



Acknowledging and Apologizing for Adverse Outcomes

(Adopted 2007)

The Institute of Medicine, in its 1999 report, *To Err is Human: Building a Safer Health System*, declared that preventable adverse events are a leading cause of death in the United States. The report estimated that more than one million preventable adverse events occur each year in this country and 44,000 to 98,000 people die in hospitals annually as a result of medical errors.¹

Americans responded to this report by initiating efforts to reduce medical errors. The patient safety movement has focused on redesigning systems, implementing safe practices to prevent accidental injury, and establishing medical error reporting systems. Because the complete elimination of errors in medical treatment, although highly desirable, is an unattainable goal, attention is also being paid to the way institutions and caregivers respond when injuries occur.²

Disclosing Errors

The Joint Commission set new standards in 2001 requiring the disclosure of outcomes of care, including those that were not anticipated, to hospitalized patients and their families.³ A number of states have passed laws requiring that patients be informed about unanticipated outcomes⁴ and many institutions, including the Department of Veterans Affairs, require facilities and providers to disclose adverse events to patients who have been harmed in the course of their care.⁵

Disclosure is commonly defined as a prompt, truthful, and compassionate explanation of how the injury occurred, its short- and long-term effects, remedies available to the patient, and steps - developed following an analysis of the root cause of the error -- that will be taken to prevent its recurrence.⁶

Disclosing medical errors respects patient autonomy and truth-telling, is desired by patients, and has been endorsed by many ethicists and professional organizations.⁴ According to the "Guidelines for Ethical Conduct for the Physician Assistant Profession," PAs "should disclose errors to patients if such information is significant to the patient's interests and well being. Errors do not always constitute improper, negligent or unethical behavior, but failure to disclose them may."⁷

Apologies

Many people believe that disclosure is incomplete without an apology. An apology is an acknowledgment of responsibility together with an expression of remorse. There is an important distinction to be made between apologies and expressions of consolation. When a patient experiences an unfortunate outcome that is not the result of provider error, it is appropriate to offer consoling comments, such as "I am sorry for what

happened.” An apology, on the other hand, is necessary when the health care provider has harmed the patient physically or psychologically through behavior that could or should have been avoided.⁸

At least two factors appear to hinder acknowledgment and apology for medical errors - fear of litigation and the culture of medicine.^{4, 9, 10} Lawyers and risk managers have routinely advised health care providers not to admit responsibility or apologize,^{2, 4, 11} but evidence suggests that liability costs can be reduced by full disclosure and apology. Programs of disclosure and apology at the Lexington (Kentucky) Veterans Hospital, the University of Michigan Health System, John Hopkins, and Children’s Hospitals and Clinics in Minneapolis, among others, have resulted in dramatic reductions in legal expenses.¹²

At the Lexington VA facility, during a seven-year period, the hospital’s average payout was \$16,000 per settlement, versus the national VA average of \$98,000 per settlement, and only two lawsuits went to trial during a ten year period.¹³ Expenses and lawsuits were similarly affected in Minnesota, where Children’s Hospitals and Clinics of Minnesota reduced the number of lawsuits by half. This is striking because of the hospital’s high liability exposure (many young patients) and the fact that Minnesota is a state that does not have a cap on claims.¹³

Experts say that breakdowns in the provider-patient relationship - not communicating honestly or completely, for example - were at the root of nearly 75 percent of malpractice claims filed against physicians.¹⁴ One study showed that of those pursuing medical negligence claims, 91 percent reported that a desire for an explanation was the reason for the legal action.⁹

When providers explain to patients what went wrong, accept responsibility if they are at fault, and apologize, the likelihood of a malpractice claim being filed drops dramatically.¹⁵

To counter the perceived risk of increased liability, a number of states have adopted or are considering apology laws that exempt expressions of regret, sympathy, or compassion from being considered as admissions of liability in medical malpractice lawsuits.¹⁶ Federal legislation has also been drafted that promotes medical error reporting, disclosure to patients, apology, and, in cases when the standard of care is not met, offers of compensation. This legislation is based on the principles of The Sorry Works! Coalition, which believes that full disclosure addresses the root cause of the medical malpractice crisis better than any other approach currently under consideration. According to the coalition, Sorry Works! restores the provider-patient relationship and improves the communication and trust between all parties, thus reducing the filing of non-meritorious claims and saving on legal expenses.¹³ While the coalition believes that legislative action or mandates are not necessary preconditions for implementation of a full disclosure program, others prefer the security provided by legislation that reduces liability.

Many articles have been written about the current “culture of medicine” that bestows an aura of infallibility on physicians and other health care providers and makes it extremely difficult for an open discussion of mistakes to occur. This culture only compounds the already emotional reaction that occurs when one makes a mistake, such as feelings of guilt and embarrassment, sorrow over causing pain to others, and fear of humiliation.¹¹

Because patients are not the only ones who are hurt when mistakes occur, changes must be made in education. Students should be taught that it is appropriate to acknowledge mistakes and essential to apologize to patients. Changes must be made in practice that help health care providers deal openly with the anguish and sense of culpability that accompany medical errors. Health care professionals should have an opportunity to move toward self-forgiveness and healing by talking with peers, trusted friends, spouses, and counselors rather than to suffer from continued guilt and depression. Morbidity and mortality conferences should not be the only venue where bad outcomes are examined and acknowledged. Patient safety experts recommend that institutions provide better support and programs for caregivers involved in such incidents, but the culture must change in all settings, not just hospitals. The current societal and professional climate needs to evolve to a better acceptance of mistakes as an inherent part of medicine, in order to encourage truth-telling.¹¹

Conclusion

Stemming the causes of medical errors requires disclosure and analysis - a transparency and openness of communication that are currently missing in health care today. Rather than foster an adversarial relationship between patients and providers, we should strive for changes that will decrease medical errors, litigation, and escalating insurance premiums. We should seek changes that will increase the availability of providers willing to perform high risk, life-saving procedures, a culture that acknowledges human fallibility, and a system that rewards honesty.

The American Academy of Physician Assistants believes that patients deserve complete and honest explanations of adverse outcomes and apologies for medical mistakes. The AAPA also supports changes in law that encourage PAs and other health care providers to apologize without incurring increased personal liability.

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