# "We're Sorry"

## The healing power of apology—and how two little words could make medicine safer

ANYONE WHO'S EVER GIVEN or received an apology knows the words "I'm sorry" can have a healing effect. For a patient harmed by a medical error, an apology from caregivers can ease profound feelings of shock, grief, anxiety, hurt, and anger. An apology can shore up the foundation of any doctor-patient relationship: trust. Yet too often, doctors and their institutions don't express regret, or even explain what went wrong.

Lucian Leape, adjunct Professor of Health Policy at the Harvard School of Public Health (HSPH), is working to change that. This former pediatric surgeon, widely regarded as the leader of the patient safety movement, aims to make apology part of full-disclosure policies at hospitals nationwide—a critical step in reducing errors that kill an estimated 98,000 patients a year and injure far more. For Leape, apology in the face of a problem that could have been prevented is not only the right thing to do, it's a "therapeutic necessity."

Leape says patients need apologies before they can forgive and heal from the "emotional wound" inflicted by their new and unexpected injury. "Apologizing doesn't always work; sometimes the anger is too great," Leape says. "But healing can't begin without it."

This fall, 16 Harvard-affiliated teaching hospitals will start rolling out disclosure-and-apology training workshops for doctors, nurses, administrators, and insurance experts with funding from CRICO/RMF, the hospitals' joint malpractice insurer. The workshops will help the hospitals put into action work by a group of clinicians, patients, lawyers, and insurance company risk managers convened by Leape in 2004, whose recommendations resulted in *When Things Go Wrong*, a 42-page set of principles for crafting disclosure and apology policies.

Unanimously supported by the 16 hospitals, this slender document underscores health care providers' "ethical obligation" to report the whole truth, and nothing but—and to support victims of mishaps, as well as distraught caregivers. Since March 2006, when *When Things Go Wrong* was published online, each hospital has drawn up a disclosure-and-apology policy that reflects its unique culture. The guide has been "downloaded thousands of times and translated into several languages"—evidence, Leape notes, of an accelerating trend toward transparency in medicine. (For copies, visit www.macoalition.org.)

### THE MALPRACTICE FACTOR

Why is it so hard for physicians to apologize? Fear of lawsuits is a major factor. Lawyers and insurance companies have long warned against apologizing to avoid litigation, even though 34 states now prohibit a doctor's expressions of remorse, fault, or causality from being used in court as evidence of their guilt. Although errors attributed to individuals are "always a health systems problem," Leape says, patients "understandably blame the person who made the mistake, not the systems failure behind it."

No one knows what impact errors disclosure will have on malpractice litigation. To assuage insurers' concerns, Leape points to research linking poor communication with patients'

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## Will full-disclosure policies spur more lawsuits? A look at three studies.

How will patients respond to the open disclosure of medical errors? Will they sue hospitals and doctors more often? According to researchers who explored this question in the *New England Journal of Medicine* in June 2007, evidence to settle the debate is scant. Malpractice cases take so long to resolve, and factors affecting malpractice rates are so variable, that "the actual effect is not known, and will not be evident for years," say the authors, who include Thomas Gallagher, an expert on the doctor-patient relationship.

But advocates of full disclosure and financial compensation for patients, including HSPH's Lucian Leape, are optimistic. They view as encouraging findings by researchers in three states.

### NO RISE IN CLAIMS

The University of Michigan Health System-made up of hospitals, clinics, and the University of Michigan Medical School, in Ann Arbor—moved in 2001 to disclose the full details whenever patients are harmed by a medical error, and to provide compensation. Over four years, the frequency and costs of malpractice litigation sharply declined. Annual malpractice claims dropped by 50 percent, while litigation expenses fell from $3 million to $1 million (see graph at right).

Two other studies show little or no change in litigation. At the Veterans Affairs Hospital in Lexington, Kentucky, the volume of claims has stayed constant since a full-disclosure program with compensation—the nation's first—was adopted in 1990, according to Ginny Hamm, an attorney with the Office of Regional Council, in Lexington, who handles the hospital's malpractice claims.

Meanwhile, at Colorado hospitals insured by COPIC, the largest private insurer in the state, the number of claims has dropped for three years running, according to a COPIC physician-manager, Richert Quinn. COPIC's program is unusual in that it links transparent communication with patients about medical errors to no-fault compensation—up to $30,000 for out-of-pocket expenses and "loss of time." Average payments are just $5,400 per patient.

Quinn isn't ready to link malpractice declines to COPIC's innovative program, launched in 2000, noting that "there may be other factors" at play. But he affirms that it "hasn't had any deleterious effect on malpractice claims."

### COMPENSATION REQUIRED

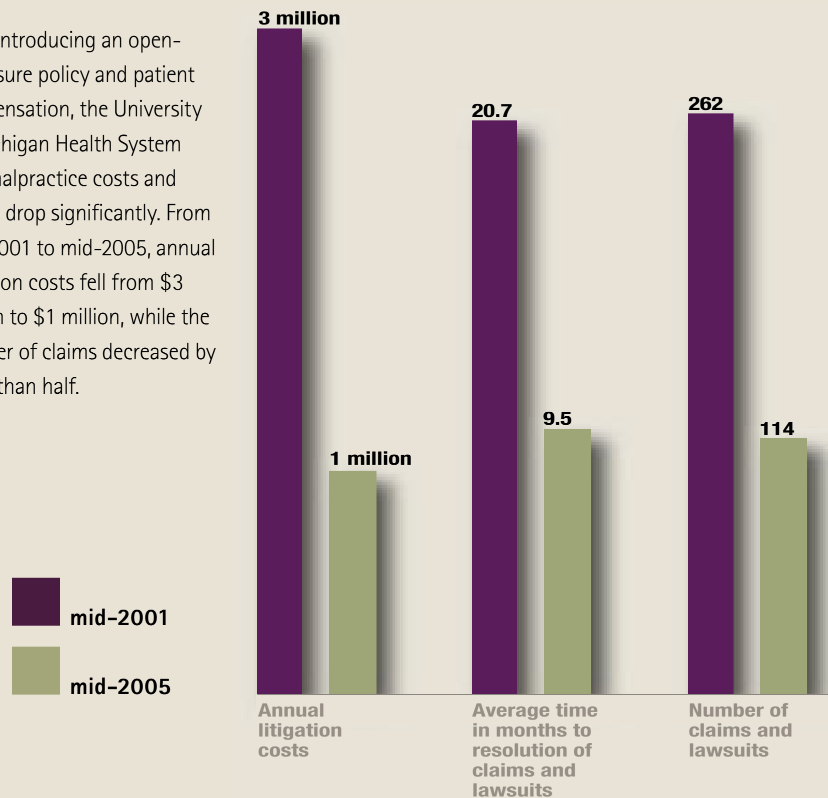
HSPH's Michelle Mello, the C. Boyden Gray Associate Professor of Health Policy and Law, is developing an alternative to the U.S. malpractice tort system that uses specialized health courts to settle injury claims. Mello predicts that unless patients who are harmed have some mechanism for receiving compensation, open disclosure will cause malpractice claims to rise. She points to results of a computer simulation that showed that the number of patients who would be deterred from suing would be dwarfed by the number who would be prompted to sue.

"In the current system, only about 2 percent of people injured by negligence file a suit," Mello notes. "So if even a small percentage more sue when they learn they've been injured by medical care, it could be costly."

Meanwhile, Leape and Mello agree, Harvard-affiliated hospitals' full-disclosure training workshops are "the right thing to do." For now, each hospital will address compensation issues with patients case by case. As one workshop leader, clinical social worker David Browning, notes, full disclosure might at least lower the huge settlements often sought in litigation. After all, he says, "It's harder to get angry at a doctor who's been caring and honest."

**WITH ERRORS DISCLOSURE AND COMPENSATION, MALPRACTICE CLAIMS DROPPED**

After introducing an open-disclosure policy and patient compensation, the University of Michigan Health System saw malpractice costs and claims drop significantly. From mid-2001 to mid-2005, annual litigation costs fell from $3 million to $1 million, while the number of claims decreased by more than half.



decisions to sue, as well as success stories in three states for hospitals that practice open disclosure and also provide compensation to patients for costs related to their injuries. In Colorado, there has been no change in lawsuit rates at COPIC, the state's largest insurer, which reimburses injured patients for lost time and expenses; nor has a veteran's hospital in Kentucky seen malpractice lawsuits increase. In Michigan, one health care system has seen a large decline over four years in both the incidence and the costs of litigation (see sidebar on page 10).

In talks around the country, Leape stresses that the patients most likely to sue are those who lose trust in their caregivers. "What we're trying to say to our brethren—physicians primarily, but also nurses, even insurance companies-is that how you handle these situations during the acute phase is absolutely crucial to how patients will handle them," he says.

"The first step is to say, 'You've had this happen, and we're sorry it did," Leape says. "Next is, 'Here's everything we know now, and what the future holds.' The third step is, 'We don't know how it happened, but we're going to conduct a full investigation and we'll keep you informed.' A formal apology follows if the investigation reveals an error or systems failure."

"As surveys and the great weight of anecdotal evidence tell us," he says, "all these measures help lessen the patient's anxiety."

### 'LEVEL WITH US'

Patient rights advocate Doug Wojcieszak seconds that. The founder of the Sorry Works! Coalition, a grassroots organization in Glen Carbon, Illinois, that champions errors disclosure and apology, Wojcieszak says most malpractice lawsuits are the product, not of greed, but of anger over a system that leaves patients and families feeling "abandoned."

In 1998, Wojcieszak's 39-year-old brother, Jim, died following a series of blunders after being hospitalized for cardiac distress. Doctors confused his chart with that of his father, whose own cardiac workup had been "perfect," Doug says. Mistakenly treated for a bacterial infection, Jim suffered three heart attacks in four days, all of which went undiagnosed—until the autopsy.

"We tell doctors, 'Look, we can live with mistakes as long as you level with us,'" Wojcieszak says. "We know from experience that it's not errors that drive lawsuits, it's lapses in 'customer service'—nurses were rude, no one returned phone calls. It's the sense that doctors are hiding that makes patients more likely to sue."

## 4 Steps to Full Communication

1. Tell the patient and family what happened.
2. Take responsibility.
3. Apologize.
4. Explain what will be done to prevent the error and systems failure from happening again.

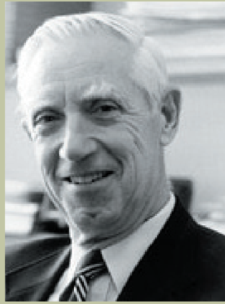
### EXPERIMENTAL HEALTH COURTS

Wojciezak and Leape say hospitals could eliminate most malpractice suits by reimbursing patients for costs incurred from their injuries, including lost time and out-of-pocket expenses. That approach is squarely at odds with current policy, however, at least in the United States. As it stands, patients' only recourse is to sue hospitals and doctors. "This only serves to increase their anger and the amount of money they try to extract from the system," Leape says. "We need to experiment with a new approach."

He points to promising research by Michelle Mello, the C. Boyden Gray Associate Professor of Health Policy and Law at HSPH, and her collaborators, who have proposed that states test a system similar to one in New Zealand. The proposal calls for patients to file claims with special "health courts" staffed by trained judges and neutral paid medical consultants. To receive compensation, patients would be required to show, not that health care providers were negligent, but that the injury would have been avoided in an optimal system of care. The compensation process would be faster, more reliable, and less adversarial than the current, lawsuit-based system. (For details, see "Malpractice Roulette" from the Fall 2005 issue of the Review at http://www.hsph.harvard.edu/review/review_fall_05/rvwfall05_malpractice.html and an August 2007 podcast with Mello at http://www.hsph.harvard.edu/multimedia/audio/2007/mello1).

### WORKSHOP FOR 'COACHES'

Another reason doctors have difficulty delivering bad news to patients? They've never been trained. *continued page 44*



**A CHAMPION FOR PATIENT SAFETY**

HSPH's Lucian Leape set the wheels for medical-errors disclosure and apology in motion in 1991 with a major study examining the root causes of medical malpractice cases in New York state hospitals. Based on the data, the Institute of Medicine (IOM) estimated that up to 98,000 Americans were dying annually from unanticipated "adverse events," including preventable errors—a missed diagnosis, for example, or the wrong medication.

In December 1994, Leape published a pivotal paper in the *Journal of the American Medical Association* (*JAMA*) titled "Error in Medicine", calling for medicine to apply the industrial model of systems redesign to prevent errors. Following reports that *Boston Globe* reporter Betsy Lehman had died tragically at the Harvard-affiliated Dana-Farber Cancer Institute from a chemotherapy overdose, Leape came into the spotlight that winter—and launched the patient safety movement. Unless errors were discussed openly and health systems were repaired, Leape argued, patients would continue to die needlessly.

In 1999, responding to his work, the IOM issued a landmark report on how hospitals evaluate the quality of their care. "To Err is Human: Building a Safer Health System" laid the groundwork for a drive toward full transparency and disclosure of medical errors. In 2001, the hospital accrediting organization known today as the Joint Commission set disclosure standards for adverse events. The nonprofit National Quality Forum, tasked with improving health-care-quality measurement and reporting, followed suit in 2006.

Through it all, Leape has served as a passionate spokesman for patients' safety and "right to know." Like adverse-event disclosure, he says, apology is "an idea whose time has come."

Most doctors are uncomfortable even explaining the circumstances surrounding complications that might have been avoided, says Charles MacFarlane, vice president for learning with Joint Commission Resources, an Illinois company that helps hospitals improve health care quality. "These are difficult conversations," he says. "Sometimes apologizing is a skill that has to be learned."

For caregivers overwhelmed by self-recrimination, discussing the problem can be hard. The workshops, sponsored by CRICO/RMF, is "to help institutions respond effectively and compassionately to patients, families, and clinicians," says David Browning, a clinical social worker involved in the effort. Browning is a senior scholar at the Institute for Professionalism and Ethical Practice (IPEP), a Children's Hospital-based initiative that helps clinicians communicate with patients about subjects that include organ donation, wrenching end-of-life choices, and medical errors. He will be partnering with Robert Truog, who directs both IPEP and clinical ethics at Harvard Medical School.

Participants will act out scenarios in which professional actors play injured patients and family members. Each half-day workshop will engage up to 25 people, who will take turns in various roles while the rest observe. "A scenario might begin with a clinician being notified that an error has occurred," Browning explains. "It will progress to the conversations he or she will have with the physicians and nurses involved, helping them to prepare for the disclosure, then finally to the disclosure and apology." Participants will serve as coaches at their own hospitals, advising others during preventable, real-life "adverse events," be they a drug overdose, wrong-site surgery, or equipment failure.

"Communicating errors is like anything in medicine," says HSPH alumnus Ken Sands, MPH 1993, senior vice president for health care quality at Harvard affiliate Beth Israel Deaconess Medical Center (BIDMC). "Some situations require expert assistance, and trained coaches must be available to provide this at all times." In the case of BIDMC, workshop participants will be drawn from a communications team created in 2006 to guide hospital clinicians in errors disclosure.

## SETTING THE STANDARD

What will be the impact of this whole effort? Leape hopes more health systems will adopt full disclosure and apology policies. He and other safety advocates in Boston, including CRICO/RMF, will pay close attention to how patients respond. CRICO/RMF representatives will keep an eye on malpractice trends, but say lawsuits are so few and slow to resolve, involving factors so complex, that changes may not emerge for years.

Openness, humility, conceding medicine's imperfections—these are "new concepts in health care," Leape observes. For years, risk managers pointedly have argued against full, open communication, apology, and restitution when treatment turns injurious. Now, change is clearly happening, he says, and for good reason: "We're saying, it's time to do what we've always known was right."

*Charlie Schmidt has written about public health and environmental health for* Environmental Health Perspectives, Science, National Geographic Online, Discover, *the* Washington Post, *and other journals and media outlets.*