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On Patient Safety

On Patient Safety: Do You Say "I'm Sorry" to Patients?

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You have just made a mistake in the operating room. Maybe you fractured the femur during a hip replacement. Maybe you accidentally lacerated the ulnar nerve during a difficult elbow procedure. Maybe your hand slipped over the exposed spinal cord and there was a contusion. You finish the operation without further incident, but obviously the patient would have been much better off had the unplanned event not occurred. Whatever happened, it will result in a prolonged healing course (at best), perhaps even a permanent deficit. What do you say to the patient and family? Obviously, you communicate the events that occurred and how this will affect the care. But do you say, "I'm sorry"?

At some point in your career you might have been advised to choose your words carefully when discussing an unanticipated event or outcome. You might have even been advised to refrain from saying the words "I'm sorry." What is the effect of saying or not saying "I'm sorry"?

For the person apologizing, "I'm sorry" can have several different meanings. It can be an admission of fault: "I'm sorry I made this mistake and caused this harm." It can be an expression of sympathy without fault: "I'm sorry that this pulmonary embolism occurred after your hip replacement; we took steps to try to prevent it, but these clots can occur despite those steps." Or it could also be an expression of neither fault nor sympathy: "I'm sorry you feel that way, but I do not agree."

The long-standing concern for physicians has not been what an apology implies, but how it may be interpreted. For many physicians, the fear is that regardless of the context, it will be viewed as an admission of fault and subsequently an invitation for legal action. As a result, many physicians are hesitant to use these words to express sympathy when adverse events occur [1].

Recently, there was a push for states to adopt apology laws. Under these laws, a physician's apology to a patient or family cannot be used against that physician in future litigation. Many states have apology laws, but they vary. Some states like Colorado and Washington will protect an apology of fault [8], while others may protect an apology that expresses sympathy, but not fault. The drive behind these laws was to promote and protect open communication. By rendering an "I'm sorry" statement inadmissible in court, the idea was that this protection would promote better, more-transparent communication with patients.

The reality is that these laws offer limited protection for the physician. If I say, "I'm sorry that I made this error that caused you harm", apology laws

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in the best-case scenario will only protect that statement. It does not protect against the actual event or actions that led up to the error. While the statement of apology may be inadmissible in court proceedings, certainly the facts surrounding the event are not. Therefore, if a patient is determined to sue, the inadmissibility of a single apology statement is a small hurdle to overcome. While these apology laws may have been well intended, the reality is they provide limited legal protection against a determined plaintiff.

While the apology law may not necessarily provide extensive legal protection, the sincere apology often goes a long way with patients. Dr. Tom Gallagher, Professor and Associate Chair of the Department of Medicine at the University of Washington has published extensively on disclosure of adverse events in medicine [4–6] and spoke with *CORR*® on the issue.

"It is clear from the literature that being clear with patients overall makes it less likely they will sue you," Dr. Gallagher told *CORR*®. "When you look across populations of patients, apologizing makes it less likely that patients will sue you, and it makes it easier to resolve those lawsuits that do get filed."

This is certainly no guarantee, but studies have suggested that full disclosure to patients is associated with lower likelihood of changing physicians, higher satisfaction, greater trust, a more positive emotional response, and less support for sanctions against the physician [7, 9]. The University of Michigan "open disclosure with offer" approach to patient injuries and malpractice claims was implemented in 2004 and has resulted in dramatically decreased costs associated with liability, compensation, and legal fees [2].

From a risk-management perspective, where success may be measured in dollars paid out in liability, compensation, and legal fees, it may be tempting to game the system. In cases where obvious errors are made, it may be financially advantageous to apologize and compensate instead of the prolonged denial and defend approach. However, in cases with less-obvious errors, it might be financially advantageous to not be so candid in terms of disclosure. Why invite the possibility of litigation or settlement with an apology if it is likely the patient, unaware of an error or event, will not sue in the first place? From a risk management and financial perspective, it might be tempting to cherry pick when to be forthright and transparent, and when to stay mum.

However, this kind of selective approach betrays the core foundation of the physician-patient relationship. One of the most precious commodities that physicians have is patient trust. More so than a client in any other industry, patients trust their surgeons. A cherry-picking approach to disclosure prioritizes liability protection above that relationship of trust. If we lose that trust, we lose our ability to care for our patients. Furthermore, if we choose to apologize, we shouldn't do so as a means to an end. We should do so because we sincerely sympathize with the patient's situation. The sympathy, sincerity, and transparency are critical components of the physician-patient trust.

While nobody wants to deal with a lawsuit, the emphasis should not be on how we deal with payouts on the back end, but avoiding these situations on the front end. Discussion of an adverse event with a patient should ideally focus less on risk management and more towards quality and safety improvement so that these events are not likely to occur again, Dr. Gallagher told me in a phone interview. Disclosure of these adverse events to the patient is often a first step for quality improvement.

According to Dr. Gallagher, there are three major components to optimally communicating adverse events to patients:

- **Communication of information**. What happened? How did it happen? Were there factors that made it more likely for this event to occur?

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- **Emotion handling**. Acknowledgement and validation of patient's and family's emotional response. Sincere expressions of sympathy and regret and possibly apology, if appropriate.
- **Followup**. Continued discussions on how the event occurred and how it can be prevented in the future. If there is clear fault, consideration of proactive resolution programs including proactive compensation. Generally, this is within the purview of risk management and not necessarily the physician directly.

Additionally, the Agency for Healthcare Research and Quality [1] has recently introduced the Communication and Optimal Resolution (CANDOR) toolkit on its website. The CANDOR toolkit can be used by hospitals and providers to expeditiously respond to adverse events and errors in a forthright and transparent manner. Although we don't yet know, I believe this toolkit will improve physician-patient communication and ultimately decrease litigious behavior.

"Discussion of adverse events leads to a culture of greater openness and transparency, which allows identification of errors and improvement of care," Dr. Gallagher said. "Organizations will get sued less because they are making less errors."

But going back to the original hypothetical: Should you say "I'm sorry" after a surgical error? I am reminded of Robert Fulghum's bestseller, *All I Ever Really Needed to Know I Learned in Kindergarten*—"Say you're sorry when you hurt somebody" [3].

Physicians and patients may be better off if we do.

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