# YOU CAN SAY SORRY

**Jane Feinmann** assesses initiatives that challenge the idea that doctors cannot afford to apologise when something goes wrong

"To err is human; to cover up is unforgivable." So said England's chief medical officer, Liam Donaldson, at the World Health Organization's world alliance for patient safety in 2004. In doing so he put an authoritative stamp on growing recognition that open and honest communication with patients and families after an adverse incident is the right thing to do—and the safest.

Despite widespread support for "open disclosure" (also known as duty of candour), along with growing public appetite for "revelation, discussion, and resolution,"[1] some are concerned that doctors' behaviour has changed little in the aftermath of an adverse incident. In the United Kingdom, the "being open" policy of the National Patient Safety Agency (NPSA) was welcomed when it was introduced in 2005.[2] The policy requires trusts to provide information, support, and training to encourage doctors to give patients a full explanation and apology when health care goes wrong.

But a 2007 review by York University reported that the policy had made slow progress.[3] In October 2008 an assessment of the policy's impact delivered to the National Patient Safety Forum, a group of senior representatives from key organisations, appointed in 2006 as the "national conscience" of the agency, concluded that the policy had had little effect: of fewer than one in three doctors who responded to a survey in 2008, only 64% "held favourable attitudes towards the policy."[4] Open disclosure, however, is an achievable goal, with a range of initiatives worldwide challenging the belief that doctors cannot afford to say sorry.

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### Litigation and disclosure

The link between open disclosure and risk of litigation is widely considered the biggest barrier to transparency. The 2008 National Patient Safety Forum study, for instance, reported that although UK defence organisations say that they are in favour of open disclosure, they still respond to a call from a doctor by "emphasising avoiding litigation rather than being open."[4]

But evidence over two decades shows that open disclosure reduces litigation costs, often considerably.[5] In 1987 after it lost large sums of money fighting two lawsuits that turned the doctors and patients concerned into bitter enemies, the US Lexington Veterans' Affairs Medical Center made a decision to investigate all cases where a medical error was suspected and to turn over evidence of mistakes to the injured patient.

A high standard of disclosure was set. For example, hospital officials insisted on disclosing the results of an investigation that showed that medical errors had hastened the death of a woman whose relatives thought the death was from natural causes. The relatives were advised to retain legal counsel and were called to a meeting where the hospital "apologised, admitted fault, explained what had happened, and discussed compensation."[5]

The financial wisdom of this policy soon became evident. In 1994 Lexington was "in the top quarter for total claims—because they were disclosing so much—but in the bottom quarter for total payments."[5] In 2000 Lexington's mean payment was $36 000 (£22 000; €25 000),[6] compared with the mean national malpractice judgment of $413 000 for veterans' hospitals. Not surprisingly, implementation of a disclosure programme became mandatory at all facilities of the Department of Veterans' Affairs in 2005.

### Recognise, respond, resolve

Other organisations followed this example. Copic Insurance, the largest medical malpractice insurer in Colorado, began to promote open disclosure in 2000, setting up the 3Rs programme (recognise, respond, resolve) as "an alternative to traditional tort and its accompanying destruction of the doctor-patient relationship," explained Richart Quinn, Copic's medical director and risk manager.

Before 2000, doctors responsible for an adverse event were "in effect encouraged by insurers, mentors, and others to practice a form of denial, behaviour that was accentuated by the legal environment . . . with patients often left with feelings of abandonment, frustration, and anger," Quinn reported in *Clinical Obstetrics and Gynecology* in 2008.[7]

Participation in the 3Rs programme is voluntary for insured doctors out of concern that compulsory enrollment could create "a group of non-willing members with a negative attitude," says Quinn, "although it's an issue we revisit from time to time." Of the two out of three of its members who now practice open disclosure, malpractice claims have been cut by half, with settlement costs reduced by 23%,[5] and the programme, according to the *New England Journal of Medicine*, is bringing about "a transformation in how the medical profession communicates with patients about harmful medical errors."[8]

### Sorry works

Such success stories are widely quoted by the consumer led campaigning organisation Sorry Works! as proof that open disclosure could be the solution to the United States' much debated crisis in medical malpractice. "Patients don't file malpractice lawsuits because they're greedy," the organisation's founder, Doug Wojcieszak, wrote in a recent editorial for Sorry Works![9] "They do it because they get so angry when communication, honesty, accountability, and literally good customer service are lacking after a perceived error: the doctor abandoning the family; the hospital administration promising investigations and meetings and never following through."

Wojcieszak founded the organisation in 2003 after his family had to sue to discover the truth about the medical errors that led to his brother's death during open heart surgery in 1998. In 2005 he set up the Sorry Works!

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coalition with two healthcare lawyers, James Saxton and Maggie Finkelstein, from the law firm Stevens & Lee. They wrote a book and provide training programmes for many hospitals, insurers, and large medical practices.[5]

A key message is the distinction between sorry as an expression of empathy and sorry as an acceptance of responsibility or admission of fault. Both may be appropriate, says Wojcieszak, but "the former should be a routine response to an unanticipated complication, while the latter must be reserved for the particular circumstance where an investigation by appropriate medical experts, risk managers, and lawyers has established fault."

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Such a policy has enabled the University of Michigan Health System to cut lawsuits by half and reduce litigation expenses by two thirds, with total average annual savings of $2m.[5] This has been achieved on the basis of a policy of a quick and fair apology with compensation where harm is found to have been done—while medically appropriate care is vigorously defended.

Yet the crucial factor in successful open disclosure may be the importance attached to making the experience therapeutic for all concerned. Not least here is the "second victim" of medical errors, the treating doctor, who, evidence shows, is at risk in the long run of "being deeply wounded, losing their nerve, burning out, or seeking solace in alcohol or drugs."[10]

### Open disclosure in Queensland

The Australian National Open Disclosure Programme became mandatory in the state of Queensland for all severe adverse events in 2008 initially for the practical reason that the population is predominantly rural and has no choice about which hospital to attend. "Following a catastrophic event, something was needed to restore trust between the patient and the hospital, and open disclosure fitted the bill," said Jillann Farmer, medical director of Queensland's Patient Safety Centre. But with the mandatory programme in place the priority has been to create a supportive system for all concerned, with the view taken that a meaningful and sincere apology is best delivered by the organisation rather than the doctor.

"Nobody expects a doctor to walk alone into a ward full of patients who have been badly hurt in a car crash; and we believe doctors facing patients badly harmed by the healthcare system have the same need for multidisciplinary support," says Farmer. Instead, throughout the programme the treating doctor is accompanied, often literally, by one of 300 part time open disclosure consultants, senior doctors or nurses who have received the training in this specialty.

The state's most expensive investment is high quality simulation training for these consultants. Professional actors improvise characters based on real cases. "Clinicians are hungry for this type of training. It's not infrequent for trainees to cry or need to leave the simulation. Yet it is regularly described as the best ever experienced," she says.

The investment pays off at the pivotal interaction in open disclosure, the meeting between the doctor and patient. This is often "heart rending and emotionally exhausting," where anger is normal and nobody can predict exactly what will happen. With patients having "very well tuned bullshit sensors," as one senior medical manager puts it, sincerity is essential. But the simulation training allows the clinicians to focus on "communication, connecting with the victim, producing dialogue, a response."[1]

"The moment when the patient truly understands that they are being listened to, that we really understand and care, is extraordinarily powerful," says Farmer. "People are so used to medical discussions being completely objective that being present to hear clinicians expressing deep emotion brings a giant leap forward in restoring trust."

### Safer medicine

The evidence suggests that open disclosure has far more than mere economic advantages, being a direct route to safer health care, says Albert Wu, an epidemiology professor and expert in open disclosure at Johns Hopkins Bloomberg School of Public Health. "Informed patients are likely to be more engaged in efforts to prevent prevent errors occurring while practitioners are more likely to make improvements, with better incident reporting and more information provided to managers on a regular basis."

In the UK efforts to kick start open disclosure continue. The NPSA is planning a relaunch of its "being open" policy. The Department of Health is also considering making duty of candour a statutory requirement for all healthcare organisations that register with England's new Care Quality Commission. "Such a move could transform the extent to which patients can expect to hear the truth after an adverse incident," said Peter Walsh of the campaigning group Action against Medical Accidents.

Yet the obstacles to open disclosure should not be underestimated. A persistent barrier at the professional level, according to a recent review, is "a lack of understanding of the real purpose of open disclosure and what the needs of clients are [with doctors] viewing it as an opportunity to discuss interesting cases."[11] Another recent study warned that litigation apart, doctors fear that making their mistakes public will damage their reputations and that they will lose referrals as well as the respect of peers and colleagues.[12] Overcoming such obstacles might indeed require "fundamental changes to organisational culture."[11]

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