

## Removing Insult from Injury—Disclosing Adverse Events

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### Perspective

You pull into a parking space, swing open the car door, and are dismayed to hear it hit the car next to you. What is the first thing that you do? Here are two possible answers—look around to see if anyone else saw what happened, then rub the scrape with your thumb to see if you can make it go away. Or perhaps you slide a detailed note under the windshield wiper including an apology, your name, phone number, and insurance information. So, which one sounds more familiar?

Despite the best of intentions, it is tough to admit a mistake. In the more consequential world of medicine, we realize that we need to tell patients, or their families, about adverse events. We learned this in medical ethics, and we know in our hearts that it is the right thing to do.<sup>(1)</sup> Still, we dread the conversations. We have a vague but disturbing recollection of the phrase, "Anything you say can be used against you." What a great relief it would be if someone whispered to us, "Don't worry, you don't have to tell the patient." Like the dented car, nobody saw the scrape—just rub off the paint and get back to your important business. Worse, we don't even know what to say. Most of us have no training in how to handle this scary and potentially explosive conversation. What do you do if the person becomes hysterical or enraged? How to even get the conversation started?

The bottom line is that most patients are never told that they have been the victim of a medical error.<sup>(2)</sup> However, patients generally want to be informed about even minor errors in their care, especially if they are injured.<sup>(3,4)</sup> Ironically, perhaps the most common reason patients sue is they felt it was the only way they could get information about what happened.<sup>(5)</sup> The patient who later learns about what happened and suspects a "cover-up" is likely to become much more upset and angry than he or she would have been after a straightforward explanation and apology.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) now requires that patients be informed about adverse events. Institutions have adopted policies to follow suit. Since 2001, our institution has specified that, "It is the right of the patient to receive information about clinically relevant medical errors," and that "the Johns Hopkins Hospital has an obligation to disclose information regarding these errors to the patient in a prompt, clear, and honest manner."

So, how to do it? We recommend a simple, four-step approach: (i) tell the patient what happened, using plain language; (ii) accept responsibility on behalf of the institution or yourself, as appropriate; (iii) apologize; and (iv) describe the next steps, including what will be done for the patient, and what will be done to prevent similar events in the future.

I believe that the apology is mandatory. It is both the right thing to do and what patients expect of us. The common belief that apologizing increases the risk of a malpractice suit is probably not true; in fact, there is a fair bit of anecdotal evidence to the contrary.<sup>(4,6,7)</sup> Following implementation of a full disclosure policy at the Veterans Administration Hospital in Lexington Kentucky, there was a swell in the number of settlements, but a steep drop in total payouts.<sup>(8)</sup> The University of Michigan Health System and our own institution have also seen reductions in legal costs following adoption of disclosure policies. A recent newspaper article, entitled "Doctors' new tool to fight lawsuits: saying 'I'm sorry'," described how a patient who received an apology dropped her plans to sue.<sup>(9)</sup>

We have developed a series of video vignettes, each of which depicts a physician disclosing an adverse event to a patient. We have shown these videos to volunteers and asked them what they thought about the discussions and the doctors. I asked a woman what she thought of a vignette in which a surgeon is very slow to respond to urgent pages, precipitating an emergency for a pediatric patient. She promptly replied, "I'd sue [him]!" I asked, "What would it take for you not to sue him?" She thought for a moment, and then responded, "He'd have to apologize and apologize, call me at home that evening and apologize, and call me the next day and apologize. Then maybe I wouldn't sue him."

There is now legislation in many states ([Table](#)) that attempts to protect apologies by making them inadmissible as evidence to prove liability in court. Most of the laws make inadmissible expressions of sympathy and regret after an adverse event. A few, beginning with Colorado's apology law, provide stronger protections, excluding from evidence even apologies that include an admission of fault. As more and more bills are being introduced related to apologies, perhaps this will help temper the defensive-medicine instinct to avoid "self-incrimination." The way I figure it, apology is cheap. It is certainly true that if you disclose an adverse event to a patient that had previously been unrecognized, you may be sued. For these cases, you are still obliged to tell the patient on ethical grounds. However, for an adverse event that the patient is already aware of, there is every reason—both ethically and pragmatically—to apologize.

We have produced a 25-minute educational video that features the vignettes mentioned above and describes how to conduct the initial disclosure of an adverse event.<sup>(10)</sup> It opens with one mother describing the tragic death of her baby daughter at Johns Hopkins Hospital. She discusses how well the disclosure discussions were handled by the chairman of the pediatrics department. "Johns Hopkins did the right thing. They told us exactly what went wrong, they apologized, and they said that they would fix the problem." Moved in part by this experience, she has become a tremendous advocate for patient safety, both at our institution and nationally, donating countless hours to our collective efforts to prevent medical errors.

When done well, full disclosure, coupled with an appropriate apology, probably prevents lawsuits, engages the patient or family members as allies in the fight to improve patient safety, and feels good. We have found that the momentary relief that some providers feel when they "leave the scene of the accident" is often followed by years of lingering guilt. Take advantage of the resources that are available to learn to

apologize, and then just do it. You'll feel better knowing that you did the right thing.

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#### **Table. States with Legislation Protecting Apology from Admissibility to Prove Liability**

**Excludes from admissibility expressions of sympathy**

California, Florida, Louisiana, Massachusetts, Montana, Oregon, South Dakota, Tennessee, Texas, West Virginia, Wyoming

**Excludes from admissibility  
expressions of sympathy and  
accountability**

Arizona, Colorado, Georgia, Illinois, Maine, Washington