



Communicating Adverse Events: The Art of Apologizing Without Admitting Liability

When a serious adverse event occurs, it is distressing to the physician, to the patient and to the patient's family. While physicians know how to handle the clinical aspects of an adverse event, many are less clear about what to say and to whom. Expressing sincere sympathy and concern to the patient and/or family is often the most important response to help diffuse a potentially volatile situation. The patient and/or family are due a prompt explanation. Many lawsuits are filed because patients are angry and confused when physicians do not communicate in a timely and appropriate manner after an adverse event. Repeated requests for an explanation of the event are a common reaction of upset patients and family members. Physicians should remain accessible for questions.

"Apologizing" to Patients

"Apology" does not have to mean an admission of wrongdoing or negligence. Rather, it can be an acknowledgment by the physician of shared regret over the outcome. After an adverse event, organize a family meeting. **Empathize** with the patient and family without admitting liability. Statements such as "I am sorry that this happened," or "I am sorry that you are in such pain" capture regret in a blame-free manner. Describe the event and medical response in brief, factual terms. If additional follow-up is indicated, discuss those plans with the patient. Show concern for the patient's condition. However, **do not criticize yourself or other caregivers for a poor outcome**. Do not point fingers at other physicians or health-care providers. Do not engage in "thinking out loud" or speculation about what happened or why. An injured patient who feels that you did your best is not as likely to

sue as an injured patient who feels deceived or abandoned by the physician. Such an apology will help you earn esteem with the patient and strengthen the physician-patient relationship.

Informed Consent

Usually an unfavorable outcome is the result of a known risk of the procedure and not the fault of the physician. Key to an apology is the issue of informed consent. A well-received response will arise from a physician-patient relationship where the physician has worked at developing a solid rapport with the patient. In the event that a poor outcome does occur after having previously explained the major risks and complications of the procedure to the patient, there is a pre-established line of communication. This established line of communication allows for a conversation such as "I am sorry to say that your relative has suffered complications from the treatment. These are the problems we are facing and here is our plan." This type of statement expresses regret, places no blame and conveys, "We are in this together."

Preserving Evidence

As soon as possible after the event, factually record the event and medical response in the chart. Document plans for follow-up if indicated. Do not alter any prior documentation or insert backdated information. Record alterations can render otherwise defensible cases almost impossible to defend. An addendum is reasonable, as long as the addendum is designated as such and dated. Accepted rationale for an addendum would be for a correction of facts (i.e., persons involved, time of event,

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sequence of events) and for clarifying information. However self-serving, addenda added months after the event may be interpreted as an attempt to alter the medical record and will be used by the plaintiff's attorney to support the plaintiff's claim—so don't do it.

Below are risk management guidelines to follow after a complication or adverse event.

- Personally let the patient/family know that a problem has occurred
- Offer an immediate explanation with ample time for discussion
- Explain the cause to the patient as accurately as possible. Avoid speculation
- Never use words or expressions such as wrong, error, mishap, accident—all imply negligence
- Never make disparaging comments about persons, products or organizations, or engage in “finger-pointing”
- Avoid characterizing complications or problems as unavoidable, extremely rare or extremely common
- Do not belittle any complication
- Help the patient cope with bad results; discuss the next best treatment options, if applicable
- Keep the lines of communication open ●

Closed Claim Abstract

The following case illustrates the importance of communication and rapport. Fortunately, it was not a MAG Mutual claim.

A 28-year-old woman, 16 weeks pregnant with her first child, arrived at her obstetrician's office as she was having a spontaneous abortion. The receptionist informed the patient of an overdue bill of \$40 and advised her that she would not be seen until she had paid the bill. The patient pleaded that she was in intense pain, in the process of losing her baby and had no money. An argument ensued in front of the patients in the reception area. The obstetrician heard the commotion, came to the front office and agreed to treat the patient. The patient, acutely embarrassed by the public scene, excused herself to the ladies' room and left, unnoticed, through a side door. She proceeded home where she aborted the fetus. She called on a neighbor for help, and she and the fetus were transported to the hospital by ambulance. She was seen

by her obstetrician at the hospital, where he told her that the miscarriage was unimportant since “It was not a real baby, it was only a lump of tissue.” The outcome of the miscarriage was never discussed. A malpractice claim was filed against the physician. The case was settled for \$1,000,000.

The physician's statement regarding a “lump of tissue” was a precipitating factor in the claim and subsequent settlement. It is, in fact, the primary reason the case was settled. The physician's statement that the baby was “not a real baby, only a lump of tissue” completely disregarded the patient's emotional state. To her, the baby she lost was real. To hear it discussed in callous terms indicated to her that the physician did not care about her, the baby or her situation. When compounded with the incident in the medical office regarding the unpaid

bill, the physician's words were inflammatory and a compelling reason that she decided to file a claim.

Another issue cited in this case involved the receptionist's actions regarding the unpaid bill. The receptionist acts as the agent of the physician and as such represents the physician and his/her policies to the public. As the employer and supervisor of the receptionist, the physician was accountable for her behavior.

There was also an allegation of negligence in allowing the patient to leave the office. Plaintiff experts testified that the physician and the staff should have taken immediate steps to monitor the patient. Failure to do so, especially while the patient was under emotional distress and embarrassment, was considered negligent. Since this case was settled, the issue of negligence was never litigated.

Physician/Patient Relations: Key to a Successful Practice

Essential to every office practice is a strong physician-patient relationship. Patients arriving at your office are often anxious and fearful. They are expecting not only excellent clinical care, but also reassurance, respect and clear communication from the physician and staff.

Few patients are equipped to evaluate the clinical skills of the physician and allied healthcare professionals.

Instead, it is through interaction with the physician and his/her staff that most patients judge the quality of the healthcare that they receive.

According to plaintiff attorneys, approximately 70-80 percent of patients who seek to file a medical liability claim do so because they are angry. This anger stems not only from adverse outcomes, but also a breakdown in

communication, failures to provide information or other non-clinical factors that create the perception of a lack of caring, concern and respect for the patient.

The physician most vulnerable to a lawsuit is the one lacking in adequate communication skills. The risk management benefits of a strong patient relationship are twofold. First, open communication with patients can have a direct impact on the quality and outcome of the medical care rendered. Patients who have good rapport with their healthcare providers are more likely to be forthcoming with information necessary to provide appropriate treatment; those who are educated about their care are more likely to be compliant with the treatment recommended.

Second, patients who feel they have a good relationship with, and receive respect from, their physician and the practice staff are less likely to turn to an attorney and the litigation process when the results are less than optimal.

Good patient relations begin the moment a patient has any contact—direct or indirect—with the practice.

Everyone from the administrative staff, to the allied health professionals, to the physicians must take responsibility for ensuring that all patient encounters are handled professionally, efficiently and with respect for the patient.

Many different patient relations' issues are cited by patients/plaintiffs as factors that influenced their decisions

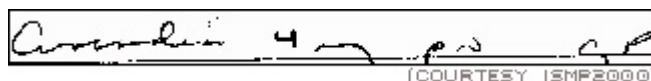
to file a lawsuit. The following are six areas that should receive particular attention.

1. Provide patients with information regarding services offered by the practice, appointment procedures, emergency coverage, patient responsibilities and other pertinent administrative aspects of medical care and treatment
2. Provide patients with a method of feedback and suggestions/complaints to the practice; ensure follow-up or response to patient complaints
3. Ensure that waiting time for patients in reception and examination rooms is reasonable
4. Ensure that all physicians and staff respect patients' privacy and right to confidentiality
5. Provide patients with information regarding fees, handling insurance claims and payment policies; ensure that collection procedures are communicated to affected patients and are handled in a manner that identifies and minimizes potential liability problems
6. Ensure that any terminations of physician/patient relationships are handled according to well-established procedures designed to minimize the risk of allegations of abandonment ●

For Doctors' Scrawl, Handwriting's on the Wall

Physicians' handwriting has long been a joke. However, poor handwriting among healthcare providers is increasingly being diagnosed as a threat to patients. Nearly all of the prescriptions issued each year in the United States are written by hand. According to the Institute for Safe Medication Practices, indecipherable or unclear prescriptions result in more than 150 million calls from pharmacists to physicians asking for clarification, a time-consuming process that costs the healthcare system billions of dollars per year in wasted time. Experts say that up to 25 percent

of medication errors may be related to illegible handwriting: A pharmacist misreads an illegible prescription; one drug is mixed up with another.



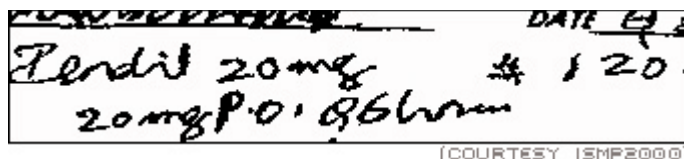
AVANDIA (*rosiglitazone*) or COUMADIN (*warfarin*)?
Avandia treats type 2 diabetes; Coumadin is an anti-clotting agent used in treating heart and stroke-related problems. Avandia is the prescribed drug in this case.

Jury Blames Doctor's Bad Handwriting for Patient Death

In 1999, a Texas jury awarded a woman \$450,000 after her husband suffered a fatal heart attack while taking the wrong medication. At issue was a prescription the cardiologist wrote for 20 mg of Isordil (for angina) every six hours. The pharmacist misread "Plendil" for "Isordil." A day later, taking what equaled a 16 percent overdose of Plendil, the patient had a fatal heart attack. The overall quality of the care received was never an issue.

The defense attorney presented compelling evidence that the medication error had not caused the patient's death.

The trial was held in a conservative part of Texas where physicians typically enjoy courtroom success.



ISORDIL(*r*) (*isosorbide dinitrate*) or PLENDIL(*r*) (*felodipine*)?
Isordil is a treatment for chest pains and can cause extremely low blood pressure; Plendil is prescribed for hypertension, or high blood pressure. Isordil was the intended drug.

Sending a Message with a Verdict

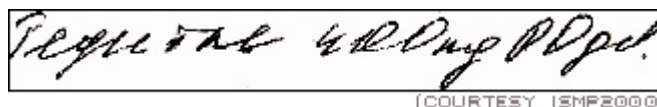
The jury later indicated that the award would have been much higher if the patient's lawyer had put a price tag on the case.

This first negligence judgment against a doctor purely for illegible handwriting focuses on the need for system changes and provides a needed wake-up call.

Addressing the Problem of Illegible Medication Orders

Handwriting's role in medication errors has not escaped notice within organized medicine. Physicians are urged to:

- Improve the legibility of handwritten orders for medications and review all orders for accuracy and legibility after writing them.
- Note the "purpose" of a prescription to avoid confusion on the part of either pharmacists or patients.
- Use direct, computerized order entry systems, or print or type medication orders.
- Evaluate new electronic point-of-care software that not only prints legible prescriptions, but also alerts doctors to potential drug or allergy interactions, using up-to-date databases of medications that are linked to the patient's records.



(COURTESY ISMP2000)

TEGRETOL (carbamazepine) or TEQUIN (gatifloxacin)?
Tegretol relieves the convulsions associated with epilepsy; Tequin is an antibiotic used in treating respiratory infections. The prescription is for Tequin.

- Avoid using decimals, nonstandard abbreviations or the letter "u" (which can easily be misread as a zero) as shorthand for "units."
- Consider preprinted prescriptions, on which physicians merely have to note the dosage and add their signature and DEA number.
- Take the time to educate patients or family members about the drug and dosage ordered. The patient should be asked to repeat the information to ensure they've understood.

For more tips on preventing medication errors, refer to MAG Mutual's desk reference, "Risk Management Handbook for the Medical Office." ●

Top Six Proven Patient Safety Practices

A federal report released by the Agency for Healthcare Research and Quality (AHRQ) recently identified dozens of evidence-based practices that could improve patient safety, including a number that investigators say are not routinely performed in hospitals and other healthcare institutions. In descending order of rank, the following six safety practices were the most highly rated in terms of strength of the evidence supporting more widespread implementation.

1. Appropriate use of prophylaxis to prevent venous thromboembolism in patients at risk.
2. Use of perioperative beta-blockers in appropriate patients to prevent perioperative morbidity and mortality.

3. Use of maximum sterile barriers while placing central intravenous catheters to prevent infections.
4. Appropriate use of antibiotic prophylaxis in surgical patients to prevent infections.
5. Asking that patients recall and restate what they have been told during the informed consent process.
6. Continuous aspiration of subglottic secretions (CASS) to prevent ventilator-assisted pneumonia.

The report, *Making Healthcare Safer: A Critical Analysis of Patient Safety Practices*, is available online at www.ahrq.gov.

MAG Mutual does not presume to establish any standard of care or establish rules for the practice of medicine. The particular patient-care strategies or range of patient-care strategies mentioned in this newsletter should be tempered by the physician's judgment.

This publication is produced to inform you of issues relating to medical professional liability insurance and other matters of importance to hospitals and physicians. Material given in this newsletter does not constitute legal advice or opinion. If you have questions in any of the areas discussed in this publication, you should seek a qualified legal opinion.

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