Assign responsibility for follow up"

- Who is going to manage the patient's next steps?
  - This is where the risk management staff (as well as the patient advocates) can be a critical resource
  - This is the hallmark of Kaiser Permanente's ombuds program
- Difficult issue: what patients should be told *versus* what needs to go into peer-review protected discussions

"Preserve evidence, document in the medical record"

- If equipment or specific hospital supplies are involved, risk manager will need to sequester them
- Document only known facts in the medical record:
  - Objective facts that relate to the care of the patient
  - The care provided in response to the adverse event
  - A synopsis of the disclosure discussion and the names of those people who were present – *do not document personal opinions*
  - The treatment and follow-up plan

“Report the incident to malpractice carrier”

- Risk manager should make this determination
- Risk manager should also inform the carrier when disclosure and apology have taken place
- If case has elements of clear-cut negligence, causation, and resulting injuries, risk manager can ask the malpractice carrier to do an expedited review

Institutional Resources

- "Disclosure Response Teams" – risk manager, administrators, patient advocates
- Routine live presentations by outside groups (Bayer Institute, other experts) – grand rounds
- Role-playing simulations for select groups
- Online programs as quick refreshers