When things go wrong: apology and communication

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To err is human
Apology and communication position statement

To err is human. Mistakes are part of the human condition. Health care providers, being human, make mistakes. The way they approach their mistakes is what matters most.
“In the beginning, all I wanted were answers. If someone had just talked to me, none of this ever would have happened.”

Danielle Bellerose
Apology and communication

“If they aren’t telling me the truth about this, what else aren’t they telling me the truth about?”

“It’s amazing how a doctor can alter your emotions... to reach out and connect in human terms.”

“Time heals, but it doesn’t heal when there are so many questions that have not been answered.”

“Incomplete communication actually created more stress and more concern.”

“The most overwhelming emotion I felt was isolation.”

CRICO/RMF 2006 Film: “When things go wrong: Voices of patients and families”

Apology and communication process

Why → When → Who

What → How → Next Steps
Apology and communication

Why

- Fear of inciting a lawsuit
- Fear of tough conversations
- Fear of vulnerability
- Uncertainty of what to say/not to say
- Waiting for a full investigation
- Waiting for a lawsuit
- Lack of leadership support

Not

Patients and families hire attorneys because of a lack of information and feelings of betrayal and mistrust
“Full disclosure is the right thing to do. It is not an option; it is an ethical imperative.”

Lucian Leape

MMIC position:

Timely and meaningful communication between providers and patients is imperative when an adverse outcome occurs.
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- It’s the right thing to do
- It’s our moral and ethical obligation
- It’s our professional responsibility
- It’s a requirement of The Joint Commission
- Patients want and expect it
- Part of the healing process

- Preserves the patient relationship
- Improves patient satisfaction
- Increases trust in the physician and organization
- Results in a more positive emotional response
- Probably reduces patients seeking legal remedy

K. Mazor, Health Plan Members’ Views about Disclosure of Medical Errors
Annals of Internal Medicine, March 16, 2004
Doing the right thing

Organizations are discovering the power of transparency

**Annals of Internal Medicine**

**Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program**

Allen Kochalski, MD, JD; Samuel R. Kaufman, MA; Richard Boothman, JD; Susan Anderson, MBA, MPA; Kathleen Welch, MS, MPH; Smita Patel, MD, MPH, and Mary A.M. Rogers, PhD

**Background:** Since 2001, the University of Michigan Health System (UMHS) has fully disclosed and offered compensation to patients for medical errors.

**Objective:** To compare liability claims and costs before and after implementation of the UMHS disclosure-with-offer program.

**Design:** Retrospective before-after analysis from 1995 to 2007.

**Setting:** Public academic medical center and health system.

**Patients:** Inpatients and outpatients involved in claims made to UMHS.

**Measurements:** Number of new claims for compensation, number of claims compensated, time to claim resolution, and claims-related costs.

**Results:** After full implementation of a disclosure-with-offer program, the average monthly rate of new claims decreased from 7.03 to 4.52 per 100,000 patient encounters (relative risk [RR] 0.64 [95% CI, 0.64 to 0.95]). The average monthly rate of lawsuits decreased from 2.13 to 0.75 per 100,000 patient encounters (RR 0.35 [CI, 0.22 to 0.56]). Median time from claim reporting to resolution decreased from 1.36 to 0.95 years. Average monthly cost rates decreased for total liability (RR 0.41 [CI, 0.26 to 0.66]), patient compensation (RR 0.43 [CI, 0.26 to 0.67]), and non-compensation-related legal costs (RR 0.39 [CI, 0.22 to 0.67]).

**Limitations:** The study design cannot establish causality. Malpractice claims generally declined in Michigan during the latter part of the study period. The findings might not apply to other health systems, given that UMHS has a closed staff model covered by a captive insurance company and often assumes legal responsibility.

**Conclusion:** The UMHS implemented a program of full disclosure of medical errors with offers of compensation without increasing its total claims and liability costs.

**Primary Funding Source:** Blue Cross Blue Shield of Michigan Foundation.
Deny and defend → disclosure and offer

“Implementation was followed by steady reduction in the number of claims and various other metrics, such as elapsed time for processing claims, defense costs, and average settlement amounts.”
FIRST PRIORITY - medical needs of the patient

- Continue communication about medical issues
- Assign and clarify primary responsibility for care
- Don’t delay necessary consults, tests, imaging

- Notify involved provider
- Notify attending provider
- Notify supervisor
- Notify MMIC for:
  - Assistance with communication plan
  - Assistance with investigation
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- TJC: When outcomes differ from anticipated outcomes, or after sentinel events
- AMA: As soon as feasible after care is addressed and patient is emotionally ready
- ASHRM: Patients want timely information – undue delay allows for atmosphere of mistrust

Ask yourself **3** questions

1. Would you want to know if it happened to you or your family member?
2. Will the outcome result in a change in treatment, either now or in the future?
3. Would having this information help the patient and family recover physically and emotionally?
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Not rushed

Mindful planning is key

But, as soon as possible

Who should be involved right away?
- Who should be involved with future care?
- Who should be involved with the investigation?
- Should we call MMIC?
- Who can evaluate whether the standard of care was met?  
  
  *Hint: You don’t need a lawyer*
Who should be present for the conversation?

- The involved provider(s) whenever possible
- The attending provider
- Patient representative or advocate
- Patient and family

Mindful planning:

- Review the facts as they are known
- Outline discussion
- Assess emotions
  - No blaming - we are united
  - Patient needs come first
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**Mindful planning:**
- Identify roles
- Set up meeting and location
- Prepare follow-up strategy

**Who**

**What**

- Introduce everyone present
- Thank the patient and family for meeting
- Identify the purpose for the meeting
- Communicate an objective statement of what happened
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- Express a sincere statement of regret
- Acknowledge harm
- Discuss the medical treatment plan and any areas of concern regarding treatment
- Offer support services

- Discuss medical care going forward
- Provide a contact person for questions
- Describe the general investigative timeline
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- Assure the patient and family that:
  - You’ll continue to care for the patient
  - You’re committed to finding out what happened
  - You’ll keep them informed

What do patients want to know?
- You’re taking the event seriously
- You’re investigating what happened
- You’re taking steps to prevent future occurrences
What if they ask for money?

Do I need to say “I’m sorry?”
I’m sorry for what happened or for what you’re going through

I’m sorry I made a mistake

Apology and communication

- Be human
- Sit down
- Silence your beeper or phone
- Make eye contact
- Listen actively
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- Allow for silence
- Let the patient vent
- Show empathy
- Be sensitive to the family’s readiness to talk
- Avoid blaming others
- Avoid minimizing the event

NO JOUSTING
Gather the facts before expressing your opinion

Be aware of your body language and your facial expressions

Stick to the facts – in discussion and in charting

Stick to your plan going forward

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Next Steps

1. Documentation
2. Follow-up communications
3. Billing issues
4. Internal investigation
5. Provider and staff support
Apology and communication

1. Documentation

Next Steps

What to document:

- Facts as they are known
- Care given in response
- Details of communication with patient and family
- Follow-up plans

What *NOT* to include:

- Jousting
- Subjective comments
- Speculation
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Next Steps 1. Documentation

What NOT to include:

- References to incident report or event analysis
- References about discipline
- Comments about potential lawsuits
- Comments about calling MMIC or attorney

Next Steps 2. Follow-up

- Assign one representative
- Maintain communication with the family
- Keep your promises
- Respect the patient and family wishes
2. Follow up

- Involve MMIC in follow-up
- Participate in follow-up communications
  - May include apology of regret
  - May include apology of remorse
  - May include resolution or compensation
- Continue to offer/provide support resources

3. Billing

- Contact your billing office
- Place a hold on account until evaluation complete
- Sending bill as usual = recipe for a lawsuit
- Don’t make promises to the patient or family
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4. Investigation

- Participate in all internal reviews
- Involve MMIC in the investigation
- Seek input from patients
- Examine root and contributing causes
- Review policies, procedures and processes
- Learn and improve

5. Provider/staff support

Realize the impact an adverse outcome can have on your team – there may be two victims:

1. Patient and family
2. Involved health care professional(s)
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Second victim

Impact:

Professional

Personal

Emotional impact of errors:

61% increase in anxiety over future errors

44% loss of confidence

42% reduced job satisfaction

42% sleep difficulties

13% felt harm to reputation

5. Provider/staff Support

Apology and communication

Next Steps

Provide support throughout the process:
- Debrief your team
- Offer support services
- Assign an internal contact
- Check in and keep them informed

MMIC patient safety solutions

- Well-being center
- Apology and communication bundled solution
Strategies

1. Assess culture, policies and processes:
   - IHI Culture Assessment Tool
   - IHI Checklist
   - IHI Work plan

2. Implement an apology and communication policy, process and structure using our:
   - Sample policy – Guidelines for Communication after an Adverse Outcome
   - Best practices
   - Process steps
   - Algorithm
Strategies

3. Implement an adverse outcome support program:
   - Patients and families
   - Health care professionals

Apology and communication resources

AHRQ Error Disclosure [Link]  
ACOG ACOG Disclosure and Discussion of Adverse Events Committee Opinion Number 520 March 2012  
ASHRM ASHRM Disclosure of Unanticipated Events Monographs  
CRICO Disclosure and Apology [Link]  
Empathetics Empathetics offers scientifically based empathy education that teaches health care professionals how to detect and manage the emotional states of patients and how to respond with empathy and compassion, even in difficult interactions.  
IHI IHI Leadership Response to a Sentinel Event: Respectful, Effective Crisis Management  
IHI IHI Respectful Management of Serious Clinical Adverse Events  
IHI IHI Disclosure Toolkit and Disclosure Culture Assessment Tool
Disclaimer

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