After medical error, apology goes a long way

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Credit: Anne Lowe/public domain

In patient injury cases, revealing facts, offering apology does not lead to increase in lawsuits, study finds

Sometimes a straightforward explanation and an apology for what went wrong in the hospital goes a long way toward preventing medical malpractice litigation and improving patient safety.

That's what Michelle Mello, JD, PhD, and her colleagues found in a

study to be published Oct. 2 in *Health Affairs*.

Mello, a professor of health research and policy and of law at Stanford University, is the lead author of the study. The senior author is Kenneth Sands, former senior vice president at Beth Israel Deaconess Medical Center.

Medical injuries are a leading cause of death in the United States. The lawsuits they spawn are also a major concern for physicians and health care facilities. So, hospital risk managers and liability insurers are experimenting with new approaches to resolving these disputes that channel them away from litigation.

The focus is on meeting patients' needs without requiring them to sue. Hospitals disclose accidents to patients, investigate and explain why they occurred, apologize and, in cases in which the harm was due to a medical error, offer compensation and reassurance that steps will be taken to keep it from happening again.

Positive results

The study reports on the outcome of a so-called communication-and-resolution program at two large Massachusetts hospital systems. Mello and her co-authors found that the program not only yielded positive results in terms of liability costs but also led to significant patient safety improvements.

"In these programs, hospitals scrutinize every serious harm event to answer the question, 'What can we learn?'" Mello said. "Traditionally, a risk manager's focus has been on the patients who complain about the care or threaten to sue. But every patient deserves to know that what happened to them is being taken seriously."

Despite concerns that telling patients about errors and proactively offering compensation could cause liability costs to skyrocket, of the 989 adverse events reviewed for the study from 2013 to 2015, only 5 percent led to malpractice claims or lawsuits. And when the program did lead to compensation, the median payment was $75,000. By comparison, the median payment nationwide in 2015 when plaintiffs prevailed in malpractice lawsuits was about $225,000, Mello noted.

"Our findings suggest that communication-and-resolution programs will not lead to higher liability costs when hospitals adhere to their commitment to offer compensation proactively," the authors wrote.

Pilot program

The authors focused on a program called CARe—Communication, Apology and Resolution—at six Massachusetts hospitals: Beth Israel Deaconess Medical Center and Baystate Medical Center, and two of each center's community hospitals.

The hospitals demonstrated good adherence to the program protocol, the authors found. Physicians were supportive of the approach, but did ask for better communication about the program and what was happening with their patients.

The low percentage of events that led to litigation should reassure hospitals concerned about the risks of being honest with patients, the authors wrote. A likely explanation, according to Mello, is that explaining why adverse events occurred defused patients' anger. About three-quarters of the time, adverse events were not actually due to error, the study said. Rather, malpractice claims frequently arise when plaintiffs perceive that the health care providers communicated poorly or attempted to cover up negligence, the authors noted.

"Given the rarity with which communication-and-resolution events resulted in settlements, it is reasonable to wonder whether the programs are worth the time they require," the authors wrote, "but risk managers in our study thought they were. By providing explanations and expressions of sympathy for harms not arising from negligence, communication-and-resolution programs may avert lawsuits springing from misunderstanding."

Objectives and improved safety

The CARe objectives are to improve transparency surrounding events, improve patient safety, reduce lawsuits and support clinicians in disclosing error or injury.

Medical events were bumped to a CARe evaluation if they met a severity threshold of either causing permanent or temporary harm that led to an extended hospitalization, required an invasive procedure or led to at least three outpatient visits.

Of the 989 total events studied by the authors, 60 of them entered the CARe program because the hospital received notice that the patient intended to sue. Another 929 entered the program when an adverse event was reported that allegedly exceeded the severity threshold, or that met other criteria.

The protocol called for compensation to be proactively offered whenever a violation of the standard of care caused serious harm. Only 9 percent of cases met these criteria. The largest payment made was $2 million. In 181 events, mostly events for which compensation criteria weren't met, hospitals offered to waive medical bills or made other modest gestures, like giving the patients meal vouchers and gift cards. About three-quarters of injuries didn't qualify for compensation because the standard of care was judged to have been met—a proportion that is

consistent with prior studies of medical injuries. About a third of the injuries weren't caused by the medical care: For example, a patient contracted an infection in the hospital but died from other causes.

"These programs are usually talked about as a way to resolve cases of medical error, but what they do more often is encourage communication with patients about non-error events—as well as systematic evaluation of each event for patient-safety lessons," Mello said.

The authors also noted that communication-and-resolution programs "can help hospitals foster a culture of transparency by supporting clinicians in making disclosures."

The safety interventions identified in the CARe investigations included new labeling for high-risk medications, color-coded socks for patients at risk for falls, radio frequency identification tags for surgical sponges, improved interpreter services, improvements for managing the selection of implantables after surgery, and a multidisciplinary checklist for breech deliveries.

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