

MORTIFICATION AS A CRISIS RESPONSE STRATEGY IN
HOSPITAL MALPRACTICE SITUATIONS:
A CONTENT ANALYSIS OF WWW.SORRYWORKS.NET

by

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(Under the Direction of Jeff Springston)

ABSTRACT

Mortification is an image restoration and crisis response strategy proposed by public relations scholars William Benoit and W. Timothy Coombs. Many healthcare professionals avoid apology in malpractice situations, treating the event as a legal problem. However, an up-and-coming organization, SorryWorks! Coalition, sees medical malpractice instead as a customer service problem. SorryWorks! takes the traditional medical culture's inclination to "defend and deny" mistakes head on, and is an advocate for appropriate disclosure, apology, and compensation in medical crisis, similar to Benoit's and Coombs' concept of mortification. This study analyzes the strategies recommended by SorryWorks! Coalition in context of Coombs' crisis response strategy based on Attribution Theory and Benoit's Image Restoration Theory. It also compares public relations strategies SorryWorks! Coalition is advocating with strategies the organization actually uses to get its points across. Results of this study suggest the possibility of additional strategies that would enhance Benoit's and Coombs' proposed frameworks.

INDEX WORDS: Public relations, crisis response strategies, Attribution Theory, Image Restoration Theory, mortification, rectification, apology, SorryWorks!, hospital malpractice, medical malpractice, medical accident, medical crisis, disclosure, compensation, open communication

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Bachelor of Arts, The College of William & Mary, 2001

A Thesis Submitted to the Graduate Faculty of The University of Georgia in
Partial Fulfillment of the Requirements for the Degree

MASTER OF ARTS

ATHENS, GEORGIA

2008

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May 2008

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CHAPTER 1

LITERATURE REVIEW

It's the most obvious statement imaginable: People go to the hospital because they hope to get well. Perfectly reasonable human beings entrust their lives to strangers in white coats and seemingly space-age instruments for what they expect to be a desired end result: improved health and a life well-lived. Whether for a simple benign skin tag removal or a serious cancer treatment, patients rely on medical staff for responsible, effective treatment: for all "i's" to be dotted and "t's" to be crossed as a means of administering the most effective care possible.

The unfortunate truth, however, is that it doesn't always work that way. Despite the best intentions and the highest level of care, mistakes do occur. Doctors, no matter how educated or bright, are human and have not yet found a way to be infallible. Even with other hospital staff checking their paperwork and retracing their steps, a trip to the hospital can prove to be disastrous, even deadly.

Too many unlucky patients discovered this reality the hard way. Betsy Lehman, a *Boston Globe* health columnist in the early 1990's, is one of them. While receiving treatment for metastatic breast cancer in the later months of 1994 from the Dana-Farber Cancer Institute in Boston, Lehman died after receiving a chemotherapy drug, cyclophosphamide (Cytosan), four times the intended dose. She was only 39.

In Lehman's case, the treatment she received was experimental, and involved four consecutive days of a chemotherapy drug at a dose meant to approach, but not exceed, the lethal limit (Gorman & Mondy, 1995). A posthumous review of Lehman's case revealed that the assigning physician mistakenly wrote down the amount of the entire four-day

period's dosage, not each daily dose in the treatment plan. Despite Dana-Farber's policy of having two pharmacists verify the dosage for anticancer drugs by recalculating amounts, the error was still overlooked (Gorman & Mondri, 1995).

The error was indisputably egregious, but it is even more surprising that this occurred with such a knowledgeable patient, and it is ironic that the victim's knowledge of medicine has been described as "...about as sophisticated as a nondoctor's can be" (Brink, 1999, p.53). Lehman was a health reporter for the *Boston Globe*, an educated consumer, privy to the treatment she would receive, and a person who no doubt chose her treatment providers with great care (Altman, 1995).

Other factors in the case heighten the surprise of this deadly error: A *New York Times* report covering the Lehman case stated that despite tests showing heart damage, doctors did not respond to her warnings that things were going drastically wrong (Altman, 1995). *Boston Globe* reports indicate an electrocardiogram present in Lehman's file dated November 19 showed abnormalities which are considered to be characteristic of Cytosin damage (Knox, 1995). Even more striking are reports revealing that the error went unnoticed by more than a *dozen* of the hospital staff, including nurses, pharmacists, and physicians, as well as the fact that there were no visible traces of breast cancer in Lehman's body at the time of her autopsy (Knox, 1995).

All of these mistakes stemmed from treatment received by the Dana-Farber Cancer Institute, the number three cancer center in the nation according to *U.S. News and World Report's* rankings each of the previous four years (Brink, 1995). At the time the incident occurred, Dana-Farber was receiving \$35 million in federal funding and \$25 million in charitable donations each year (Knox, 1995). Based on the reputation of the

hospital, the generous annual funding, and the knowledge of medical treatment possessed by the patient involved, a transgression of this magnitude was certainly unexpected, and clearly embodied the features of a significant malpractice event. The Lehman case proves that even the most reputable medical environments are unable to escape mistakes, error, guilt and shame created by the unnecessary loss of human life in a medical treatment setting.

The national media attention given to the Lehman case led to reform at Dana-Farber, and was considered a “wake-up call” for medication errors on the part of hospitals and healthcare providers nationwide, even leading to the inception of the National Coordinating Council for Medication Error Reporting and Prevention which strives to prevent and evaluate the cause of medical errors (Mason, 1999). However, it is unfortunate but perhaps inevitable that such intervention was necessary. Further, while many hospitals rightly investigate ways in which the system can be improved and such incidents can be avoided after an egregious error such as the Lehman case occurs, these are not the only issues that arise.

In addition to reducing similar occurrences, it is necessary to acknowledge the fact that sometimes mistakes do occur in hospitals, and will continue to do so—no matter how difficult this admission may be for hospitals and their staffs. Given this, public relations practitioners in health and medical settings must face an important question: When mistakes do inevitably occur, what is the proper way to communicate with patients? Should errors be kept under lock and key, as they traditionally have been, or should they, at the other end of the spectrum, be disclosed to patients and families, with full apologies from doctors and hospitals?

It seems obvious that patients and their families who have been harmed by medical errors would expect practitioners and institutions to admit what happened and apologize. However, this response has traditionally been seen within the medical community as either inadvisable or unrealistic.

Medicine and the law intertwine to thwart the impulses of a physician who wants, on a personal level, to apologize. Liang and Ren (2004) observe, “The present legal landscape... prevents such communication in the healthcare industry. The adversarial nature of our legal system punishes candor and rewards the manipulation of fact, thus discouraging open and honest communication of system issues” (p.503).

Doctors frequently practice “defensive medicine,” aggressively protecting themselves against liability any way they can (Liang & Ren, 2004). One mitigating factor may be the temperament of those choosing to enter the profession (Rowe, 2004), a position which demands confidence in one’s own decisions. Apology and disclosure are frequently in conflict with this “defend and deny” tradition in medical practice. Regardless of what a physician may want to do on a personal, human level in response to a malpractice event, it can be difficult to navigate through the messages they receive from the hospital administration and legal counsel. Admission of serious errors can also serve as a source of shame for a physician, who characteristically possesses a personality insistent on excellence, and belongs to a medial culture that both demands precision and is quick to assign blame when errors occur.

In spite of the fact that doctors frequently submit to the prevalent culture of shame and blame in the medical community in an effort to avoid the dreaded malpractice lawsuit, research is increasingly showing that *patients* have an understanding that medical

errors sometimes occur, and that the way in which medical care providers *communicate* with the affected patients has an effect on litigious intent (Duclos, Eichler, Taylor, Quientela, Main, Pace & Staton, 2005). Although patients understand that mistakes can happen, physicians who deny errors run the risk of fueling litigious intent, yield the perception that poor medical treatment has been given, and give the impression of a lack of concern (Lester & Smith, 1993). Further, research has shown that once a patient perceives a medical provider fears a lawsuit, the patient becomes fearful and communication between the two parties worsens (Duclos, Eichler, Taylor, Quientela, Main, Pace & Staton, 2005).

Communication has such a strong role in malpractice lawsuits that some researchers have even been led to draw the conclusion that, "...medical negligence may play a relatively minor role in malpractice lawsuits" (Lefevre, Waters, & Budetti, 2000). Other researchers stress that improved communication with patients may help prevent lawsuits, regardless of whether this can be termed "competent" medicine (Lester & Smith 1993, p. 272). Despite the current nature of medical practice, many patients have also reported that an apology is important to them in the event that something goes wrong (Duclos, Eichler, Taylor, Quientela, Main, Pace & Staton, 2005).

Strengthening the patient-provider relationship and communication could potentially create "...a culture of improvement for all, not punishment against one" (Liang & Ren, 2004), improve patient-provider relationships considerably and reduce litigation. Despite these proposed benefits and the recent research substantiating the importance of good communication with patients, it is important to note that little attention is given to physician-patient communication skills training (Lefevre, Waters & Budetti 2000).

Perhaps the lack of attention to physician-patient communication skills training is due to the fact that communicating with patients and their families who are faced with an unmet standard of care can be riddled with controversy and conflicting interests, leading a physician to avoid the situation entirely. On the one hand, the doctor who admits an error may face shame and guilt within his or her profession, and may be sued. On the other hand, the physician who conceals an error may be even more likely to be sued, though he may escape being chastised by the medical community.

However, current research seems to indicate that enhanced physician-patient communication and apology in the face of wrongdoing appears to be the most desirable solution long-term, and analysis of the approach can arguably help improve our understanding of healthcare communications. Healthcare providers are frequently and justifiably most interested in reducing the reoccurrence of similar malpractice situations, and they require the support of their patients to remain in operation. Therefore, pleasing patients despite the inevitability of human error must also be a primary goal. It then makes sense to evaluate medical malpractice situations, particularly those in which enhanced communication and apology are a factor, in terms of public relations theory as well.

Crisis Management

Crisis management, which in this case means stopping malpractice litigation before it starts, is a fundamental element of public relations practice. As healthcare situations illustrate, no matter how good an organization is, how careful it may be, or how admirable its intentions are, the unfortunate reality is that things sometimes can and do go

wrong. At one time or another, public relations practitioners will likely find themselves challenged by undesirable circumstances that must be addressed in an ethical way, finding the solution that benefits everyone involved. This happens in all practice settings, not just healthcare.

This ubiquitous threat has caused public relations scholarship to focus more on crisis situations in recent years: the necessity of having a planned response strategy and finding the crisis response strategy that is the most appropriate to each situation at hand. Because a healthcare crisis may be an actual matter of life or death, these situations can tell us a lot about what works and what does not in a public relations strategy.

Of particular interest in crisis communications are the theories of William Benoit and W. Timothy Coombs. They have each suggested public relations theoretical frameworks for responding to crisis situations. Specifically, both Benoit's image restoration theory and Coombs' crisis response strategy based on attribution theory have received remarkable attention and study. Their work has resulted in case studies covering drug companies such as Tylenol and Vioxx as well as other non-medical products such as Odwalla in order to test these theories and assist in further developing new strategies for effectively managing crisis situations. Though crisis management strategies may not yet be perfected, attention to this important area of study seems to be growing, as Coombs confirms in his research (1999).

In current public relations theory, image restoration and attribution theories are mainstays of crisis response strategy. Benoit's image restoration theory focuses on preserving an organization's image after a crisis. Coombs' crisis response approach based on attribution theory focuses on matching crisis strategy with crisis type (Coombs 2004).

Benoit argues that “The way image repair strategies function to repair a damaged reputation can best be understood through an analysis of the nature of the attacks, reproaches, or complaints” (Benoit, 2004, p. 264). Further, an organization’s reputation is threatened when a reprehensible act is committed, and it is viewed to be the fault of the organization at hand (as is the case in many malpractice situations); otherwise, there is no reason to form a negative impression of the organization (2004). Benoit also asserts that an apology may lead the audience to pardon an offense more readily. In either event, “A firm commitment to correct the problem— repair damage and prevent future problems— is an important component of image restoration discourse (Benoit, 2004, p.277). Note that logically, a medical malpractice situation can serve as a reprehensible act that is viewed to be the fault of the organization at hand. Benoit’s theory supports apology as a way for an organization to repair its image and increase a public’s willingness to forgive an offense (Benoit 2004).

Benoit’s approach involves five main image restoration strategies: denial, evasion of responsibility, reducing the offensiveness of the event, corrective action, and mortification. Which one is used depends on the nature of the crisis situation (Benoit 1997). Benoit explains each strategy, breaks them down, and lays out specific methods of recourse. Table 1 is an abbreviated version created by Benoit (1997, p.179; 2004, p.266), and describes and defines available crisis response strategies.

Table 1

Benoit's Image Restoration Strategies

STRATEGY	KEY CHARACTERISTIC	EXAMPLE
<i>Denial</i>		
Simple denial	Did not perform act	Coke does not charge McDonald's less
Shift the blame	Another performed act	Exxon: Alaska and Coast Guard cause delay
<i>Evasion of Responsibility</i>		
Provocation	Responded to act of another	Child who broke toy
Defeasibility	Lack of information or ability	Executive not told meeting moved
Accident	Mishap	Sears' unneeded repairs inadvertent
Good Intentions	Meant well	Sears: no willful overcharges
<i>Reducing Offensiveness of Event</i>		
Bolstering	Stress good traits	Exxon's swift and competent action
Minimization	Act not serious	Exxon: few animals killed
Differentiation	Act less offensive than similar ones	Nixon: attack Viet-Cong, didn't invade Cambodia
Transcendence	More important considerations	Nixon: New action needed to win war
Attack Accuser	Reduce credibility of accuser	Pepsi: Coke charges McDonald's less
Compensation	Reimburse victim	Disabled movie-goers given free passes
<i>Corrective Action</i>	Plan to solve problem/prevent recurrence	AT&T promised to improve service
<i>Mortification</i>	Apologize	AT&T apologized for services interruption

One of Benoit's suggestions for repairing an organization's image after a crisis seems especially relevant to malpractice situations. He wrote: "...a company that is at fault should probably admit this immediately... Apart from the fact that this is morally the correct thing to do, attempting to deny true accusations can backfire" (Benoit, 1997,

184). In the same passage, Benoit acknowledges that companies are sometimes reluctant to apologize because they fear litigious action, which is often a worry in hospital malpractice situations. A company, he asserts, must decide which is more important: restoring its image or avoiding possible litigation (Benoit 1997). Though optimistic about the potential for apology to improve a situation, Benoit cautions that a company's "...powers of persuasion are limited" (Benoit, 1997, 183). Thus, Benoit strongly recommends apology, though not without a caveat.

Coombs' crisis response strategy based on attribution theory focuses on the importance of matching crisis response and crisis type, using attribution theory as the basis for choosing the appropriate crisis response. Attribution theory, he claims, "... posits that people make judgments about the cause of events based upon the dimensions of locus, stability, and controllability" (Coombs, 1995, p.448).

Coombs identifies several crisis types: faux pas, accidents, terrorism, and transgressions. According to Coombs, the type is determined by whether the crisis arose from something internal or whether it was external to the organization (Attribution Theory's dimension of locus of control), and intentional or unintentional (dimension of controllability) (Coombs 1995). Table 2 is Coombs' Crisis Type Matrix (1995, p. 455); Table 3 expands on Coombs' theory by defining each of the crisis types.

Table 2

Coombs' Crisis Type Matrix

	UNINTENTIONAL	INTENTIONAL
EXTERNAL	Faux Pas	Terrorism
INTERNAL	Accidents	Transgressions

Table 3

Coombs' Crisis Types Defined

Faux Pas	The organization tries to do the right thing, but an external source challenges the correctness of the organization's action, and tries to make the action into a crisis
Accident	Unintentional, often random, not controllable
Transgressions	Intentional. The organization knows their actions are wrong and potentially harmful to publics.
Terrorism	Action taken by an external source, intent to harm the organization

Coombs asserts that when the public imputes locus, stability, and controllability to the organization, their perceptions are more negative, and the incident is more damaging to the organization. In medical malpractice settings, this means that the more a patient and family believe the hospital is at fault, the worse their impression of the medical providers, and the more likely they are to pursue litigation. As previously noted, however, recent research indicates that enhanced physician-patient communication may lessen this tendency. This is actually not surprising, as Coombs also sees evidence suggesting that “quickness, consistency, and openness” are beneficial in crisis management (Coombs, 1999, p. 125).

Coombs (2004) also argues that attribution theory, which describes how publics “attribute” blame or responsibility for crisis, should be used to match a crisis response strategy and crisis type (Coombs, 2004). Coombs further believes that the purpose of crisis response strategies is to repair an organizational image through the composition of messages, and he presents five options: nonexistence strategies, distance strategies, ingratiation strategies, mortification strategies, and suffering (Coombs 1995). Table 4 is a summary of the strategies as explained by Coombs (1995, p.450-453).

Table 4

Coombs' Crisis Response Strategies

STRATEGY	DESCRIPTION	METHODS
Nonexistence strategies	Explain that crisis did not exist, there is no connection with the organization	<i>Denial, clarification, attack, intimidation</i>
Distance strategies	Admission that the crisis occurred. Attempt to increase public acceptance of the situation and reduce the crisis's association with the organization	<i>Excuse, justification</i>
Ingratiation strategies	Seek public approval, associate organization to things its publics view positively	<i>Bolstering, transcendence, praising others</i>
Mortification strategies	Attempt to gain forgiveness from publics, acceptance	<i>Remediation, repentance, rectification</i>
Suffering strategy	Attempt to gain sympathy from publics	<i>Portray organization as a victim</i>

It should be noted that since Coombs' compilation of these strategies, he has since refined his position on crisis response strategies to comprise of three clusters, or "postures": *deny*, *diminish*, and *deal* (Coombs, 2007; Coombs & Holladay, 2004). While the strategies are categorized more narrowly, the goals remain very similar. The *deny* posture (attack accusers, shift the blame, clarification) asserts that a situation did not occur or the organization is not responsible. The *diminish* posture (excuse, justification) signifies an attempt to reframe an event or change a publics' perception of the reason for the crisis. The *deal* posture represents an attempt to better an organization's image through strategies such as suffering, bolstering, praising others, compensation, corrective action, and apology (Coombs, 2007; Coombs & Holladay, 2004).

However, for the purposes of this paper, we will focus on Coombs' initial categorization of crisis response strategies. While Coombs' new categorization has the

benefit of reducing complexity, his initial categorization offers the advantage of yielding the opportunity for a more detailed organization and analysis of crisis response strategies. In this case, a more extensive analysis is ideal.

Given the great detail and thorough description provided by both Benoit and Coombs, as well as the current trend to analyze crisis situations and strategies, these theories are the ideal tools for understanding the public relations strategies used in medical malpractice situations. Both the traditional approach, avoiding discussion and not admitting responsibility, and the new strategy of having physicians talk to patients, apologizing for not meeting standards of medical care, can be analyzed within the context of Benoit and Coombs' theories. The unfortunate results of using traditional strategies are well-documented, and enhanced communication and apology in malpractice situations are becoming better recognized, indicating that apology merits further study in the context of Benoit and Coombs' theories. The best way to do this is to analyze a response strategy that embodies this new approach and is gaining momentum. Fortunately, such an approach exists, and it is being used more and more frequently across the nation.

Sorry Works!

The Sorry Works! Coalition (www.sorryworks.net) "...is dedicated to promoting full disclosure and apologies for medical errors as a 'middle-ground' solution in the medical liability crisis" (Wojcieszak, Banja & Houk, 2006, p. 344). Founder Doug Wojcieszak, a former public relations professional, experienced the anguish of having his brother die very unexpectedly during a hospital stay. Wojcieszak and his family received scant explanation from the physicians or hospital administration about what had happened, and Sorry Works! is his way of holding providers and hospitals responsible for

the medical care they provide. Hospitals that adopt the Sorry Works! approach promise to tell patients and their families of medical mistakes made, apologize, and offer monetary compensation as appropriate. The hospital also agrees to take action to ensure that similar mistakes will not be made in the future. This is what Coombs calls “rectification,” a subcategory of mortification, in his Crisis Response Strategy Table.

The traditional response to medical malpractice situations and the reasons for its existence are not lost on the SorryWorks! Coalition. They are well-aware that the traditional response to a malpractice situation by hospitals and physicians has often been to avoid taking responsibility or apologizing in the event of a bad medical outcome or adverse medical event in order to avoid the filing of malpractice suits and prevent victims from using that information against the hospital and physicians in a court of law (Wojcieszak, Banja & Houk, 2006). However, in line with recent research, the Sorry Works! Coalition believes that implementing their nontraditional strategy which embraces the importance of apology will actually make patients less angry and in return less likely to pursue litigation than if a traditional strategy is used (Wojcieszak, Banja & Houk, 2006).

The Sorry Works! approach gives hospitals and physicians a practical, hands-on response to a potential crisis. Though sometimes missed by a medical practice steeped in tradition, “Scholars increasingly accept the view that a proactive strategy, one that focuses on preventing crises from occurring in the first place, is the optimal approach to crisis communication” (Hua-Hsin & Pfau, 2004, p. 302). The Sorry Works! approach may diminish public perceptions of wrongdoing and defuse an otherwise explosive degree of anger.

Admittedly, the most compelling reason a hospital adopts the Sorry Works! Program is not its utility as a public relations strategy, but the prospect of avoiding lengthy, costly litigation procedures. In addition to the current novelty of the SorryWorks! method, fear of just this issue may be the reason for limited hospital involvement in the SorryWorks! approach as the movement, founded in 2005, launches.

While the SorryWorks! Web site (www.sorryworks.net) shows that an impressive number of states have enacted some sort of limited apology or disclosure law (approximately 70%), it lists only a handful of individual hospitals with actual disclosure policies, several of them university hospitals. The largest hospital participant is the Veterans Healthcare Administration (VHA). The impressive national scope of the VHA highlights the importance of apology and disclosure as an issue in healthcare in the United States today. However, there is a possibility that its standing as a government agency may also provide VHA with legal protection that a smaller, individual hospital might not receive in the event of a malpractice situation. As a result, a smaller hospital may have less incentive to join the SorryWorks! movement, regardless of their good intentions. Though at first glance disclosure and apology are a less compelling prospect to the smaller hospital, the possibility remains that the SorryWorks! strategy could help to maintain and strengthen relationships between the hospital, physicians and its publics, and preserve a positive, competent image even in the case of smaller hospitals.

The SorryWorks! Coalition's strategy relies most obviously on Benoit's and Coombs' strategy of mortification: the organization or corporation confesses and begs for forgiveness following an adverse event (Benoit 2004). Mortification also involves taking precautions to ensure that the same problem does not happen again (Coombs 1995).

Coombs describes three types of mortification strategies: remediation (offering compensation to those affected by the crisis), repentance (requesting forgiveness), and rectification (taking action to prevent the event from occurring again) (Coombs 1995). Each of these strategies is fundamental to the SorryWorks! Coalition's philosophy.

Mortification is an obvious ethical and respectful response to many crisis situations, and approaches which exemplify this strategy merit further investigation. Greater focus on mortification strategies should be a priority, as it has been found to be common for a company to find itself in a situation where it must apologize for its behavior for one reason or another (Thompson & Rawson, 1998). Further, some evidence has shown that an apologetic response may have a significantly positive effect on publics' attitudes (Lyon & Cameron 2004), which is a desirable attribute in any crisis situation.

The Sorry Works! program is an ideal case study for mortification as a crisis communications strategy because of the strong emotions linked to the crisis involved. Hospital mistakes are often life and death situations, and are frequently accidents of the worst kind for the people involved. Because of the potential intensity of such a crisis for the individuals involved, opinions formed by victims and their families will be stronger and more intense than they might be if less were at stake, especially given the additional element of unwelcome surprise.

The SorryWorks! Coalition's Web site, www.sorryworks.net, provides comprehensive information about their vision. Here, the SorryWorks! Coalition outlines their strategy, lists hospitals that utilize disclosure policies consistent with their vision, and seeks to recruit new hospitals and medical professionals to their way of thinking, offering training in the implementation of disclosure policy. The site includes press

releases and other media coverage of this new way of responding to medical errors. Based on the large amount of information provided on this Web site, a content analysis of media presented on the site concerning their approach can help promote a more thorough understanding of their public relations response to medical malpractice situations.

Specifically, an analysis of the Web site will reveal what strategies the SorryWorks! Coalition promotes, what strategies they actually use to get their message across, and whether and how the strategy is viable in relation to Benoit's Image Restoration Theory and Coombs' crisis response strategies based on Attribution Theory. Our understanding of Benoit's and Coombs' theories, as well as the purpose of the SorryWorks! Coalition, leads us to two distinct hypotheses:

H1: The SorryWorks! Coalition will focus most intently on promoting the strategy of mortification with an emphasis on remediation and rectification, as well as Benoit's strategies of mortification, corrective action, and compensation.

H2: SorryWorks! will utilize different communication strategies in order to get their own message across; strategies that they may or may not promote for doctors and hospitals to use themselves.

Note in the second hypothesis that while SorryWorks! is not combating what would be classified as a crisis situation when using their own public relations strategy to convince others that SorryWorks! is a desirable framework to use for medical malpractice situations, their strategy can still be analyzed using the framework of Benoit's and Coombs' theories. As Coombs points out, a public relations response is situational (2004). Many of the strategies used in crisis response literature have the potential to be used in other contexts.

The audience the SorryWorks! Coalition is trying to address will also be examined.

One central question arises when considering the audiences targeted by the articles presented by the SorryWorks! Coalition:

RQ1: Is the SorryWorks! Coalition mostly trying to address hospitals (as organizations), healthcare professionals (as individuals), legislators, or the general public with their message? Are they trying to reach each audience equally?

CHAPTER 2

METHOD

Sample

All content was drawn from the www.sorryworks.net Web site. In order to keep content to a workable level, only the 50 most recent press releases and news articles at the time of selection were included in the analysis. No articles added to the Web site later than August 21, 2007 were included. The earliest article examined was dated April 5, 2005.

Procedure

SorryWorks! In relationship with Benoit and Coombs

The 50 press releases included in the sample were examined to determine where the SorryWorks! Coalition falls within the context of Benoit's and Coombs' theories. The presence of Coombs' non-existence, distance, ingratiation, mortification, and suffering strategies in each article were assessed, as well as Benoit's strategies of denial, evasion of responsibility, reducing the offensiveness of the event, corrective action, and mortification. The articles were coded within subcategories of each of these strategies, which were broken down into "Benoit's Image Restoration Strategies" and "Coombs' Crisis Response Strategies" as outlined in Table 1 and Table 4. A chart was created, which listed all categories and subcategories of Coombs' and Benoit's theories across the top. Across the side, the articles were labeled Article 1a through Article 50a, then concluded with labels marked Article 1b through Article 50b.

The article labels of 1a-50a and 1b-50b were necessary because each article was coded twice. On one run, the articles were assessed from the perspective of the

SorryWorks! Coalition and was coded according to what public relations strategy each article was *advocating*. Because each story was hand-picked or written by the SorryWorks! Coalition, each was considered to bear the group's "stamp of approval." On the second run, articles were coded to determine what public relations strategy the SorryWorks! Coalition was actually *using* in the articles. For example, in the first run, SorryWorks! might stress that apology is important in malpractice situations (a mortification strategy). However, in the second run, stressing the positive aspects of apology would indicate that they were actually performing an ingratiation strategy by bolstering, and would be coded as a bolstering strategy, not a mortification strategy. The SorryWorks! Coalition was not apologizing for anything; instead, it was highlighting the positive aspects of its program.

A second coder was enlisted to help establish inter-coder reliability. The first ten press releases were reviewed and five trial runs were performed from both the "advocating" and "using" standpoints. As a result of these trial runs, more specific rules were created to ensure that different people coding the articles would produce similar coding results. Based on the subjective nature of the strategies and very different results on the first few runs, it became necessary to create an extensive list of established rules, as follows:

Table 5

Coding Rules

CATEGORY	RULE/GUIDELINE DESCRIPTION
General Rules	<ul style="list-style-type: none"> - Look for instances of each category/subcategory of Coombs' and Benoit's theories throughout the articles from either the "advocating" or "doing/using" perspectives. - Code all articles from the "advocating" perspective at one time. Code the articles from the "doing/using" perspective at a separate time. (One coder reviewed the advocating articles first, the other coder viewed the "doing/using" perspective first.) - <u>One</u> strategy per theorist per sentence/main idea (ie. "Transcendence" or "Attack," not both). - The following strategies are coded the same for both Benoit and Coombs: mortification = repentance; compensation = remediation; corrective action = rectification; transcendence = transcendence; and simple denial = denial. - Differentiate between Benoit's bolstering ("Reducing Offensiveness of the Event") and Coombs' bolstering ("Ingratiation Strategy").
Advocating Run	<ul style="list-style-type: none"> - Key words used are important. - Each mention of "apology" is classified as a mortification strategy, and all mentions of apology receive a "tick" mark. For Coombs, it is classified as "repentance." - The word "remorse" is categorized as a repentance/mortification strategy. - Each "tick" mark for Coombs' mortification strategy of repentance is <u>also</u> coded as Benoit's mortification strategy. Coombs' rectification strategy is <u>also</u> coded Benoit's corrective action strategy. Coombs' remediation strategy is <u>also</u> coded as Benoit's compensation strategy.

- The word “reimbursed” constitutes Coombs’ remediation; Benoit’s compensation.
- Terms such as “investigate,” “analyze,” “analysis,” “find out the cause of the situation” go in the categories of rectification and corrective action.
- Bolstering: for advocating, only code if they are saying that the medical agency/organization/doctor should make themselves look good (as opposed to the bolstering rule for using/doing, see below).

Using Run

- Focus on main ideas presented and distinguish between paragraphs.
- Suffering strategy is coded when the article portrays the organization or the patient as a victim (as SorryWorks! is working on behalf of patients). Also, one tick mark is given for each story in the article.
- Good intentions—one “tick mark” per main idea or per paragraph when this occurs.
- For categories such as “good intentions,” “praising others,” “attack,” etc., look for value-laden adjectives.
- Provocation: Look for “if... then...” statements. For example, “if you didn’t get us angry/mess us up/etc.,... then we wouldn’t have to sue/ask for money/etc.”
- “It’s not all about the money” constitutes a transcendence strategy.
- An instance of a hospital or institution using a SorryWorks! strategy/one of apology constitutes a “praising others” strategy. One per hospital/institution. Further information about how good the program is constitute instances of bolstering.

- Bolstering: for using/doing, code when SorryWorks! praises their own program (as opposed to the bolstering rule for advocating, see above).
- Bolstering: Distinguish between Coombs' ingratiation and Benoit's reducing offensiveness of the event.

Based on the first three practice runs, four categories were created in addition to the crisis response strategies: Disclosure, open communication, forgiveness, and empathy. The categories were included because though they could not be distinctly classified in any of the subcategories of Benoit's or Coombs' theories, they occurred frequently in the articles and given their frequency, appeared to be central to the message that SorryWorks! was trying to convey. This led to some additional rules for advocating strategies:

Table 6

Additional Coding Strategies

CATEGORY	RULE/GUIDELINE DESCRIPTION
Additional Rules	<ul style="list-style-type: none"> - Each mention of disclosure goes into this column. Only mark instances where they use the actual word. - The phrases "open communication" and "Tell the Truth" go in the "open communication" column. - Instances of "listening," "discussing," and "transparency" go into the category of open communication. - For "empathy" and "forgiveness" code the actual words. - "Condolences" goes in the empathy category.

Publics

The publics targeted by www.sorryworks.net were assessed by asking, for each article, “Who is the target audience of this article?” The first ten articles were reviewed by two coders to determine reliability.

Analysis of Data

Inter-coder reliability was established by using the Holsti Method (1969). The percentage of agreement between the two coders for the first ten articles was calculated for each image restoration and crisis response strategy independently for both the Advocating and Using runs. The percentage of agreement for all strategies were then added and averaged. Agreement for the fifth and final run of the data was 95.04 percent.

The additional 40 articles were then coded after the fifth run, and final data results were analyzed using SPSS software. The occurrence of Benoit’s and Coombs’ strategies, as well as the number of articles containing each strategy, were compared.

Chi squared analyses of the data were also performed. Possible audience targets included healthcare professionals, doctors, hospitals, legislators, the general public, academics, and lawyers. Target audiences were identified by reviewing articles and asking the question, “Who is this article geared towards?” Both the content of the article and the name of the publication were taken into consideration when asking this question. For example, an article in a nurse’s journal would be categorized as targeted towards “Healthcare Professionals.” An article written by a doctor and encouraging other doctors to apologize for errors, would be categorized as targeted towards “Doctors.” Each article could be coded as having only one target audience. In the infrequent event that there was

a question about which category an article belonged to, the most obvious target was chosen. Each target audience is defined in greater detail in Table 7.

Table 7

Target Audience Descriptions

CATEGORY	DESCRIPTION
Healthcare Professionals	Members of the healthcare profession, not limited to doctors. This might include professionals such as nurses, lab technicians, or medical secretaries, etc.
Doctors	Article targeted directly/specifically/primarily to doctors, not inclusive of other healthcare professionals
Hospitals	Hospital administrators
Legislators	Lawmakers
General Public	Anyone in the public at large who might be interested in healthcare as a current issue, such as potential patients, loved ones, or other people who are not involved in the healthcare profession
Academics	Academic critique of a study methodology, recommendations of ways in which previously published studies can be improved
Lawyers	Lawyers

CHAPTER 3

RESULTS

The 50 articles were reviewed to determine the total number of times Benoit's and Coombs' strategies, plus the additional strategies (disclosure, open communication, forgiveness, and empathy), occurred. The number of articles that contained each strategy was also recorded. Table 8 displays the frequency with which each strategy was used overall (Total Occurrence), and the number of articles in which each strategy occurred (Article Presence).

Table 8

Descriptive Statistics: Advocating vs. Using

Strategy	N	Total Occurrence		Article Presence	
		Advocating	Using	Advocating	Using
Mortification	50	416	0	44	0
Repentance*	50	416	0	44	0
Disclosure**	50	243	0	33	0
Compensation	50	104	0	28	0
Remediation*	50	104	0	28	0
Corrective Action	50	78	0	29	0
Rectification*	50	78	0	29	0
Open Communication**	50	50	0	27	0
Forgiveness**	50	30	0	7	0
Simple Denial	50	15	0	7	0
Denial*	50	15	0	7	0
Empathy**	50	11	0	9	0
Transcendence	50	2	57	1	27
Transcendence*	50	2	57	1	27
Bolstering	50	0	0	0	0
Bolstering*	50	0	313	0	47
Attack Accuser	50	0	162	0	38
Attack*	50	0	162	0	38
Praising Others*	50	0	103	0	35
Portray Organization as Victim	50	0	45	0	25
Good Intentions	50	0	42	0	23

Provocation	50	0	11	0	9
Suffering	50	0	4	0	1
Accident	50	0	1	0	1
Shift the Blame	50	0	0	0	0
Defeasibility	50	0	0	0	0
Minimization	50	0	0	0	0
Differentiation	50	0	0	0	0
Clarification*	50	0	0	0	0
Intimidation*	50	0	0	0	0
Excuse*	50	0	0	0	0
Justification*	50	0	0	0	0

* Coombs' Strategy ** Additional Strategy All unmarked strategies are Benoit's.

N= 50 articles reviewed

Table 8 data support the hypothesis that the articles would emphasize and promote Coombs' mortification (repentance) strategy with an emphasis on remediation and rectification, as well as Benoit's strategies of mortification, corrective action, and compensation. These overlapping approaches are all "mortification strategies": mortification/repentance, compensation/remediation, and corrective action/rectification; each instance of Benoit's Mortification was also coded as Coombs' repentance, each instance of Benoit's compensation was coded as Coombs' remediation, and each instance of Benoit's corrective action was coded as Coombs' rectification.

A review of Table 8 also demonstrates support for the second hypothesis: that SorryWorks! would use different means for promoting their own message, and would not rely solely on those they urge doctors and hospitals to use during a crisis. In fact, there was little overlap in the strategies the SorryWorks! Coalition promoted and the ones they actually used. The coalition promoted a cluster of mortification strategies while using bolstering and attack strategies to communicate this message.

Another finding is that strategies SorryWorks! often recommends are not a part of Coombs' and Benoit's frameworks. Neither theorist addresses disclosure, for example, which was mentioned with a frequency second only to the mortification/repentance strategies. Open communication and forgiveness were also promoted with a greater frequency than any strategies outside the mortification/repentance, compensation/remediation, and corrective action/repentance axis.

The present study also examined the audience targeted by each article. Chi-squared tests were run to analyze the relationship of each target audience to each of the strategies that were used or advocated in the articles. From the Advocating perspective, both transcendence and disclosure were promoted significantly more with the general public ($X^2=15.986$, 6 df, $p<.014$; $X^2=154.494$, 102 df, $p<.001$, respectively). Similarly, from the Using perspective, praising others and accidents were used significantly more frequently in articles aimed at the general public ($X^2=93.887$, 48 df, $p<.000$; $X^2=93.887$, 48 df, $p<.000$ respectively).

It is important to note, however, that because there was only one article of the set of 50 that used an "accident" strategy, its relationship to its audience target was necessarily significant. One article could only be coded as having one target audience; had there been two or more instances of "accident" strategies, the target audience may or may not have varied, potentially affecting the significance of the results for this strategy very easily.

No other significant relationships concerning the audience targeted in each article were found.

CHAPTER 4

DISCUSSION

Perhaps the most striking observation in this study is that while the SorryWorks! Coalition strongly advocates the mortification strategies proposed by Benoit and Coombs, it also consistently recommends strategies outside of their frameworks. Given the purported success of the SorryWorks! Coalition's recommended approach to malpractice situations, its ability to enhance communication between healthcare providers and their patients, and to reduce litigation, it seems logical to consider the potential of the newly found strategies of disclosure, open communication, forgiveness, and empathy as possible new tools in a public relations practitioner's crisis communications arsenal. Perhaps with more extensive research, these new strategies can gain theoretical merit and become a permanent part of crisis response strategies, either under the umbrella of "mortification strategies" or, given their distinctive nature, as a separate "disclosure" category.

Additionally, it is interesting to note discrepancy between what strategies the SorryWorks! Coalition advocates that hospitals and physicians use, and the strategies they actually use themselves to get their point across. Again, it is important to remember that while the SorryWorks! Coalition is advocating for medical professionals to use certain crisis response and image restoration strategies in the event of a crisis, their own public relations strategies differ from what they advocate at least in part because their strategy is not in response to an actual crisis. Instead, the SorryWorks! Coalition's public relations strategy involves advocating a way for others to either avoid or react effectively to medical crisis situations. Nonetheless, given the mission of the SorryWorks! Coalition

and the differences between the strategies they advocate and the strategies they actually use is still of interest.

For example, it certainly is easier to advocate that others use apology than to actually find the courage to apologize when one is at fault and someone else's mortality is on the line. Further, for such a "feel good" message about the appropriate response to medical malpractice situations, it is remarkable that the second-most common strategy used by the SorryWorks! Coalition is to go on the defensive by using an "attack" strategy.

It can be argued that given the reprehensible activities behind a less-than-sympathetic traditional medical culture of "defend and deny," an attack strategy may actually be a very appropriate and even useful way to get one's point across from the other side. Further, given the traditional medical culture and the potential benefits of apology and disclosure, it is apparent that forceful encouragement by *someone* to do the right thing in medical malpractice situations is necessary.

Future research questions might include: Can these new strategies be beneficial for any company handling a crisis? Or are they better utilized in a healthcare setting? Can the traditional concept of "defend and deny" be a thing of the past for healthcare workers and other companies alike? Or are there only certain situations in which these new strategies are more feasible than others? Researchers should explore using these new strategies to revise image restoration theory and crisis response strategy based on attribution theory.

This study was limited to only 50 articles archived on the SorryWorks! Coalition Web site. Given a greater number of articles, more data could be accumulated about each area of study, but most importantly, more information could be gathered about the

audiences targeted by the agency. Perhaps the target audiences changed over time; perhaps the agency's methods of persuasion changed over time. In future research, a larger number of articles could be examined and studied for changes in strategy over time.

Additionally, future research could further clarify the efficacy of the SorryWorks! Coalition. Financial settlement data from hospitals, both those who do and do not embrace the tenets of the program, could be reviewed and analyzed. Interviews with members of the SorryWorks! Coalition, hospitals embracing the program, and hospitals who are resistant to the program could also be conducted and compared.

The success of SorryWorks! Coalition's mission and the easy availability to its exhaustive Web site afford a great opportunity to explore both the potential for an end to a "defend and deny" medical culture and the potential to develop new, effective, and honest crisis response strategies. Through future experimentation and analysis comes the potential for heightened achievement in both healthcare communications and the theory and practice of public relations.

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APPENDIX

Coded Articles Retrieved from www.SorryWorks.net No Later than August 21, 2007

<http://www.sorryworks.net/article50.phtml>

Sincere Apologies Are Priceless

Rita Marie Barsella, RN, BSN
Nurse.com
Monday July 2, 2007

In health care, an apology can make a world of difference. When an unexpected outcome occurs or an error is made, Doug Wojcieszak, founder of The Sorry Works! Coalition, says an apology is essential to an organization's full disclosure program. Wojcieszak recently spoke at "Seeing Your Way Clear to Apology and Disclosure," a conference, hosted by The Joint Commission, that extolled the virtue of apology and full disclosure in health care's culture.

The Joint Commission requires that accredited hospitals have full disclosure policies. But policy and practice are two different things. The U.S. Department of Veterans Affairs (VA) has a system-wide practice of full disclosure. Their program was modeled after a program started by Steve Kraman, MD, at the VA hospital in Lexington, Ky. Several other hospitals, including the University of Michigan Health System, have developed similar disclosure practices. In 2005, based on the success of the VA's program, The Sorry Works! Coalition was formed.

Wojcieszak says programs that promote open communication and full disclosure are the answer to tort reform. He says lawsuits are generated by anger and the current medical malpractice crisis is actually a customer service crisis. Wojcieszak speaks from experience. He founded The Sorry Works! after the death of his brother.

Personal tragedy fuels the movement

Wojcieszak's brother was admitted to an Ohio hospital for pain. He died during his hospitalization. An autopsy revealed he had had at least two untreated myocardial infarctions as an inpatient. The family looked for answers and an explanation, but the hospital refused communication. They sued the hospital and won a sizable amount -- minus an apology.

"It made money the only thing worth fighting for," says Wojcieszak. He says to this day, his mother still grieves that they never received an apology.

According to Wojcieszak, an apology should be offered as soon as an adverse event occurs. He says the apology does not equal an admission of guilt, but it demonstrates an acknowledgment of the event and an assurance that an investigation into the root cause of the event will take place.

Wojcieszak does not advocate frivolous payouts. He says there are three core principles to successful disclosure programs such as the ones implemented at the VA and the University of Michigan --

- Quick and fair compensation when inappropriate medical care causes injury
- Vigorous defense of medically appropriate care (there should be no compensation if there is no fault)
- Learning from mistakes and implementation of changes to prevent future errors

"Medicine is not perfect, and human beings are not perfect," says Wojcieszak. "We have adverse events, and we have adverse events with errors. Right now, unfortunately, the system is set up to take good people with good intentions and turn them into bitter, ugly enemies. It produces anger by the bucketful and litigation by the truckload."

Wojcieszak says the medical community needs to stop waiting for legislation to solve the malpractice debate. He says programs involving apology and full disclosure are not rooted in legislation but start with hospitals and practitioners making a commitment to their customers -- the patients and their families.

Let the healing begin

During the two-day Joint Commission conference, several speakers addressed the value of a sincere apology, while others reinforced the need for transparency and accountability with full disclosure. It was said that just, swift compensation, when appropriate, is an important component of full disclosure.

Several speakers cautioned that apology and disclosure are not blanket protection against litigation, nor should that be the motivation for implementing disclosure programs. Rather, they said, apology and full disclosure are part of the future of healthcare improvement.

Michael S. Woods, MD, author of *Healing Words: the Power of Apology in Medicine*, said there is a misconception that an apology is about guilt. He said an apology is about empathy rather than guilt.

"We suffer from the 'deny and defend' medical culture," said Woods. He labeled the perception that an apology leads to liability a "myth." Woods said an apology is the "natural progression of a respectful relationship."

When an unexpected outcome occurs, Woods suggested saying "I'm sorry. I know this is not what you expected. It's not what I expected either." To be sincere and believable, Woods said apologies cannot be relegated to severe, adverse outcomes; they should be inherent to the health practitioner's daily practice.

Woods said an apology emphasizes the intrinsic importance of an individual. He said an apology is the stepping stone to disclosure.

Lucian L. Leape, MD, one of the founders of the National Patient Safety Foundation and author of the 1994 *Journal of the American Medical Association* article "Error in Medicine," advocated full disclosure as a means of preserving the trust he calls the "cornerstone" of the relationship between the patient and practitioner. He said an apology starts the healing process for both the patient and the practitioner.

"There is not a single study that shows that being honest with a patient makes you more likely to be sued," said Leape. "All the evidence is the other way around."

Leape concurs with Wojcieszak, saying that lawsuits often occur because patients are angry. They are angry not only because something went wrong, but also because of the way the situation was handled. He cites the rise in patient advocacy groups as a testament to the fact patients are unhappy with a system that hides information they desire and demand -- information, Leape said, that is rightfully theirs.

"There is something seriously wrong when a patient has to file a claim," said Leape. "They should never have to file a claim, much less sue."

Richard C. Boothman, JD, chief risk officer for the University of Michigan, offered testimony to the U.S. Senate in 2006 regarding medical justice. He said litigation is often a patient's only recourse for information and answers, adding that the system of waiting for a lawsuit to be

filed is backward and ill-conceived. Boothman said patients have a right to information, and hospitals have an obligation to acknowledge mistakes up front.

"People go to lawyers not because they want a million-dollar payout," said Boothman. "People go to lawyers because they want answers and they don't trust their caregivers to give them answers. People go to lawyers because they don't get any information at all."

Boothman said that since 2001, the University of Michigan has successfully implemented its policy on apology and full disclosure. He said they have had a dramatic reduction in claims, they have improved their employee satisfaction rate, and they have used each incidence as a tool for improving clinical safety.

According to Boothman, patients want assurance that something will be done to correct a problem and that it will not happen to someone else. He said openness and honesty lead to safer patient care.

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<http://www.sorryworks.net/article48.phtml>

Study Finds Gap Between Practice, Attitudes Toward Medical Errors

**University of Iowa
May 10, 2007**

When it comes to disclosing medical errors to patients, there is a gap between physicians' attitudes and their real-world experiences admitting such errors, according to a University of Iowa study.

From a survey of faculty physicians, resident physicians and medical students, researchers found that while nearly all respondents indicated that they would disclose a hypothetical error, less than half reported having disclosed an actual minor or major medical error. The survey results are published in the online version of the *Journal of General Internal Medicine*.

"Our goal was to learn more about clinicians' attitudes but also what they actually have, and have not, done," said the study's lead author Lauris Kaldjian, M.D., Ph.D., associate professor of internal medicine in the UI Roy J. and Lucille A. Carver College of Medicine and director of the college's Program in Biomedical Ethics and Medical Humanities. "We were interested in what factors or beliefs might be motivating physicians who are more likely to disclose errors to their patients."

Kaldjian and his colleagues received survey responses from 538 faculty physicians, resident physicians and medical students from academic medical centers in the Midwest, Mid-Atlantic and Northeast regions of the United States. Survey questions focused on respondents' attitudes toward disclosing medical errors; whether they would disclose an error from a hypothetical medical situation; and whether they had ever disclosed a real-life medical error.

Ninety-seven percent of the faculty and resident physicians indicated that they would disclose the hypothetical medical error that resulted in minor medical harm (resulting in prolonged treatment or discomfort) to a patient, and 93 percent responded that they would disclose the error if it caused major harm (disability or death) to a patient.

However, only 41 percent of faculty and resident physicians reported actually having disclosed a minor medical error, and only 5 percent responded as having disclosed a major error. Moreover, 19 percent acknowledged having made a minor medical error and not disclosing it; 4 percent indicated having made and not disclosing a major error.

Taken at face value, the responses would imply that more than half of the physicians surveyed have never made a medical error in their careers. This is striking, Kaldjian noted.

"It seems fair to assume that all of us have made at least a minor error, if not a major error, sometime in our careers," he said.

Kaldjian acknowledges biases that can influence survey data like this -- for example, a respondent's reluctance to reveal information that may be embarrassing or unflattering. The point remains, however, that there appears to be a discrepancy between how physicians and trainees believe they would act when faced with a medical error situation and how they have acted when in these situations, he said.

"Most doctors recognize that they're fallible, but they still strive for perfection and, for the most part, hold each other accountable to a high standard of practice that approximates perfection," Kaldjian noted. "The idea persists that the physician rides into the clinic on the white horse. To come in as the healer and then realize that you have harmed is a difficult thing to accept, let alone admit."

Fear of malpractice has been cited as a reason why doctors do not disclose medical errors, but the study authors report that their survey found that physicians who had been exposed to malpractice litigation were not less inclined to disclose errors. The researchers also found differences among the survey respondents based on training level. Physicians with more experience were more willing to disclose medical errors, suggesting that with increased clinical competence and confidence, doctors become more comfortable with error disclosure, according to the study.

Kaldjian also noted preliminary survey data showing that physicians who indicated that forgiveness is an important part of their spiritual and religious belief systems were more likely to disclose medical errors to their patients.

"This is not to say that forgiveness should be a course in medical school," Kaldjian said, "but it does suggest that medical schools should consider ways to encourage trainees to draw upon the deeper personal beliefs they bring to the practice of medicine that may be relevant to the challenges of disclosing medical errors."

The study was funded by a Robert Wood Johnson Foundation grant to Kaldjian through the foundation's Generalist Physician Faculty Scholars Program. The article is available [online](#).

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<http://www.sorryworks.net/article47.phtml>

RESPONSE TO HARVARD DISCLOSURE STUDY

In January 2007, several Harvard University researchers published a paper on disclosure. This paper can be found at this [link](#). Below is our response to the paper, and also at this [link](#) is the response from Dr. Steve Kraman and several Australian physicians.

SORRY WORKS! RESPONSE TO HARVARD DISCLOSURE STUDY

The journal Health Affairs recently published a study on disclosure and its potential cost impacts by five Harvard researchers (Studdert et. al; January/February edition). We applaud attempts to better understand and research disclosure. The authors take many novel approaches to attempt to quantify the total systematic cost of claims if all healthcare institutions conducted disclosure. They surveyed numerous experts (attorneys, physicians, risk managers, insurance professionals, etc) on the potential value of claims and then fed these results into a computer model. Surprisingly, the model said overall claims would cost more with disclosure, not less. Why the difference between the model and the numerous institutions and organizations reporting reduced litigation and cost savings with disclosure? The answer can be found in the methodology used by the Harvard researchers.

The real experts are not medical, insurance, and legal professionals in a simulated study but the patients and families who have actually experienced adverse medical events. Unfortunately, not even the most gifted researcher can replicate the positive emotional impact of disclosure on patients and families and how those feelings influence financial decisions and litigation. If this sounds "touchy feely" it is, because in the words of Sorry Works! board member Dr. John Banja disclosure "is all about the feelings." By constructively addressing feelings after adverse events, disclosure mitigates anger among patients and families and the urge to financially punish doctors, hospitals and insurers. This "touchy feely stuff" is the reason that disclosure reduces lawsuits and settlement costs.

Yes, claims (not lawsuits) may increase with disclosure, as the Harvard researchers suggested in their study. However, it appears that the Harvard researchers operate in the typical mind frame that medical malpractice is "all about the money." When institutions conduct disclosure, money becomes a secondary or tertiary issue, as it should be. Disclosure acknowledges the humanity of patients and families, which mitigates anger, and when anger is off the table people can become very reasonable and creative about what constitutes fair compensation. Yes, sometimes checks - even big checks - will have to be written to pay for the damage caused by medical errors, but they're not "jackpots" because patients and families are not trying to punish the institution. Furthermore, there are plenty of stories coming from disclosure institutions where patients and families have had - for example - patient safety lectures or wings of hospitals named after loved ones. There are also plenty of incidents where compensation was rejected completely by patients and families simply because the "sorry" was good enough.

Simply assuming that every disclosure event will result in a claim where significant sums of cash are paid - as the Harvard researchers did - is a bad assumption and shows a total lack of understanding of what truly motivates patients and families after adverse medical events.

Furthermore, the Harvard researchers did not quantify the reduction in litigation expenses for meritorious claims as well as the decrease in non-meritorious litigation with disclosure. Across the med-mal industry, seventy to eighty percent of claims are closed with no compensation being paid. These are major cost factors that are a real drag on the med-mal industry with traditional deny-and-defend risk management strategies - and disclosure's ability to rein in these costs is one of the big selling points for institutions considering Sorry Works!

Given all reasons above, the only feasible way to measure the financial impact of disclosure is to directly study institutions conducting disclosure. However, this was the most surprising facet of the study: The authors did not study real-world institutions conducting disclosure!

There are many institutions that are reporting positive experiences for their bottom line with formal and informal disclosure programs (most notably the University of Michigan), but the authors simply did not contact or study these organizations. Surprising and disappointing.

Future studies should more closely study the phenomenon of disclosure and apology in medical and insurance organizations that are actually operating disclosure programs. However, please understand: Institutions that embrace disclosure and apology undergo massive culture changes with numerous tangible and intangible financial benefits. It will be difficult if not impossible to measure the financial and other benefits of disclosure in a computer model. Instead, researchers interested in future studies on disclosure will need to engage in the painstaking efforts of observing and understanding organizations conducting disclosure. We look forward to such efforts.

<http://www.sorryworks.net/media55.phtml>

'Sorry' solution: Malpractice bill frees doc to apologize

By Jessica Fargen
Boston Herald Health & Medical Reporter
Sunday, March 18, 2007

A proposed law in Massachusetts would give doctors more freedom to be honest with patients about medical errors without fear that their apologies might be used against them in court.

It's just one part of a national and local push to get more physicians to say "I'm sorry."

"Patients say, 'If I'd had an apology, it would have helped my own healing,'" said Deborah Wachenheim, coordinator of a consumer health quality group at Health Care for All, and backer of a proposed bill that would legally protect doctors who apologize. "Just hearing the apology can make such a huge difference."

The Bay State legislation, proposed by state Sen. Richard T. Moore (D-Uxbridge), chairman of the health care financing committee, would make doctors' statements of regret or admissions of errors to a patient or family inadmissible in court.

The bill is only one part of a cultural shift in the health care system in response to rising malpractice costs and a growing patient right-to-know movement.

Hospitals across the country, including many in the Boston area, have adopted so-called apology and disclosure policies, which can allow a physician to admit an error, explain what happened and apologize. Sometimes, the hospital offers money upfront to cover associated costs.

Doug Wojcieszak, spokesman for SorryWorks! Coalition, which advocates for apology and disclosure policies, said health systems around the country are slowly embracing the idea, which has cut down on malpractice claims and saved money at some hospitals.

"They've had this risk-management strategy for years - deny and defend," Wojcieszak said. "They think that's the way to limit lawsuits. What the experience has been is that doesn't prevent a lawsuit, it encourages one. They make people angry."

Medical errors also kill. About 100,000 people in this country die each year as a result of medical errors, according a national study.

Last year, the 14 Harvard-affiliated hospitals in Massachusetts agreed in principle to a consensus agreement that laid out an apology and disclosure policy, although hospitals have instituted their own individual procedures. Wojcieszak said some studies have shown that even with moderate to severe errors, patients are less likely to sue if a physician acknowledges a medical error.

"We've got to quit playing games with patients, said Dr. Lucian Leape, an adjunct professor at the Harvard School of Public Health and national patient-safety expert.

"A patient has a right to know absolutely everything. We have no right to keep anything from patients," said Leape, one of the authors of the Harvard agreement.

Dana-Farber Cancer Institute adopted a policy in 2001 that requires the hospital staff to acknowledge a medical error within 24 hours of its occurrence, prior to any investigation.

Maureen Connor, Dana-Farber's vice president of risk management, said the document gives doctors guidance and makes patients feel informed.

"Simply put, this is the right thing to do," said Connor, who also worked on the Harvard agreement.

Some physicians and attorneys say hospital policies must go hand-in-hand with legal protections, such as the one contained in Moore's bill, for true malpractice reform to work. Massachusetts doctors pay some of the country's highest medical malpractice insurance rates.

"The health-care providers need to be assured that they will be reasonably protected under those policies," said John P. Ryan, a Boston attorney who defends physicians in malpractice cases.

Added Dr. Kenneth Peelle, president of the Massachusetts Medical Society, who supports Moore's legislation: "We think it's a different way of approaching some of the problems with malpractice claims than what we've been seeing in the last couple years."

<http://www.sorryworks.net/media54.phtml>

WALL STREET JOURNAL STORY ON APOLOGY AND DISCLOSURE

**Doctors Learn to Say 'I'm Sorry'
Patients' Stories Of Hospital Errors Serve to Teach Staff
Wall Street Journal
Laura Landro, The Informed Patient
January 24, 2007; Page D5**

When 6-year-old Jill Hartel was hospitalized toward the end of a long battle with leukemia, her mother woke up from a fitful sleep at her daughter's bedside, horrified to find a nurse administering an intravenous dose of Benadryl, though a medication allergy was clearly marked on her medical chart.

More than 12 years after Jill's death from complications unrelated to the error, her parents, Lisa Alecci and Steve Hartel, who work and live in the Boston area, say they can't forget the cold treatment they suffered at the hands of hospital staffers, who among other things, failed to transfer her medical chart from the emergency department, and excoriated her distraught father for failing to alert them to the allergy. "I still double over in tears when I think of the way they tried to blame us," says Ms. Alecci. "No one ever came back to apologize either for giving the drug or for the way it was handled, which was as bad as the error."

The couple are among a number of families and patients who agreed to share such experiences -- without identifying themselves or the hospitals involved -- for "When Things Go Wrong: Voice of Patients and Families," a new training film for medical staffers financed in large part by Crico/RMF, the patient safety and medical malpractice company that covers 18 hospitals and 10,000 physicians affiliated with Harvard Medical School. Though their harrowing stories about being stonewalled or ignored after suffering grievous injuries such as botched operations and life-threatening medication errors are sure to make doctors uncomfortable, the film's creator, Tom Delbanco, a Harvard medical professor and physician at Boston's Beth Israel Deaconess Medical Center, says the "bad news" stories make the most powerful teaching cases to show clinicians how they often avoid and isolate patients at the time they are needed most.

"We need to shock doctors out of their complacency about what's happening from the patient's perspective," adds Luke Sato, chief medical officer of Crico/RMF, which will provide copies of the DVD and training manual free for seminars and courses within the Harvard system and sell it to others for \$237 to \$395 based on the number of copies via its Web site (rmf.harvard.edu1). Dr. Sato says the aim is to help doctors better understand the impact of medical errors and the importance of apology, but also to prevent such errors from happening in the future.

Over the past few years, the "disclosure and apology" movement has spread rapidly in health care, as a growing number of states pass laws protecting a doctor's apology from being used at trial, and as more hospitals adopt policies requiring that doctors and nurses promptly disclose errors and apologize to patients and families when warranted. But getting doctors and other medical staffers to drop their traditional reluctance to face patients they've harmed, and to overcome their fear of reprisal, has proven a tougher task -- especially since the very legal departments and risk managers that are now encouraging open communication have long stressed "defend and deny" policies that often threw up a wall of silence after a medical error.

Now hospital risk managers and insurers are taking a different tack, in part because of mounting evidence that disclosure and apology programs, which often include an up-front offer of a financial settlement, can sharply reduce malpractice costs.

At the University of Michigan Health System, which adopted new policies encouraging full disclosure of errors and apologies to patients when warranted, the number of presuit claims

and lawsuits has dropped from 260 pending in July 2001 when it implemented the new approach to malpractice claims, to fewer than 100 pending at present. The average legal expense per case is also down more than 50%, according to chief risk officer Richard Boothman, whose department works closely with physicians after a medical error or adverse event to discuss how to handle communication with patients. "Many doctors really want to be open and apologize to patients, but are led to believe it can end up in financial disaster, when the truth is quite the opposite," Mr. Boothman says.

Using real patients in training programs to get the message across can be more effective than dry lectures or simulations using actors, which often don't pack the same emotional punch. Mr. Boothman is asking patients who have experienced a medical error or other problem such as a delay in diagnosis to speak about their experiences on video for use in training workshops, including a woman whose breast cancer went undiagnosed for 2 1/2 years and hired a lawyer to explore a claim, but later agreed to a settlement that included a college fund for her children. "When I talk to doctors, it is these personal stories that affect them far more than a power-point presentation with numbers and grids," Mr. Boothman says.

Another effort, the Sorry Works! Coalition, a nonprofit group that includes doctors, lawyers, insurers and patient advocates, was launched in February 2005 by Doug Wojcieszak, a political and public-relations consultant whose brother died after a medical error in a Cincinnati hospital in 1998. Though the family won a lawsuit, "We still grieve that the doctors never sought us out and apologized," he says. The coalition (sorryworks.net) works with state pilot programs and insurance companies to promote full disclosure and apologies as a solution to the malpractice crisis, focusing on a protocol that requires health-care providers and their insurers to apologize if an analysis shows that an error took place or a standard of care wasn't met -- admitting fault, providing an explanation of what happened and how the hospital will ensure the error isn't repeated, and offering compensation.

For patients and families such as the parents of Jill Hartel who have been affected by medical error, the opportunity to educate doctors about how to admit fault and express remorse through such educational programs as "When Things Go Wrong" can help ease the pain of feeling victimized by the health-care system. "Doctors have had it drilled into them for so long that if they ever admitted any kind of mistake, they would get sued, and they desperately need to understand that isn't the case," says Mr. Hartel, "Anything I can do to help one or more doctors get the importance of compassion will benefit me and hopefully will benefit them."

<http://www.sorryworks.net/media53.phtml>

Could "I'm Sorry" End Malpractice?

NEW YORK, Feb. 7, 2007

(CBS) Linda Kenney went into the hospital for what she expected to be a short stay for ankle surgery in 1999. Days later in the ICU, she found out she was lucky just to be alive.

"Nothing could have prepared me for what had happened," Kenney told *The Early Show* **medical correspondent Dr. Emily Senay**. "Woke up with my chest re-wired and tubes everywhere."

She suffered a rare complication where anesthesia entered her blood stream and caused her heart to stop. The man who gave her the almost lethal injection was anesthesiologist Dr. Rick Van Pelt.

"Within about 30 minutes from the onset of this event, Linda was on the operating table with her chest opened and was connected to a bypass machine," Dr. Van Pelt said.

In some cases, patients fall victim to unavoidable complications, in other cases there truly was an error. Initially, Kenney wasn't given the whole story - typical of many cases where a serious medical complication has occurred.

"They told me I had an allergic reaction to anesthesia, which I knew was an outright lie," Kenney said.

"The message was, 'Don't talk.' We just went on like nothing happened. I was at work the next day like nothing," Dr. Van Pelt said.

Kenney tried to put her near-death experience behind her but Van Pelt could not put it behind him.

"This was a patient who put their trust in me and in spite of doing that, here I was having just about killed somebody and it was something inside of me said I have to be responsible for that," he said.

He wrote Kenney a letter apologizing for what happened. Showing empathy and working with the patient to figure out what happened are things that Hospital Risk Managements are teaching medical professionals to do. **Dr. Senay** said they are using DVDs and discussions to help doctors.

Doug Wojcieszak never got an apology letter after his brother, Jim, died of from medical error so he sued the doctors and the hospital where Jim died.

"It's not greed that drives most people to file medical malpractice lawsuits," Wojcieszak said. "It's anger. They get - people get angry when they think there's a cover-up."

Wojcieszak's anger turned into action. He created the Sorry Works Coalition with a simple idea: Reduce malpractice lawsuits by telling patients the truth followed by an apology.

"Basically, what it is is we're advocating good customer service. Without apology and disclosure, there can be no patients' safety because as long as you're coving up and denying, you're never gonna learn," Wojcieszak said.

According to healthcare litigation attorney Jim Saxton even lawyers say empathy works. "That 'I'm sorry' done the right way with the right process can, number one, derail a lawsuit," Saxton said.

It could also reduce costs. After the University of Michigan health system changed its medical error policy on malpractice cases, legal fees per case were more than cut in half. The legal climate is slowly changing. Twenty-nine states now have laws that protect doctors from lawsuits when they say they're sorry.

It was the apology that opened the door for Kenney the patient and Van Pelt the doctor. They talked on the phone and two years later they met face to face for the first time since that day in 1999.

"I think about it now and I needed to know that this had an impact on - that it wasn't just me and my family," Kenney said. "That he didn't almost just kill a patient and have no feelings later."

"I think for me the biggest piece of this conversation was her offering me forgiveness. That still sends a chill down my spine," Van Pelt said. "Forgiveness goes both ways. It helps both sides and I think that what's so powerful about an apology and about forgiveness."

<http://www.sorryworks.net/article44.phtml>

CRITTENDEN'S MEDICAL INSURANCE NEWS: MOVEMENT TO APOLOGIES TO GAIN STEAM

Efforts to bring positive resolutions to adverse medical/patient outcomes - for both physicians and hospitals - will increase dramatically this year as insurers and insureds try to find a reasonable and cost effective method to mitigate frivolous lawsuits. The Sorry Works! Coalition can be expected to remain at the forefront of this movement, followed by the COPIC Insurance Co.'s 3Rs program, and the National Quality Forum (NQF). The Leapfrog Group (TLG) and Common Good's Health Courts, represented by Paul Barringer, will also have a hand in further shaping possible resolutions. More than 18 states have passed apology laws protecting a doctor's remorse from being used at trial. Case law in Vermont provides immunity for apologies. Florida, Nevada and Pennsylvania statutes require written disclosure of bad outcomes to patients. Although COPIC's 3Rs program, based on quickly recognizing, responding to, and resolving a patient injury, is credited with helping reduce the carrier's claims from 12 per 100 doctors in 1998 to 6.2 per 100 doctors in 2005, not every adverse outcome is a candidate for early intervention. Type of injury, attorney involvement or unrealistic expectations may mandate a trial.

Sorry Works! spokesperson Doug Wojcieszak will take his coalition's message this month to ProMutual Insurance Co. and to Physicians Liability Insurance Co. (PLICO) in March. Sorry Works! stresses the idea that greed is not the underlying motivator in most med mal suits, citing anger and frustration as the driving force behind patients and their families seeking court settlements when questions aren't answered and/or when they feel summarily dismissed by a hospital or physician. The Sorry Works! model encourages meetings between the doctor and the patient, listening, discussing the facts, explaining the reasons for a bad outcome, and offering condolences. The program also suggests negligence should be admitted with an apology and an offer of a settlement. Medical Protective also supports an apology framework that is not destructive to a doctor while respecting the patient and avoiding blame. However, the carrier, where Kathleen Roman is risk management education leader, also wants insureds to avoid apologies simply intended to make a patient go away. Participation in Med Pro's accredited risk management education program can grant an insured physician a 5 percent premium discount for up to three years. Aetna steps up as the first health plan to adopt TLG's Never Events program, which includes making an apology, reporting an incident to the appropriate authority, performing a root-cause analysis of the situation, and waiving any costs associated with it. TLG publicly acknowledges hospitals that commit to this program. It estimates that there are more than 1,300 rural and urban hospitals in its network. Companies such as IBM and Intel have also committed to using this program. TLG's Never Events is based on the National Quality Forum's two-year effort to create a list of 28 Serious Reportable Events. The Centers for Medicare and Medicaid Services endorses the NQF program, as do Kaiser Permanente and Blue Cross Blue Shield. NQF's goals include developing a national strategy to measure and report healthcare quality, and standardizing performance measures so that comparable data is available nationwide.

<http://www.sorryworks.net/article43.phtml>

Dec. 2006

Making Honesty the Policy

Many hospitals are discovering that error disclosure brings financial rewards and an imageboost-not million-dollar lawsuits.

If hospitals view patient safety only in terms of taking steps to prevent errors, they're missing a significant part of the pule. Mistakes will happen no matter what precautions a facility takes, so senior leaders must consider how their organization will react in the aftermath. Are your physicians encouraged to clam up and go on the defensive? Does your risk management office automatically assume battle position at the first hint of a lawsuit?

That's the way it's been in the industry for a long time. Hospitals have traditionally hunkered down and protected their assets when something bad happens, fearing that leveling with patients, families and attorneys will cause greater harm than keeping quiet. But some facilities are taking a different tack and owning up to mistakes sooner rather than later. Hospitals that have adopted a policy-and an attitude-of transparency are reaping legal and financial benefits while improving their image at the same time.

Apologies at work

Although he didn't know it at the time, Steve Kraman, M.D., became a pioneer in medical error disclosure in 1987. As chief of staff of the Lexington (Ky.) VA Medical Center, Kraman worked with the hospital's attorney and the risk management committee to craft a policy that ensured that hospital administration knew about adverse outcomes as soon as possible so they could gather evidence in case of a lawsuit.

The policy didn't last a year. When presented with a clear case of wrongful death, Kraman says, "We didn't feel comfortable with what we'd planned to do-simply file it away-because the family had no way of knowing." Instead, Kraman called the family, told them a problem had been discovered, and invited them to bring an attorney in for a meeting. "We explained what happened, apologized on behalf of the facility, told them what we'd done to try to prevent things from happening in the future, and told them they were owed compensation," says Kraman. Within a few weeks, the attorneys arrived at a settlement that both sides thought was fair. The case became a model for the hospital's disclosure policy, and the VA system later used the model for its own mandatory disclosure initiative.

"The normal practice was to circle the wagons, hide everything and make it hard for people to sue," Kraman says. In 1999, he compared Lexington's claims experience to the rest of the VA, and although his research showed Lexington paid more settlements than average for similar hospitals, total costs were lower. "We ended up paying reasonable amounts based on actual loss, and almost no expenses went to long, drawn-out court cases," says Kraman, now a professor at the University of Kentucky College of Medicine. He adds that disclosure sessions often ended with handshakes and even hugs from patients grateful for hearing the truth. "It sounds almost 'Pollyannaish,' but if you treat people decently they generally respond in kind," he says.

The difficult trek to the high road

Slowly, hospitals across the country, and even some malpractice insurers, are following in Lexington's footsteps. But making the move to transparency isn't easy; numerous fears and bad habits have to be overcome.

Experts agree the biggest problem is that hospitals and physicians don't understand what causes people to sue. A common assumption is that patients and family members want million-dollar settlements. To avoid a lawsuit, providers have historically remained tight-lipped when an error occurs. Patients, in turn, head straight to an attorney's office when they perceive the hospital has something to hide. "It's generally not about money," says Kraman.

"A doctor at the hospital that they've put their trust into all of a sudden slams the door when a mistake is made, and they feel they've been abandoned."

Many providers also fear that exposing safety records to scrutiny will result in more lawsuits, but this concern is largely unfounded. Hospitals with disclosure policies often see a reduction in the number of lawsuits and a decrease in settlement outlays. The University of Michigan Health System's young disclosure program, for example, has seen a steady drop in claims since being instituted by Chief Risk Officer Richard C. Boothman in 2002 (see chart above). The average claims processing time of the Ann Arbor system, which staffs approximately 800 beds, is down from 20.3 months in 2001 to 9.5 months, and average litigation costs have dropped by more than half.

Still another roadblock to transparency is the belief that apologizing guarantees a bad result in court, but Geri Amori, Ph.D., senior director of the Risk Management and Patient Safety Institute in Lansing, Mich., debunks this myth. "People think saying 'I'm sorry' will give the plaintiff more money," she says. Instead, a physician who proves willing to communicate early on and to admit wrongdoing may appear more favorable to a judge and jury than someone who is withdrawn and unresponsive, Amori says, adding that admitting a fact is different than taking responsibility for a liability.

Gaining steam

Hospitals aren't the only ones acknowledging the potential benefits of open discourse. Denver-based COPIC Insurance Company offers member physicians a voluntary disclosure option that includes formal disclosure and offers the patient immediate compensation up to \$30,000. Between October 2000 and December 2004, patients were reimbursed for 305 incidents at an average cost of \$5,326. No cases resulted in litigation.

According to the American Society for Healthcare Risk Management, 17 states have apology immunity laws on the books designed to protect physicians. To Doug Wojcieszak, founder of The Sorry Works! Coalition, a disclosure advocacy group, the real value of such laws is the peace of mind they give physicians. "The laws help physicians get over their cultural inhibitions, but if a doctor admits fault and takes responsibility, they shouldn't pretend like that didn't happen when they get to court," he says.

In Congress, a bill sponsored by Sens. Barack Obama, D-Ill., and Hillary Rodham Clinton, D-N.Y., aims to address medical malpractice issues via disclosure. Boothman, who helped draft the legislation, says the bill would help circumvent arguments about settlement caps by providing grants that would boost patient safety through transparency.

Healthcare executives, too, are realizing that much more than money is at stake. The hospital that's seen as a facility that cares, even when things go bad, will find it easier to build solid patient relationships. Changing how hospitals address mistakes can potentially improve the working environment of clinicians, as well. "When doctors and nurses make a mistake and hurt somebody, they can beat themselves up pretty badly," says Kraman. "If you're told to shut up and hide, that never goes away. This is a way of making it right so they can get on with it."

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<http://www.sorryworks.net/article42.phtml>

Having to Say You're Sorry

PDF file—printed separately (Tradecraft article- A more efficient Medical Malpractice Insurance Model)

<http://www.sorryworks.net/article41.phtml>

Simple Words Can Yield Big Rewards

You can probably think of a few times when a short apology soothed a tense situation, but can you remember a time when saying you were sorry reaped financial rewards? Simple as it sounds, apologizing for clinical errors has been shown to reduce medical malpractice lawsuits. By offering a sincere, accurate admission of regret, along with a promise to remedy the situation, you may be able to reduce your risk of a liability lawsuit.

Why apologies are worth it

Apologizing for a mistake can be complicated for O&P professionals, who make determinations about patient care in a world where expensive liability lawsuits are common. For instance: When is an apology due? What if a mistake did not result in tragedy, but merely an unintended, correctable outcome? How can a practitioner know whether his admission of wrongdoing will later come back to haunt him in a court of law? In addition, apologizing forces a clinician to confront fears of being sued, embarrassed or perceived as unprofessional.

Despite these issues, the movement toward "sorry policies"-empathizing with patients and apologizing for unfortunate or unintended outcomes-is gaining momentum. One group, the Sorry Works! Coalition (www.sorryworks.net), is a national group of patients, practitioners, hospital administrators, insurers and others who advocate sincerely apologizing for a clinical error, as well as offering prompt and fair compensation. Their goal-reducing litigation expenses-is based on the premise that most lawsuits are filed out of anger, not greed. They argue that establishing a sorry policy will ward off vindictive legal battles.

How it works

Here's how a sorry policy works. When an unintended outcome occurs, the practitioner and his insurance company's risk management team disclose all of the situation's details to the patient and the patient's family. Full disclosure, according to Dr. Steve Kraman, former chief of staff at the Lexington Veterans' Administration Medical Center, involves a direct, sympathetic and complete rendering of the facts of the patient's case to the patient. The practitioner should then apologize and promise a full review of the situation.

"If something bad happens, the very first thing that a medical professional can do is go to the family and say, 'I'm sorry this happened, I feel bad about it, you feel bad about it [and] we're going to do something about it right away,'" says Doug Wojcieszak, spokesperson for Sorry Works!

When apologizing, practitioners should avoid making statements like, "I shouldn't be you telling this, but..." or "We're sorry if you feel that way." Wojcieszak says that comments like those just make patients angrier, and therefore more likely to sue. Instead, be genuinely regretful. Avoid offhand remarks. Keep the lines of communication open and courteous.

According to Wojcieszak, the practitioner should also advise the patient to consult with a lawyer about the mistake and invite the patient to bring his or her lawyer to subsequent meetings, regardless of whether the case ultimately goes to litigation. Why? "Three words: credibility, credibility, credibility," says Wojcieszak. Being invited to bring a lawyer gives the patient confidence that the practitioner is looking out for the patient's interests. Additionally, lawyers often instruct patients to accept more reasonable compensation than they might demand otherwise.

You have the resources

Although sorry policies have met with success at several big hospitals, most small O&P facilities think they don't have the resources that those institutions do. But that's not true. Wojcieszak says that even facilities with just two or three staff members can reap big savings from sorry policies, and that, through their insurance carriers, they have access to the same kind of risk management services as big hospitals. In fact, your insurance carrier's risk

management team will likely offer training in how to offer an apology-stick close to their guidelines.

Make it a program

"I get this question a lot: 'I want to do this. How do I get this going?'" says Wojcieszak. He strongly recommends establishing a formal program well before an actual mistake occurs. "This only works as a program," he says. "It isn't an ad-hoc, case-by-case, whatever-feels-right thing."

To that end, Wojcieszak suggests practitioners call their insurance carriers and ask how to set up a formal program. "Then, when the adverse event happens, there's a call and the program snaps into action," he says.

To protect practitioners, groups like Wojcieszak's push for so-called "apology legislation." Generally, under these laws, providers' apologetic expressions of sympathy (e.g., "I'm sorry you had to go through this.") cannot be used against them in court. In some states, the apology is inadmissible in court even when it includes an admission of fault. (For instance, "I'm sorry I fitted you incorrectly.") For a list of these states, see the sidebar, "Know Your State's Apology Law."

Know Your State's Apology Law

Twenty-nine states have enacted laws excluding expressions of sympathy after accidents as proof of liability. They are:

- Arizona
- California
- Colorado
- Connecticut
- Delaware
- Florida
- Georgia
- Hawaii
- Illinois
- Louisiana
- Maine
- Maryland
- Massachusetts
- Missouri
- Montana
- New Hampshire
- North Carolina
- Ohio
- Oklahoma
- Oregon
- South Carolina
- South Dakota
- Tennessee
- Texas
- Vermont
- Virginia
- Washington
- West Virginia
- Wyoming

Make it a principle

Aside from the possible financial benefits, apologizing for an unintended outcome or mistake can deepen patient relationships and emphasize your practice's honesty and integrity. But to do so, it can't exist only at the practitioner level.

Wojcieszak says that everyone affiliated with your company, from the person at the front desk to the person paying the bills and anyone in between, has got to be willing to change from a "defend-and-deny" patient-relations strategy to one of truly compassionate care. And a reputation like that is always good for business.

This article was adapted from information contained in "When and Why You Should Apologize to Patients," which was printed in Aon's 2006 HPSO Risk Advisor.

<http://www.sorryworks.net/media51.phtml>

Indiana Hospital says sorry/offers compensation - applause!

Indiana Methodist Hospital (located in Indianapolis) made national and international headlines this week for publicly apologizing to the families of two premature infants killed by a drug overdose (four other infants were given the overdose too, with one infant still in critical condition.)

Hospital leadership has met with the families, apologized, admitted fault, and offered compensation. They have also vowed to fixed their processes so the same error is never repeated.

In short, this is Sorry Works! in action. The four elements of effective apology (remorse, admission of fault, explanation of how the mistake will be prevented in the future, and compensation) are present. Hospital leaders invited Sorry Works! to speak to their leadership last summer (2005), and it appears our message resonated. We applaud the hospital leadership and encourage other hospitals and med-mal insurers to follow their lead.

Below is an article written and published by the Associated Press on the story with quotes from Sorry Works! Please forward to colleagues.

For more information on Sorry Works! speaking engagements and teaching programs, contact 618-559-8168 or e-mail doug@sorryworks.net.

AP Centerpiece: Hospital apology could go a long way**DEANNA MARTIN and JENNY MONTGOMERY**
Associated Press**Tue, Sep. 19, 2006**

INDIANAPOLIS - Methodist Hospital has changed the way drugs are handled since six premature infants were given overdoses of a blood thinner, causing two girls to die.

Hospital officials also have apologized to the affected families, which advocates say is often one of the most important steps after such medical mistakes are made. Hospital leaders on Tuesday added that they would financially compensate the families for their loss.

Expressions of regret and offers of up-front payments do not always come so quickly after such mistakes, said Doug Wojcieszak, the founder the Sorry Works! Coalition, a group that advocates more openness in reporting medical errors.

Although money might not be what grieving families want now, it could take away some anger later, said Wojcieszak, who said he lost a brother to medical error.

"They've had their hope and their love tied up in their children, and then something like this happens," he said. "Obviously you can never replace a life, but people need healing. They need people to take ownership of those mistakes."

Of the four other infants who were given the overdose, three were in stable condition, while a fourth was in critical and unstable condition, officials said.

Methodist has blamed the overdoses on human and procedural errors. Heparin comes in premeasured vials, which hospital pharmacy technicians place in a computerized drug cabinet.

Early Saturday morning, a technician with more than 25 years experience took the wrong dosage from inventory and stocked it in the drug cabinet in the Newborn Intensive Care Unit, officials said. Nurses accustomed to only one dosage of heparin being available administered the wrong amount.

Emmery Miller and D'myia Alexander Nelson, both less than a week old, died.

Methodist was solely responsible for the error, said Sam Odle, president and CEO of Methodist Hospital, which is part of Clarian Health Partners.

"Of course we have offered our apologies and our deepest regrets," Odle said. "Ultimately the blame for our errors falls upon the institution. A weakness in our own system has been exposed and has been corrected."

Medical errors are estimated to kill thousands of people each year - some studies put the number between 44,000 and 98,000. Cases similar to the problem at Methodist have happened before.

In 1990, three premature infants died in Philadelphia after receiving an incorrectly mixed intravenous solution. In 1991, two premature babies died in Dallas after being overdosed of an antibiotic when a hospital technician prepared the wrong mixture.

Jim Conway, a senior fellow at the Institute for Healthcare Improvement said hospitals need to work to find ways to prevent errors.

"Every one of us will make mistakes, and it's the responsibility of health-care organizations to put in place systems that support safe practice," Conway said.

Some hospitals and doctors have resisted in the past admitting mistakes publicly because they fear lawsuits.

But certain reporting systems allow hospitals to report errors without the fear of a lawsuit, said Rick Croteau, with the Joint Commission on Accreditation of Healthcare Organizations.

"We are seeing, in effect, a shift in the culture that allows people to be more open and demonstrate that they're doing the right thing," Croteau said.

The Indiana Department of Health was expected to approve a rule Wednesday that will require hospitals to publicly report various types of mistakes to the state, a change that was expected even before Saturday's deaths. The first round of data was not expected until 2007.

Michael Cohen, president of the Institute for Safe Medication Practices, said Methodist's error could happen at any hospital with similar medication systems.

Clarian was one of thousands of hospitals nationwide that participated in the 100,000 Lives Campaign aimed at reducing lethal mistakes and breakdowns in care to prevent unnecessary patient deaths. Earlier this year, the leaders of the campaign said hospitals had prevented 120,000 deaths in the past 18 months by changing procedures.

Cohen said even with error reporting, it can be difficult for consumers to determine what mistakes mean.

"The public shouldn't see it as a scorecard," Cohen said. "You can't draw conclusions that one hospital is any less safe than another."

<http://www.sorryworks.net/article37.phtml>

Why Docs Won't Say Sorry

HealthDay New
MONDAY, Aug. 14

Doctors are more likely to admit to medical errors that are apparent to patients, according to a new U.S. survey.

The researchers also found that most doctors believe patients should be told about medical errors, but there was a wide range of opinions about when and how to inform them.

In addition, the survey showed that doctors' specialties affect their attitudes about disclosure, but the malpractice environment does not.

A team at the University of Washington School of Medicine in Seattle surveyed 2,637 doctors (1,233 in the United States and 1,404 in Canada). Among those surveyed, 49.7 percent were medical specialists, 40.3 percent were surgeons, 8.5 percent were family doctors, and 1.4 percent did not list their specialty.

The survey, published Monday in the Archives of Internal Medicine, revealed that:

- 64 percent of doctors agreed that errors were a serious problem.
- 98 percent supported disclosing serious errors to patients, and 78 percent supported disclosing minor errors.
- 58 percent had disclosed an error to a patient and 85 percent of those were satisfied with the disclosure.
- 66 percent agreed that disclosing a serious error reduces malpractice risk.
- Doctors' estimates of how likely they were to be sued didn't affect whether they believed that patients should be told about medical errors.

"The medical profession should consider whether the culture of medicine itself represents a more important barrier than the malpractice environment to the disclosure of harmful medical errors," the authors concluded.

"Patients justifiably expect that harmful medical errors will be disclosed to them. Increasing physician engagement in efforts to communicate openly with patients following errors and to enhance patient safety could provide a much-needed boost to patient's confidence in the quality and integrity of the health care system," they added.

More information

The American Academy of Family Physicians has more about [medical errors](#)

<http://www.sorryworks.net/article36.phtml>

Analysis: Why docs. don't say sorry

HEALTH FEATURES

By Olga Pierce

Aug 15, 2006, 19:00 GMT

WASHINGTON, DC, United States (UPI) -- The psychological difficulty of telling a patient about a medical error may do more to prevent physician disclosure than the litigious medical malpractice climate, a new study says.

'We think doctors' attitudes about disclosure come much more from the culture of medicine -- attitudes derived from training -- than the external malpractice environment,' said Thomas Gallagher, associate professor of medicine at the University of Washington and lead author of a study appearing this week in the Archives of Internal Medicine.

'At the moment, because they have so little guidance, physicians vary considerably in what they would say and often are not meeting patients' needs,' he told United Press International.

Medical errors result in tens of thousands of deaths and tens of millions of dollars worth of additional costs to the American healthcare system each year, yet the Institute of Medicine has estimated that as few as five percent of these mistakes go reported.

Doctors and politicians have pointed to the lawsuit-happy legal system, but, according to the study, the difficulty of looking a patient in the eye and telling them they have been harmed may be a bigger factor.

In the survey of 2,637 physicians in the United States and Canada, 98 percent supported disclosing serious errors to patients and 78 percent supported disclosing minor errors, but when they were presented with four scenarios of common physician errors they were much more divided about what to say.

Only 42 percent would use the word 'error,' 56 percent would mention the adverse event but not the error, 50 percent would give the patient specific information about what the error was and 13 percent would not reveal any details not requested by the patient.

Contrasted with what patients want -- an admission of error, information about the health ramifications, steps to taken to prevent repetition of the same mistake, and an apology -- this disconnect indicates a need for changes in the way doctors talk about mistakes, Gallagher said.

'This points out how early we are as a profession in the area of transparency. The vast majority of doctors haven't had any training in disclosure, and these conversations are really difficult.'

The study also calls into question the role of malpractice lawsuits in preventing disclosure to patients.

It confirmed the conventional wisdom that doctors who are more concerned about being sued are less likely to give patients information about medical errors that could be used against them. But that also holds true in Canada, the survey found, where the ability of patients to sue their doctors is much more limited and doctors are sued one-fifth as often.

'If you took the Canadian malpractice environment and magically transported it to the (United States), it would not make a big difference for patient disclosure,' Gallagher said.

A more fruitful approach, he said, is to develop guidelines -- like those currently being discussed by the National Quality Forum -- to help doctors know what to say to patients when they make a mistake.

Some states have also passed laws allowing doctors to apologize without admitting legal liability, which helps, he said. 'An apology is an important part of disclosure. It's clear that patients really value an apology.'

Doctors also need help conveying errors that are due to more of a system breakdown than individual mistakes, Gallagher said. One example in the study involved an insulin overdose that resulted from sloppy physician handwriting, which should have been caught by pharmacy and hospital safeguards.

Patients need to hear someone take responsibility in such a case, but it is not fair for them to leave thinking the physician is entirely to blame, he noted.

Eventually -- similar to strides made in the last 30 years in telling patients bad health news -- the medical profession will get better at letting patients know a mistake has been made, Gallagher said. And when it does, it could actually reduce the number of malpractice lawsuits.

Malpractice insurance companies that have experimented with early disclosure, apology and compensation policies have saved money, although no far-reaching studies have been done on the subject.

And while in some cases, disclosure of an error a patient may not have noticed on his own could precipitate a lawsuit, 'overall there is a good business case to be made for disclosure,' he said.

In the end, malpractice savings will be far eclipsed by the benefits to patients who have better information about their health and may experience fewer errors as a result of more open conversations within the medical profession, he added.

The good news from the study is that 94 percent of doctors said they would definitely or probably disclose an error, Cecil Wilson, board chair of the American Medical Association (AMA), told UPI.

'Patients deserve to know, and the AMA supports that,' he said, 'but in practice, disclosure may not be as frequent and complete as it should be.'

More training and information would be helpful to doctors because 'like anything else, it's always helpful to know how to go about it, especially in an area with so many emotions and concerns,' he said.

But the threat of lawsuits should not be discounted as a major factor in determining how much physicians feel they are able to tell their patients, Wilson said, and that will require a legislative fix.

'Our perception is that fear of medical liability litigation is one of the major deterrents,' he said.

<http://www.sorryworks.net/article34.phtml>

Disclosure of Medical Errors Desirable but Difficult, Researchers Find

August 3, 2006

Disclosing medical errors made by physicians is extremely important yet often extremely difficult. Two University of Iowa studies examine why this is the case and how increased understanding might help patients, doctors and health care systems overall.

One study involved a review of more than 300 previously published papers on factors that hinder or help doctors' disclosure of mistakes. Those findings appear in the April 2006 issue of the Joint Commission Journal on Quality and Patient Safety.

The second study suggested a new framework for understanding these factors, based on the literature review and new research involving five focus groups. Those findings appeared online May 31 in the Journal of General Internal Medicine.

"It's a challenge to understand the diversity of reasons, both positive and negative, that affect a physician's willingness to disclose his or her own errors," said Lauris Kaldjian, M.D., Ph.D., associate professor of internal medicine in the UI Roy J. and Lucille A. Carver College of Medicine and director of the college's Program in Biomedical Ethics and Medical Humanities.

"The physician's focus should always be on the patient, but at the moment of a medical error, we also must consider the professional who was involved in that error," Kaldjian said. "Often an error is not directly an individual person's fault, but a system-based problem. Yet disclosing errors can be a very individual issue because sometimes only one person knows about it and, as a result, disclosure becomes an individual responsibility."

Kaldjian said disclosing medical errors can contribute to three main goals of quality health care: patients deserve to know when things do not go the way they were expected, hospitals and clinics need to be aware of mistakes in order to improve patient safety, and sharing one's own medical mistake with colleagues can help educate other doctors so that they do not make the same error.

"Typically, these three goals are handled separately, and I believe this is a weakness in the way errors are addressed," Kaldjian said. "A better understanding of what helps or hinders error disclosure could result in ways to address these three goals together as part of one unified process."

The literature review revealed 91 factors involved in physician error disclosure, and the focus group research added an additional 27 factors.

"One comment from the focus groups clearly showed how emotionally traumatic errors are for physicians ? by referring to that 'sinking feeling' when a doctor realizes that an effort to help someone has actually harmed them," Kaldjian said. "Whatever else you say about medical errors, we need to remember that it's really difficult terrain."

The research also showed that some physicians are frustrated with reporting systems set up by hospitals to encourage error reporting because there is little or no feedback.

"Some doctors said they felt like they're sending a message into a black hole. This can make them less likely to take time out of a busy schedule to report an error. So, feedback is important," Kaldjian said.

Some doctors said the "bottom line" in terms of positive motivation to report an error was the desire to be straightforward with patients. Yet, physicians also noted that talking about errors "doesn't earn you points," and that the culture of competition in medicine can discourage doctors from being straightforward about mistakes, even among colleagues.

To promote further study of positive and negative factors underlying error disclosure, the research team developed a taxonomy of four positive and four negative domains.

"Most of the literature to date has focused on the negative side, but this new taxonomy gives equal attention to the positive side. We can learn from the doctors who are willing to talk about their errors and what helps them disclose their errors," he said.

The overall domains that motivate doctors to report errors include: responsibility to patients, responsibility to self (the physician's integrity), responsibility to the profession and responsibility to the community.

The overall domains that inhibit doctors from reporting errors include fears and anxieties (including, but not solely, malpractice), attitudinal barriers (e.g., perfectionism), uncertainties (about how to disclose errors or whether an "error" truly occurred), and feelings of helplessness, for example, that disclosing an error will result in losing control over the situation.

"A key theme is that physicians deserve support. Even the best doctors may make mistakes for reasons that are hard to understand -- we all have strange moments when we have lapses. However, we need to pay attention to the difference between honest mistakes and mistakes that happen when professionals are knowingly negligent," Kaldjian said.

Kaldjian and colleagues next will examine the many factors to see which appear to be most influential in terms of shaping physicians' beliefs and attitudes about error disclosure.

In addition to Kaldjian, investigators involved in the studies included other researchers from the UI Carver College of Medicine, the UI College of Nursing, and the Center for Research in the Implementation of Innovative Strategies in Practice at the Department of Veterans Affairs Iowa City Health Care System.

Kaldjian is supported by funding from the Robert Wood Johnson Foundation's Generalist Physician Faculty Scholars Program.

University of Iowa Health Care describes the partnership between the UI Roy J. and Lucille A. Carver College of Medicine and UI Hospitals and Clinics and the patient care, medical education and research programs and services they provide.

Source: UI Health Care at <http://www.uihealthcare.com>.

Find this article [here](#).

<http://www.sorryworks.net/media49.phtml>

Emerging med-mal strategy: 'I'm sorry'

July 14, 2006

Peter Geier

Staff reporter

National Law Journal Online

Doctors' apologies for medical mistakes may not be a cure-all for litigation, but explaining unforeseen outcomes and making early settlement offers have proven effective, say lawyers who have participated in the process in the last decade.

The concept is called "full disclosure/early offer," and it's spreading.

The U.S. Department of Veterans Affairs Veterans Health Administration—as well as a number of hospital systems and insurers across the nation—are among the entities that have adopted variations of the policy.

Two states—Illinois and Vermont—have recently passed legislation providing for pilot programs to test the efficacy of full disclosure/early offer policies. Tennessee, Texas and New Jersey may soon follow.

The concept also is being promoted as a solution to the national debate over medical liability between tort reformers who would create an administrative system of "health courts" and the plaintiffs' bar and its supporters.

Senators Hillary Rodham Clinton, D-N.Y., and Barack Obama, D-Ill., are currently sponsoring the National Medical Error Disclosure and Compensation (MEDiC) bill, a national version of the full disclosure/early offer policy.

Plaintiffs' and defense attorneys agree that the program—often referred to as Sorry Works! from The Sorry Works! Coalition, a Glen Carbon, Ill., advocacy group—is a sound strategy miscast in the public perception as a touchy-feely ritual.

Sorry Works! founder Doug Wojcieszak said that health care providers "willing to admit when they have made an error and quickly get on top of it...cut down on the anger that leads to litigation."

"Patients bring lawsuits when they can't get answers," Wojcieszak added.

Chris Mather, spokeswoman for the American Trial Lawyers Association in Washington, acknowledged positive aspects in Sorry Works! programs, such as doctors' apologies and letting people know what happened to them or a family member while in a health provider's care.

However, ATLA is concerned that in some instances the statute of limitations clock could be ticking while such processes are under way, that there is no requirement that patients be told that they can bring their own attorney and that statutes that protect doctors' apologies could be expanded to protect incidents, Mather said.

Key is open exchange

Although health care providers and insurers sometimes make their disclosures to unrepresented patients, lawyers say that the key to the policy lies in the open exchange of information, particularly between experienced counsel, that enables the early settlement of meritorious claims.

The hospital systems participating in the program include the University of Michigan Health System in Ann Arbor and Baltimore's Johns Hopkins Medicine. Insurers include COPIC Insurance Co. of Denver, and West Virginia Mutual Insurance Co. of Charleston, W.V.

Richard C. Boothman, chief risk officer for the University of Michigan Health System, which implemented its program in 2002, said that "this is not about making apologies, it's about being honest."

"Transparency, honesty and open discussion all make sense to intercept patient claims that become litigation, because once they become litigation, they take on a life of their own," he said.

Boothman came to this realization in his prior private defense practice representing the University of Michigan and the Cleveland Clinic Health System, when "I kept seeing opportunities missed by trying to be smarter in claims handling," he said.

The key is knowing the difference between reasonable and unreasonable medical care: If a health care provider made a mistake, the institution steps up right away and tries to do the right thing, he said. But if it believes there was no mistake, it's ready to fight.

And rather than focus on medical malpractice, emphasis is placed on improving patient safety and physician-patient communication-educating a patient as to the nature of his claim and why it may or may not be a compensable error, Boothman said.

"Do this, and medical malpractice litigation goes away or is reduced to background noise," he said.

A drop in claims

According to Boothman's testimony to the U.S. Senate Committee on Health, Education, Labor and Pensions last month, claims against the University of Michigan have dropped every year since 2001 despite increased clinical activity over the same period.

In August 2001, there were 262 total claims, ranging from presuit notices to active litigation; in August 2002, there were 220 total claims; 193 claims in August 2003; 155 claims in August 2004; 114 claims in August 2005; and since that time, the total number of claims has fallen to fewer than 100, Boothman said.

Within the same period, the university has cut its average claim-processing period from 20.3 months to 9.5 months, halving its average litigation costs. Also, its total reserves on medical malpractice claims dropped by more than two-thirds, he testified.

Linda D. Turek a partner at Sachs Waldman in Detroit; Peter A. Davis of Davis & Kuhnke in Ann Arbor; and Robert A. Tyler of The Tyler Law Firm in Southfield, Mich., have handled several cases with Boothman and respect his method-even if they don't always agree with his assessment.

Turek, a former emergency room nurse, said that the downside of settling cases is not giving her clients the chance to let a jury hear their story, which is an important part of the process to them, she said.

Turek and Tyler both said that they used the full disclosure/early offer policy approach with defendants in other cases.

"It's not the typical approach but it can be done when you've got experienced lawyers on both sides of the fence in a matter," Tyler said.

Davis said that Michigan's courts have become unfriendly to plaintiffs over the past decade and that, generally, hospitals, doctors and insurance companies often don't respond to notices of intent to file an action, which plaintiffs are required to file six months before they file suit.

"But with Boothman and the University of Michigan, we don't have to serve notice," Davis said. "We call him and send him the file and charts-or he comes over to our office and looks at them-and the process begins right away."

Davis added that "[w]e understand the process really well, and have a pretty good idea as to which claims will settle and which won't. If there's little chance of settlement, we don't take the case."

A credibility boost

Mary P. Foarde, general counsel of Minneapolis-based Allina Hospitals & Clinics, a not-for-profit network of hospitals and clinics, said that Allina's disclosure program "started in late 2001, when we had a very bad case and were gun- shy about trying cases."

Allina's program involves a philosophy similar to Boothman's-straight talk about mistakes and compensation offers, a vigorous defense of cases in which it believes no mistake has been made and using lessons learned to improve patient care.

Allina maintains that the policy of full disclosure/early offer and not settling bad cases "helps our credibility when we do decide to fight a case, and also deters people from suing us on shakier cases," she said.

Chris A. Messerly a partner in the Minneapolis office of Robins, Kaplan, Miller & Ciresi and president elect of the Minnesota Trial Lawyers Association, said that if Allina "believes a case has merit, they're quick to resolve the case," adding that his firm settles most of its cases against it without filing a lawsuit.

Michael A. Stidham, whose Jackson, Ky., practice includes representing Department of Veterans Affairs (V.A.) patients, has settled three cases with the Veterans Affairs Medical Center in Lexington, Ky.-two on the same morning-and lost a bench trial in a medical malpractice case that involved a suicide.

Stidham said that he likes the system and thinks that its wider application could help to reduce docket backlogs. In contrast, a case against a local hospital can take three to four years to get to trial.

"The only thing I really find lacking in it at this point is that I don't believe they tell the prospective plaintiffs that they have the right to discuss their offers with an attorney. A lot of men and women don't understand why they're receiving these offers," he said.

Stidham noted that "I didn't always get everything I wanted, but I didn't leave with a bad taste in my mouth, and left with a satisfied client, which is the most important thing."

The 'golden rule'

Ginny M. Hamm, the special assistant U.S. attorney assigned to the V.A. medical center in Lexington who worked with Dr. Steve S. Kraman, former hospital chief of staff, to introduce a centerwide disclosure program in 1987, said that a full and lengthy explanation always precedes an offer.

Since Hamm did her first disclosure case in 1989, the "golden rule" has been to tell veterans or their families that they should seek counsel when the hospital meets with them to disclose what went wrong, she said.

Kraman, as chief of staff, would speak to the veteran and his family on behalf of the entire medical center, offering an apology and explaining the error, then "hand off to me for the settlement," she said. Hamm added that if the V.A. determined that no mistake was made, it would hold a "closure" meeting explaining its finding to the veteran.

Kraman, who now serves on the board of The Sorry Works! Coalition, said that he was aware of only two cases in which angry patients sued for damages.

"The vast majority of people respond in kind. If treated honestly, they don't even want money. They want to see that some good comes out of a bad situation," Kraman said.

Joanne E. Pollak, general counsel of Johns Hopkins Medicine, said that while Hopkins has had an official full disclosure/early offer policy in place for about three years, it had already been working unofficially with families and their lawyers to resolve claims before starting the program.

"When something unexpected happens to a patient in Hopkins' care, Hopkins either tells the family what happened if it knows or, if not, it investigates what happened and gets back to the family with the facts after it has completed its investigation," Pollak said, adding that a doctor's apology is not part of the procedure.

Robert J. Weltchek of Weiner & Weltchek in Lutherville, Md., noted that the settlements "don't happen in one fell swoop, more like in two stages."

"The first thing is to get the doctors out of the case," he said. "The hospital does this because they're salaried employees of the hospital, and chances are it's going to end up paying the judgment anyway, whether the doctors are sued individually or not." Weltchek said.

"Hopkins usually steps up to the plate for the doctor, but admissions of liability and being sorry never have been part of my dealings with them," he said, adding that taking the doctors out facilitates the negotiations because it "takes the personal out of the case. Hopkins is very good at keeping the emotion out of it."

<http://www.sorryworks.net/media48.phtml>

Doctors starting to say 'I'm sorry' Duck, deny may not be best way to avoid suits

Monday, May 15, 2006

Harlan Spector

Plain Dealer Reporter

It turns out that never having to say you're sorry is not good for love - or medicine.

In the case of love, the divorce rate peaked after the sappy 1970 movie "Love Story" proclaimed that apology is uncalled for between sweethearts. As for medicine - where the standard response to blunders has been to duck and deny - well, you've heard about the malpractice liability crisis?

Some forward-thinkers in health care are changing the deeply entrenched policy of admitting no wrong.

With the blessings of hospital risk managers and a push from a group called the Sorry Works! Coalition, doctors are increasingly reaching out to patients and families to explain medical errors and apologize for them.

The era of full disclosure is in its infancy, but already advocates tout promising results. The University of Michigan Health System began acknowledging harmful mistakes and offering compensation to injured patients in 2001. The health system reported that the new policy saved \$2.2 million a year in litigation costs. The Veterans Health Administration also has adopted a disclosure policy.

"I've observed that patients are willing to forgive," said Joseph Feltes, a Canton lawyer who represents several hospitals. "But you've got to be upfront with people."

Medical errors kill as many as 98,000 people a year in the United States, according to a groundbreaking 1999 report from the Institute of Medicine.

Experts say medical mistakes don't trigger most malpractice suits, but rather anger over being spurned by caregivers after something goes wrong.

As many as 80 percent of malpractice claims arise from communication breakdowns, according to a recent article in Patient Safety and Quality Healthcare, an online publication.

Feltes tells a story of a widow who sued her late husband's doctor for malpractice and refused reasonable settlement offers. Asked by a judge why she refused to settle, the woman said she was angry that her husband's longtime physician never spoke to the family or apologized after the death.

Michele McBride of Lyndhurst said her family might not have filed suit in 2003 if a doctor had come clean after her 22-year-old sister, Shannon, bled to death following a tonsillectomy. The family lost the case at trial in Lake County Common Pleas Court.

"No one ever sat down with me or my family and said, 'This is what happened to Shannon,'" said McBride, 32, who last year formed a consumer group with another sister called Patient Safety Cleveland. "You have this doctor, this nurse who help you through your entire stay at the hospital. But if something goes wrong, you're cut off."

Advocates say full disclosure not only improves the litigation climate but also encourages better safety practices.

University Hospitals Health System has a policy that encourages full disclosure of medical errors, spokeswoman Loree Vick said. The Cleveland Clinic Health System has no formal policy but educates its physicians about the importance of being forthcoming with patients about complications or outcomes that fall short of patient expectations, spokeswoman Eileen Sheil wrote in an e-mail.

Many states wrestling with tort reform have passed laws that shield doctors from legal liability for apologies. Ohio passed such a measure in 2004. But state law does not protect a doctor's admission of error, which some say is a stumbling block to full disclosure.

Dr. Lloyd Jacobs, president of the Medical University of Ohio in Toledo, told the Ohio Medical Malpractice Commission in 2004 that the "punishing" atmosphere of the state legal system made openness difficult to achieve.

Ohio's insurance director, Ann Womer Benjamin, who chaired the commission, said in an interview that doctors are concerned about potential liability being attributed to them for any discussion.

"We have a state where the litigation system is strong; trial lawyers are a strong voice and do not want to impede a person's ability to go to court and file a claim," she said.

Ultimately, though, the acceptance of open disclosure may rest more with doctors than lawyers and legislators. It starts with medical schools, which are traditionally weak on teaching communication skills, Jacobs said.

Changing the duck-and-deny culture may take decades, he said.

"Those people over 45 years old are skeptical," Jacobs said. "Those under 35 years of age are enthusiastic."

For more information, visit the Sorry Works! Coalition at www.sorryworks.net and Patient Safety Cleveland at www.patientsafetycle.bravehost.com

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<http://www.sorryworks.net/media47.phtml>

Sorry Works injects decency into malpractice debate

April 20, 2006
From The Morning Call
Margie Peterson

One of the sad things about the medical malpractice crisis is that it has stifled the instinct toward decency.

From the time we can talk, people are taught that when we do something that hurts someone we should apologize.

But for years doctors, on advice from lawyers and insurers, were too often discouraged from apologizing when they made a medical error for fear it could be used as an admission of guilt if they were sued.

That's bad advice, according to Doug Wojcieszak, spokesman for Sorry Works, an Illinois-based coalition that encourages the medical community to adopt full-disclosure and apology policies.

An apology and an explanation would have gone a long way when Wojcieszak's brother died after a series of medical mistakes, he told me in a phone interview. Instead, when his father approached the hospital staff for an explanation and some sense of how the doctors planned to make sure it didn't happen to others, the staff told him their lawyers instructed them not to talk. Wojcieszak said his family sued and eventually recovered a settlement.

A better way can be found in the University of Michigan Health System, which dramatically cut the number of pending lawsuits against its hospitals after adopting a full-disclosure policy in 2002. It also reduced the costs of defending against suits from an average of \$65,000 per case to \$35,000 per case and cut the time it took to resolve cases from three years to about a year.

Under the policy, a hospital investigates suspected errors, and sits down with the patient and the patient's lawyer to review what happened. If the staff was found to have erred, they apologize and offer a settlement. If the treatment was shown to have been justified, the staff meets with the patient to explain why.

Should the patient decide to sue anyway, the hospital defends against the litigation. It's just as important that hospitals stand up for doctors and don't cave in and settle unwarranted lawsuits, Wojcieszak said.

A survey of trial lawyers in Michigan found that more are taking a pass on marginal medical malpractice cases because of the Health System's reputation for fairness, he said. "Because if University of Michigan is saying, 'We didn't make a mistake,' they probably didn't," he said.

Such hospitals are catching up to Department of Veterans Affairs hospitals, which pioneered full-disclosure policies in the 1980s, said Dr. Jim Bagian, chief of patient safety for the VA. "Most of the time people sue, they don't sue to collect damages," Bagian said. "They sue because they're mad. They're mad about how they were treated after the injury. People want you to admit there was a problem and [want to know] what are you going to do to make sure that it doesn't happen to someone else."

That last part is especially important, said health care consumer advocate Charles Inlander of Fogelsville, who is on the board of Sorry Works.

"This is really about making sure when errors occur, they're fixed and they're acknowledged," Inlander said.

On that he gets no argument from Dr. Ray Singer, a local thoracic surgeon and president of the Pennsylvania Association for Thoracic Surgery.

Pennsylvania already has a law that requires hospitals to notify patients within seven days if they made a serious error in their care, Singer noted. But patients don't generally sue doctors they like and those who have been upfront with them, he said. "The fact that you've been so open and honest has probably decreased your risk of being sued in the first place," Singer said.

By appealing to all sides' better instincts, the Sorry Works approach undercuts the rhetoric about blood-sucking lawyers and quack doctors that usually accompanies the medical malpractice debate.

<http://www.sorryworks.net/article32.phtml>

**Testimony of Doug Wojcieszak, Spokesperson, The Sorry Works! Coalition,
before the Tennessee General Assembly**

April 18, 2005

For the record: My name is Doug Wojcieszak (pro-nounced Woe-ches-zak) and I am the spokesperson for The Sorry Works! Coalition. We are a national non-profit group based in Illinois. Our membership is comprised of doctors, healthcare providers, lawyers, and patient advocates.

Mr. Chairman and members of the committee - I want to thank you for inviting me here today to testify. I consider this an honor and a privilege, and I hope my comments can add value to your efforts.

As a former legislative staff member for the Illinois House Republicans, I am going to take a slightly different approach with my testimony today. Instead of overwhelming you with a power point presentation and charts and graphs full of data, I am going to speak to you from the heart. I am going to look each of you in the eyes and explain why Sorry Works, apologies for medical errors, and full-disclosure is not only a middle ground solution to the medical malpractice crisis, but also the most comprehensive solution to the problem. A solution that can work here in Tennessee, which was recently tabbed a "crisis state" by the American Medical Association.

I am going to talk to you as a person who lost his oldest brother to medical errors, and as a person who has worked for both tort reformers and the plaintiff's bar in the fight over medical liability reform. From a personal and professional perspective, I believe Sorry Works! to be the best solution all-around solution for the med-mal crisis.

I will show how Sorry Works! addresses the root causes of medical malpractice and treats all stakeholders in the crisis - doctors, hospitals, lawyers, insurance companies, and patients - fairly.

And I will demonstrate how Sorry Works! lowers lawsuits and liability costs for doctors and insurance companies while providing swift justice for victims and their attorneys without constitutional limits. Furthermore, by infusing honesty in hospital systems, doctors learn better from errors, thus increasing patient safety and further reducing liability exposure.

I want everyone to understand that what I am advocating to you is more than doctors simply saying, "I'm sorry." While offering an apology is very, very important, there is much more to this than apologies...it's about accepting responsibility for problems, fixing the processes so those errors don't happen again, and also fixing problems of injured patients and families.

Finally, I will address the different pieces of Sorry Works! legislation pending before the Tennessee General Assembly.

The story of Sorry Works! begins in Lexington, Kentucky at the Veterans Administration Hospital.

In the mid-80's, the hospital had lost two multi-million dollar lawsuits. Not only did these lawsuits cost large sums of money, but they also turned doctors and patients into enemies. It wasn't the way they wanted to practice medicine.

So, they implemented a new, unconventional policy: apologies and upfront compensation for medical errors.

Here's how their program works:

After an adverse medical event - i.e, a bad outcome, unanticipated death, unsuccessful surgery, etc - doctors and hospital staff perform a root cause analysis. The analysis seeks to determine if the acceptable standard of care was met. The analyses sometimes involve the assistance of outside experts and usually take a few weeks to a couple months to complete.

During the analysis the hospital staff stays in close contact with the patient and/or family so they don't suspect a cover up or feel abandoned.

If the root cause analysis shows that the standard of care was not met, the doctors and medical staff meet with the family and their attorney, apologize, provide explanations of what happened, tell how they will fix the processes so the error doesn't happen again, and offer fair, upfront compensation.

However, if the standard of care was met (i.e, no error or negligence), the doctors and hospital staff still meet with the patient, family, and their attorney to provide explanations, open medical charts, answers questions, and basically prove their innocence. The hospital will empathize with the patient, but no settlement will be offered under any circumstances. Furthermore, the hospital will defend itself and their doctors to the death if a lawsuit develops - no settlements will be offered!

Conventional wisdom said they were crazy, but the Lexington staff happily reported in the December 1999 edition of *Annals of Internal Medicine* that their facility ranked in the lowest quartile of VA facilities for malpractice payouts; their average settlement per case was \$16,000 versus the national VA average of \$98,000. The Lexington approach spread to other VA hospitals in Los Angeles and Las Vegas and last fall was mandated in all VA hospitals nationwide.

The University of Michigan Hospital system adopted the Lexington program and has cut their lawsuits in half. Michigan also reports saving \$2 million in defense litigation expenses annually - or 2/3 of their defense litigation budget - because cases are being settled in months instead of dragging out for years.

Michigan's lawsuits are back to pre-1990's levels, and they also report having "excited actuaries." In fact, their actuaries are so excited they just released \$50 million from their reserves.

Michigan is reporting other exciting results....

When they started their program four years ago, the majority of the medical staff thought the hospital leadership was "crazy" for offering apologies and compensation for errors.

Today, in a recently completed survey, ninety-three percent of Univ. of Michigan medical staff support the program.

Better yet - in another voluntary survey, the Michigan trial bar said the program is changing their behavior. Better than 70% of trial lawyers surveyed said they are settling cases for less than would normally seek in trial & they are declining cases they would have taken a "flier" on in the past. The Michigan trial bar says they are changing their behavior out of respect for the positive behavior changes implemented by the University of Michigan Health System. Indeed, good feelings beget good feelings - all of this without any legislative initiative or tort reform.

Similar positive results have been reported at 28 Kaiser hospitals, 39 hospitals in the Catholic Healthcare West System, and Stanford University Hospital system.

Harvard Teaching Hospitals are joining the program this spring.

COPIC insurance of Colorado reports similar results. Malpractice claims against their 1,800 doctors have dropped by 50 percent since 2000 and settlement costs have fallen 23 percent.

So, how does this honesty program work? Why has it produced these results?

Reason #1: Anger Reduction

Forget everything you have heard about greedy lawyers and greedy plaintiffs being the cause of medical malpractice lawsuits. It's anger - not greed - that is the root cause of most medical malpractice lawsuits. Anger literally forces people to call a plaintiffs attorney.

Patients and families become angry when doctors and medical staff clam up and cut off communication after a bad outcome. They become angry when questions are not answered. And they become really, really angry when doctors try to cover-up mistakes and lie about it. Indeed, the cover up is always worse than the crime.

The traditional risk management approach to medical errors is usually called "deny and defend." This is where defense lawyers sweep in tell doctors and medical staff to keep quiet. I'm here to tell you today that deny and defend is a tried and failed risk management strategy. It produces anger and it's the chief reason we have a medical liability crisis.

As legislators grappling with this thorny public policy issue you must look for ways to encourage hospitals, doctors, and insurance companies to steer away from deny and defend and move toward the approach originally developed in Lexington, KY.

Dealing with people with honesty and fixing their problems removes anger, and in most cases the urge to file a medical malpractice lawsuit. When anger is removed, so is the urge to financially punish doctors and hospitals.

It's common sense....imagine having a doctor stand in front of you, apologize, tell you what he or she did wrong, how they are going to fix their processes so the mistake isn't repeated, and offering you upfront compensation. It's hard to imagine being angry at that doctor, and even harder to imagine wanting to file a lawsuit.

If you don't believe me, look at the numbers and data coming out of the hospitals doing this program - they speak for themselves.

Reason #2: Reduction of non-meritorious lawsuits

Hospitals that practice Sorry Works! are known as "straight shooters." They call it straight when they make a mistake, and because of it are more likely to be believed when they say a bad outcome wasn't their fault.

Some experts say non-meritorious or non-paying lawsuits account for 60% to 80% of all suits filed against doctors. These claims cost huge sums of money to defend and prosecute.

As legislators, if you want to reduce non-meritorious lawsuits - or frivolous lawsuits as they are sometimes called - you must again encourage hospitals, doctors, and insurance companies to abandon deny and defend practices and move towards honesty and transparency.

Honesty and transparency restores the reputation of hospitals and doctors and literally immunizes them against non-meritorious lawsuits.

When Michigan began their disclosure program, their chief risk officer met with all the major trial law firms and explained the program. The risk officer said they would try to catch all errors before people left the hospital, but, invariably, mistakes will slip through. He asked the trial lawyers to come talk with them before filing a lawsuit - bring in their clients to talk with Michigan and their doctors to determine if an error was made - or not.

The chief risk officer of Michigan tells story after story of such meetings where lawyers learned that bad outcomes were not caused by errors, and those trial lawyers saying "thank you" to Michigan for saving them time and money on a non-meritorious case.

Reason #3: Turning litigation logic on its head

As legislators I'm sure you heard doctors complain about being forced to settle a lawsuit where they did not commit an error but the insurance company insisted on settling because it was cheaper than defending the charges. And I'm also sure you've wondered why hospitals and insurance companies sometimes fight cases of clear, gross negligence, such as a wrong-side surgery, where the patient or family is drug thought court system for years, and the hospital or insurer is stung with a big verdict.

With Sorry Works, everything is in reverse. Cases of clear negligence are settled quickly and fairly, which saves large sums of money on defense litigation expenses and also lowers settlement costs because patients and families aren't trying to financially punish doctors. Conversely, when the doctor and hospital feels they have not committed an error, they will defend the case to the death with no settlement, which sends a strong signal that further reduces the filing of non-meritorious or frivolous lawsuits.

Reason #4: Reducing medical errors

Infusing honesty in hospital systems helps doctors learn better from errors, which increases patient safety and further reduce liability exposure. Hospitals that practice Sorry Works! report that their physicians become better at doing medicine.

The University of Michigan Hospital System believes they are going to become the safest teaching hospital in the country because of this program.

Now there many emotional knee-jerk responses to Sorry Works! Without question, what we are proposing with Sorry Works! goes against conventional wisdom, but it makes all the sense in the world. The data is there to support it, and common sense says it works too. However, the doubters continually offer up knee-jerk emotional responses to Sorry Works! and I want to address the most common rebuttal today:

Challenge: What if sorry doesn't work? A doctor has just admitted guilt.

Response: So, a doctor apologizes for an error and offers compensation, but the compensation is rejected and a lawsuit is initiated.

Classic story from the University of Michigan hospital system: They gave the wrong type blood to a patient, and the patient went into shock. Fortunately, they caught the mistake quickly and corrected the situation, but the patient did have to endure some pain and suffering and extra time in the hospital.

The Michigan staff apologized and offered \$10,000 in upfront compensation. The patient and his attorney thought they should get \$250,000. They went back and forth, and Michigan's final offer was \$40,000, which the patient and attorney rejected.

The case went to trial and the Michigan lawyer began the trial by admitting fault for the mistake, apologizing, explaining how Michigan was going to fix the problem so it wouldn't happen again, and telling the judge and jury the whole reason for the trial was to simply determine fair compensation for the plaintiff.

The jury awarded \$0.

As I close my presentation, I want to leave you with legislative suggestions.

As legislators you have an opportunity to provide leadership on this issue and encourage healthcare and insurance organizations in Tennessee to adopt Sorry Works!-type programs.

You have a bill before the committee submitted by Rep. Briley, and it is my understanding that there are a couple other apology bills before the Tennessee General Assembly.

I understand there are some serious questions and pushback on these bills, and I'm sure my testimony today will add to the discussion and debate.

Here is my suggestion: Pass a shell bill today and keep working this issue alive for the remainder of the session so people from all sides can craft a compromise.

This compromise bill should include:

- An apology immunity statute similar to Colorado's statute. Doctors have been told for decades not to apologize lest it be used against them in court. Apology immunity statutes remove this excuse. They are a good PR tool, but, in reality, a legal nothing. Think about it...a trial lawyer is not going to want to introduce a doctor's apology to a judge and jury because will humanize a doctor, whereas defense counsel should want to tell a judge and jury his client tried to do the right thing by apologizing and offering compensation, but the plaintiff is greedy – remember the Michigan case.
- Include in the bill the mandatory disclosure language adopted by the Pennsylvania legislature. In Pennsylvania, healthcare facilities are required to notify patients and families in writing within 7 business days after a bad outcome. These letters are not required to include an admission of fault or even an apology, but the letter itself puts a stop to the deny and defend games that have precipitated the med-mal crisis.
- Provide grants or funds to help healthcare and insurance organization with the implementation of disclosure programs.
- Mandate training on full-disclosure/Sorry Works! for all medical students in Tennessee and also mandate it as a continuing education requirement for all currently licensed healthcare professionals.

These legislative ideas can push and promote the idea of disclosure in your state.

One last idea – as may have noticed from comments and testimony NONE of the hospitals and insurance organizations I spoke about had a legislative mandate to do Sorry Works! They just did it on their own and have been very successful.

This is the beauty of Sorry Works...while legislation can help encourage Sorry Works, hospitals and insurers don't have to wait for the legislature to act. They can do Sorry Works! on their own –today!

So, the next time a medical, hospital or insurance organization asks you as legislators to fix the medical malpractice crisis, your response should be a question: "Tell me, have you implemented Sorry Works!-type disclosure programs yet?"

<http://www.sorryworks.net/article23.phtml>

Vermont's Model Sorry Works! Legislation (S. 198)

Vermont legislators are considering model Sorry Works! legislation this spring that is a true road map for every other state in the union. Click on this [link](#) to view the legislation.

EXCLUDED ARTICLE: SORRYWORKS IN JAPANESE< TOO—this was in Japanese and would not load on my computer.

<http://www.sorryworks.net/media45.phtml>

Finally, Patient Safety Advocates Can Feel Good About Tort Reform

**By Doug Wojcieszak; Susan E. Sheridan, MIM, MBA; Martin J. Hatlie, JD
Patient Safety and Quality Healthcare; www.psqh.com**

January/February 2006

In 2005, Illinois became the first state to adopt an innovative disclosure program known as Sorry Works! Incorporated into a larger medical liability reform bill (Ill. Gen. Ass. Pub. Act 094-0677, 2005). Sorry Works! is a pilot project that supports provider organizations that agree to implement and study the impact of full disclosure of medical errors. It also provides economic and regulatory protection in the unlikely event that their disclosure activities increase liability exposure. No constitutional rights are abrogated; no plaintiff or defendant is denied access to the courts. Sorry Works! is a true middle-ground solution that incentivizes behavior that an increasing body of research strongly indicates will benefit consumers, healthcare providers, and their liability insurers alike. Innovative plaintiff and defense lawyers have also expressed support. In short, the Sorry Works! approach is creating exciting new opportunities for partnerships among people and organizations that, regardless of their position on tort reform, support systems-based care and the future of the physician-patient relationship.

Within weeks after Illinois enactment, the Sorry Works! program was integrated into federal legislation now known as the National Medical Error Disclosure and Compensation (MEDiC) Act (S. 1784). Introduced by Senators Hillary Rodham Clinton and Barack Obama in September 2005, the bill will:

- Provide grants to implement full-disclosure MEDiC programs and immunity for full disclosure — a portion of the grant funds are dedicated to covering any added liability exposure incurred by providers who participate.
- Establish, in consultation with other organizations, a National Patient Safety Database to collect and analyze data generated by MEDiC pilot programs.
- Establish an Office of Patient Safety and Health Care Quality within the U.S. Department of Health and Human Services to administer and study the MEDiC program.

Request for Support

Each of the authors of this column has substantial experience in the tort reform movement. While we identify primarily as consumer advocates for improved patient safety, we acknowledge the concerns that doctors, nurses, healthcare organization executives, and others have with litigation. We are aware that lawsuits sometimes produce unfair or seemingly irrational outcomes for defendants, just as they sometimes do for patients and their families.

Macroscopically, we are very troubled about the role fear of litigation plays in undermining both patient safety and the physician-patient

relationship. It is fundamental that reducing patient harm depends on robust information-sharing about risk and that the physician-patient relationship must be grounded in mutual trust. Fear of malpractice litigation undermines both of these highly desirable goals. Accordingly, we strongly support incentivizing full disclosure through supportive, economically effective nationwide policy. We ask for your help to generate additional sponsors for S. 1784, both Republican and Democrat, and call for hearings.

Why S. 1784? Why Now?

As an issue, disclosure is politically ripe. Organized medicine — the American Medical Association, among others — has led in developing the ethical dimension of the issue (AMA, 1994; Sweet & Bernat, 1997; Brazeau, 1999). In addition, a growing body of research suggests that disclosure is highly desired by patients and families who have experienced adverse treatment outcomes and discourages lawsuits from being filed when it is done (Hickson, 1992; Vincent, et al., 1994; Wu, 1999; Gallaher, et al., 2003). The experience of prominent healthcare systems that do disclosure, such as the Veterans Health Administration and University of Michigan Health System, has been positive (Kraman & Hamm, 1999). Liability insurers who have acted on this research, taught disclosure skills, and either incentivized or implemented disclosure programs also have been very successful. Although some insurance company data is unpublished for proprietary reasons, these organizations increasingly report high rates of satisfaction among healthcare professionals and consumers, more liability claims that are settled early or likely avoided altogether, and reduced overall liability costs.

Moreover, the impact of disclosure on the physician-patient relationship is profound. Emotionally fraught as these conversations often are, they are crucial to healing both the professionals involved and the families impacted. As such, they are the surest way to regenerate trust after tragedy.

As a patient safety improvement strategy, it is notable that disclosure to patients is an aspect of system transparency. As such, it can be a culture-carrier. Honest conversations after an adverse outcome provide the opportunity to increase awareness among consumers about inherent risk in healthcare and the importance of sharing lessons learned. By infusing honesty in medicine, full disclosure also dissipates one of the primary obstacles to error reporting, i.e. fear that the patient or family will find out about what happened. Hence, incentivizing and supporting full disclosure is likely to increase reporting of adverse outcomes and lessons learned to the Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) sentinel event reporting program, the new federally protected Patient Safety Organizations, and other voluntary reporting programs.

How Do We Start?

To expedite change, the data and experience with disclosure summarized above needs to be amplified in the public and policymaking arena. Despite the increasingly evidence-based merits of disclosure and well-respected disclosure champions in the healthcare sector, the fear barrier is deeply entrenched in medical and legal culture. Ethical exhortations, white papers, legislation protecting apologies from being used as admissions of fault, and standards enforced by JCAHO all have had

limited affect at the sharp end. Recent survey data suggests that only about 55% of physicians fully disclose treatment failures to patients or families (Lamb, et al., 2003).

What is needed is a new coalition of leaders with the courage, perspective, and collective voice to dispel the current attitudes held about disclosure, transforming them into a win/win future. These leaders already are beginning to emerge from the physician and consumer communities, as well as among liability insurers, the hospital industry, defense counsel, and the plaintiff's bar, as part of The Sorry Works! Coalition. The resonance among these diverse stakeholders about the benefits of disclosure testifies to both the ethical concerns and economic forces that are aligning.

We encourage doctors, healthcare organizations, insurance companies, bar associations, lawyers, patient advocates, and concerned citizens to sign and circulate our petition to show support for the Sorry Works! legislation, S. 1784. (The petition is available at www.sorryworks.net/petition.phtml.) The petition drive is not only a chance to send a strong message to Congress, it's also a great way to partner in achieving a middle ground, systems-based solution that will benefit every person and every organization that cares about patient safety and patient-provider trust.

Doug Wojcieszak is a public relations and public affairs consultant and the founder of The Sorry Works! Coalition, a nationwide group of doctors, patient advocates, lawyers, and insurers that promotes full-disclosure as a middle ground solution to the medical malpractice crisis. He may be contacted at doug@sorryworks.net.

Susan Sheridan is president and co-founder of Consumers Advancing Patient Safety (CAPS), a non-profit organization dedicated to fostering the role of consumer as proactive partner. She also leads the World Health Organization's (WHO) Patients for Patient Safety Initiative. Sheridan is a member of PSQH's Editorial Advisory Board and may be contacted at ssheridan@patientsafety.org.

Martin Hatlie is president of Partnership for Patient Safety (p4ps), a patient-centered initiative dedicated to advancing the reliability of healthcare systems worldwide. He co-founded CAPS and serves as an officer on its board. He also serves on the Sentinel Event Advisory Group of the Joint Commission on Accreditation of Healthcare Organizations, the Steering Committee of the WHO Patients for Patient Safety program, and the PSQH Editorial Advisory Board. He may be contacted at mhatlie@p4ps.org.

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<http://www.sorryworks.net/media44.phtml>

Mistakes Happen

By Robert Redlin
Physicians Practice

January 2006

What's the first thing you should do if a medical error harms a patient in your practice? No, it isn't calling your attorney.

Instead, risk management experts say you should tend to your patient's needs while relying on your incident recovery plan to get you safely through the incident's aftermath.

Don't have an incident recovery plan? Join the club. Risk management consultant Sarah Freyman Fontenot says many medical practices don't put enough thought into handling post-incident situations until they occur. They risk angering patients enough to cause them to lodge malpractice lawsuits, even when the bad outcome was not caused by a medical mistake.

"The overwhelming evidence from studies going back a decade or more shows that full disclosure and talking to the patient and the family — being frank and prompt — all greatly reduce the incidence of claims against physicians," says Fontenot, a Houston-based nurse and attorney who teaches health law to physicians, nurses, and other health professionals.

What evidence? A 1994 study by Howard Beckman, MD, and colleagues, for example, found that breakdowns in the physician-patient relationship — frequently miscommunication — were at the root of nearly three out of four malpractice legal actions filed against physicians. Beckman's study is one of dozens in the growing body of research into why some patients with bad outcomes sue their physicians for malpractice but others don't. In most cases, the physician's bedside manner seems to be the major contributing factor in soothing the anger of patients and their families.

Adds Fontenot, "That doesn't mean physicians should run around giving mea culpa's every time anything goes wrong. It's very possible that they provided state-of-the-art medicine and the patient just didn't get the result expected."

So, what should you do when things don't turn out as expected? Instead of clamming up or, perhaps just as hazardous, trying to improvise a response, you should develop an incident recovery plan and follow it. The plan should include making a full disclosure to the patient, debriefing staff and other physicians, documenting the incident, looking for process improvements, and making any required notifications.

Full Disclosure

Telling patients and their families about a medical error — or an "unanticipated adverse outcome" as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) calls it — is how organizations meet their ethical and fiduciary responsibilities, says Sandy Reifsteck, a nurse and regional consultant for the Institute for Health Care Communication in Champaign, Ill.

These errors can be caused by:

- Unreasonable patient expectations.
- Biological variability.
- Decisions that don't turn out well.

- Actions or omissions by providers that their peers would judge as professionally deficient.

JCAHO standards go beyond reporting medical errors. The organization now calls for its accredited institutions to have full-disclosure policies in place and put them into action whenever there is an unexpected outcome, not just when an error occurs.

Full disclosure to patients represents a distinct departure from the medical community's traditional approach to handling errors. Although full disclosure to a patient — and even apologizing if an error has occurred — may seem counterintuitive in today's litigation-frenzied world, that's what many attorneys, consultants, and physicians' malpractice insurance companies are advising doctors to do.

"We're trying to correct a culture that for 40 or 50 years has told physicians to duck and cover when there's a problem and it's something that we won't turn around overnight," says Doug Wojcieszak, spokesperson for The Sorry Works! Coalition, an Illinois nonprofit that advocates for laws giving legal protection to physicians who voluntarily disclose errors to patients.

According to Wojcieszak and other experts, a recommended scenario after an error or bad outcome includes:

- Immediately informing the patient and his family of the mishap.
- Expressing your concern and laying out the next steps in the course of care.
- Notifying your insurance company, risk management staff and legal counsel.
- Arranging to meet with the family and their legal counsel to fully explain what happened and how you are going to fix it.

Yup, You Should Apologize

It's one thing to express empathy for a patient whose course of treatment did not go as planned, or whose surgery was unsuccessful, when you were not at fault. It's quite another to accept responsibility and apologize when the patient was damaged due to your genuine negligence — an apology may seem in order, but doesn't that put you on tenuous footing should the patient sue?

In fact, it does. But experts say you should do it anyway, because the patient is likely to find out what happened through a medical records review, regardless of what you tell him, and straightforwardness could go a long way toward preventing him from calling a lawyer to begin with.

Moreover, a growing group of states — 16 so far — have acted to provide a level of liability protection to physicians who communicate promptly and honestly about errors.

Not everyone, though, agrees that openly accepting responsibility is wise, even when you believe you're at fault.

"We advocate what we call a blameless apology," says Pam Hutcherson, a nurse and risk management specialist for Tennessee-based State Volunteer Mutual Insurance Company (SVMIC). "You express sympathy for the situation but do not immediately acknowledge blame until the facts are in."

Isn't there the danger that full disclosure will void your malpractice insurance policy? Not necessarily.

"Our company's policy says you agree to assist in your defense and communicate with us promptly about incidents, but it's never inappropriate to say, 'I'm sorry the surgery or treatment didn't go as we planned,'" says Hutcherson.

Disclosure Lowers Risk

Does a formal program of full disclosure — and apology when an error has occurred — actually lower liability risk in the real world? It does at the University of Michigan Hospital System in Ann Arbor, where chief risk officer Rick Boothman says a full-disclosure program has cut the number of pending lawsuits in half. The program has reduced defense litigation costs from an average of \$65,000 per case to \$35,000 per case, resulting in annual savings of nearly \$2 million in legal costs.

That's not to say patients who are injured won't expect settlements, but you may be able to avoid the agony of a lengthy legal action.

Full disclosure is often recommended, but it does not have to be accompanied by an admission of error. Nor is it something to jump into without some advance planning. "You don't want doctors running out and disclosing things [without knowing] how to disclose it," says Reifsteck.

Wojcieszak agrees, "If there was a bad outcome but no medical error, then we're not suggesting doctors apologize and hand out money for every bad outcome." All the same, he says, meeting with patients and their families and opening the medical record is the key to good patient relations.

Hutcherson says any formal meeting between a physician and patient to discuss an error or bad outcome should be done with the knowledge of the organization's chief medical officer (CMO). "Anytime you pull a physician out of production into a conference like this, you certainly want management and the CMO to know what's going on," she says.

Practices are Different

So, if many large institutions have successfully implemented full-disclosure programs, does that mean such a program is right for your practice? Not necessarily. In a hospital, a surgical error might be immediately apparent. But the errors or bad outcomes that occur in ambulatory care might not be detected for days, weeks, or even months.

Say a patient calls your practice complaining of pain and nausea. Your triage nurse incorrectly assumes it is the flu but a few days later you learn that the patient had emergency surgery to have his appendix removed.

"He'll remember that he called you and nothing was done to help him right away, and he got sicker," says Debbie Wills, SVMIC's vice president of risk management.

Most small organizations fail to prepare to handle the aftermath of medical incidents, says Wills. And they often have no tracking mechanism to provide early detection, if not prevention, of errors. Automated lab test tracking systems and electronic health records are among the technical solutions that may help reduce medical errors or omissions.

What should your practice do in the fumbled triage example? For starters, debriefing your staff can give you a better view of the processes that may have led to the error.

"When something happens, you have to very quickly pull together the people who were involved and set up debriefings and start documenting what happened, just like they do in the hospital setting," Hutcherson says.

Perhaps the triage nurse relied on a medical assistant's notes of the patient's phone call instead of speaking with the patient. Maybe she is frequently interrupted and asked to help room patients or handle other clinical tasks instead of focusing on incoming patient calls. Or maybe she needs more training. In any case, you won't really know if you don't investigate, says Hutcherson.

"You really need follow-through; ideally it is some sort of policy or procedure in the office where you have talked through the steps you'll go through after an incident — whom to debrief, what to document, who documents it, what you do with the documentation," she says. "That happens in hospitals but I just don't see that it exists very much in the medical practice office setting."

At Proliance Surgeons Inc., a large surgical practice in the Seattle area, even the smallest incident can prompt the practice's staff to create a "risk management folder," says CEO David G. Fitzgerald. He describes the folders as "watch files" that help track events and spot patterns of incidents. Something as simple as a patient getting into an angry verbal exchange with a physician could spark the creation of an incident folder, he says.

Fitzgerald says the 130-physician practice initiates between 50 and 70 folders annually. "We start these conversations often in a quality assurance committee setting because in Washington, we have legislation giving that kind of committee attorney-client privilege to what's discussed," he says.

Training is Critical

A 1997 study led by University of Chicago researcher Wendy Levinson suggested that how the doctor talks with the patient, not medical negligence, is the most important reason a patient with a bad outcome decides to sue her doctor.

Michael Woods, who teaches seminars for doctors and malpractice insurers and writes about the importance of apologizing, has described how not to talk to a patient. Woods, now practicing in Colorado, explains how in the early 1990s, his body language may have angered a patient enough to sue him.

A medical resident under Woods' supervision had accidentally punctured a patient's artery during an appendix removal, which led to additional surgery. Woods says that during a subsequent visit the patient got the impression Woods was too casual about the incident. As a busy surgeon who spent long hours on his feet, Woods had absent-mindedly propped his feet up on a desk to rest them while talking to the patient. That simple gesture may have spurred the patient to sue.

Reifsteck agrees that patient relations can echo consumer relations in many ways — appearances do count. "Just be aware that this is a consumer-driven world and know that it is watching you closely," she says.

Robert Redling, MS, is a writer with more than ten years' experience focusing on medical practice management. He can be reached via editor@physicianspractice.com.

This article originally appeared in the January 2006 issue of Physicians Practice.

<http://www.sorryworks.net/article25.phtml>

Dr. Lucian Leape of the Harvard Medical School on Apology

Dr. Lucian Leape, M.D is nationally and internationally renowned patient safety expert from the Harvard Medical School. Dr. Leape was one of the founders of the National Patient Safety Foundation (NPSF). A recent NPSF newsletter featured a powerful piece from Dr. Leape entitled, "Understanding the Power of Apology: How Saying "I'm Sorry" Helps Heal Patients and Caregivers."

Dr. Leape makes the case for full-disclosure and apology after medical errors in his article. The most important part of the article is at the end where Dr. Leape counsels his colleagues that if they still get sued after a disclosure event the apology and disclosure will play to their advantage – not disadvantage – in the courtroom.

To see the article, visit this link: <http://www.npsf.org/download/Focus2005Vol8No4.pdf>

<http://www.sorryworks.net/media42.phtml>

It's OK to apologize

By Reni Gertner
Long island Business News

Friday, January 6, 2006

Say you're sorry.

Apparently, the art of apologizing is taking hold in the legal world, with many risk managers, lawyers, physicians, public relations specialists and hospital administrators arguing that heartfelt apologies are reducing medical malpractice litigation – and minimizing recoveries even when lawsuits do arise.

"Doctors are told to run away after bad outcomes, and that's why we have so much medical malpractice litigation," said Doug Wojcieszak, who founded Sorry Works!, an Illinois-based coalition to promote disclosure and apology policies at hospitals.

Robert M. Higgins, a medical malpractice attorney in Boston added that many of his clients say they wouldn't have come if "they just accepted responsibility or acknowledged the mistake."

This is a "hot issue," said Lancaster, Pa. attorney Jim Saxton, who represents medical professionals and hospitals and has written books about proactive risk management.

While some apology proponents advocate complete disclosure, many attorneys suggest that health care professionals who want to apologize be careful about how much they say.

Ralph C. Martin II, who practices at Bingham McCutchen in Boston, said, "There is a distinction between admitting liability or that you've done something wrong, and something short of that which conveys empathy for someone else's human condition."

And it's not just whether someone says he is sorry; it's also how he says it and whether he means it that makes a difference.

Risk managers generally advocate open disclosure of errors. In the medical arena, this means admitting someone made a mistake, explaining why it happened and determining a reasonable amount of compensation.

If a physician or other health care professional made a mistake, "every patient is entitled to an open and honest disclosure of facts," said Rick Boothman, chief risk officer for the University of Michigan Health System, which has an apology and disclosure policy. "Some things are clear mistakes, while other things are just bad outcomes despite our best efforts. Either way, we get them the facts."

But lawyers argue that whether a physician, nurse or health care professional should apologize after a bad outcome – and how much they should say – should be determined on a case-by-case basis.

In general, "Deciding what you want to demonstrate between empathy and responsibility depends on what your knowledge of the circumstances is, what your perceived liability is and what message you want to send to a number of internal and external constituencies," Martin said.

Saxton said that doctors need to be careful, because apologies could be misinterpreted as an admission of error.

In addition to malpractice claims, attorneys advising doctors should remember that a poorly stated apology could lead to licensing complaints – which can sometimes be more damaging to the client than a medical malpractice claim.

<http://www.sorryworks.net/article24.phtml>

Forgiveness: Rx for Safety



Forgiveness. Is there anything more difficult to do than ask for forgiveness? Is there anything more powerful to enable a healing process to begin than asking for forgiveness? Like many physicians, I have struggled with my imperfections in a world where perfection is expected – and imperfection is punished. Once we come to acknowledge the Alexander Pope quote (and the title of the first Institute of Medicine Report in 1999), "*To Err is Human*", the next step is to remember that he also noted, "*To Forgive, Divine*"¹.

Take a journey with me to the foundation of improvement in health care: forgiveness. It is safe to talk about what *organizational* change needs to occur to spur improvement in the high risk, high consequence environment of health care. It is much harder to talk about *individual* changes among health care professionals (clinicians and managers) that might lead to safer and more professionally satisfying roles in health care. This commentary will explore both types of changes, because organizations are fundamentally about people – their behaviors, beliefs, hopes, and conflicts.

In peeling the onion of health care dynamics, the layers that come off before forgiveness include high error rates, unanticipated adverse outcomes, compassion, high liability costs, service problems, and a failure to make patients and families the center of the health care universe. Before outlining the forgiveness connection, let me share a story.

At the National Patient Safety Foundation annual meeting last year, I chose to attend a small breakout session on "The consumer perspective of safety". During that session, as a nationally known patient safety advocate generated group discussion about her experience in losing her mother more than a decade earlier, one of the audience members had a profound comment. He is a well known figure in the health care industry. His wife was the victim of medical error several years ago that left her brain injured and in a long term care facility. His life has been forever altered by this tragedy. This is what he said:

"People want to forgive, but we (health care professionals) don't make it easy for them to do that."

He and others in that session spoke about the silence that they encountered when trying to learn what happened. Wanting to prevent someone else's loved one from a similar fate, they described the frustration and anger that arise when no one talks with them. Worse yet, many related the unwanted and unpleasant experience of having to speak through attorneys in a highly adversarial situation.

After thinking about the importance of allowing forgiveness to occur in these tragic, unanticipated, and unintentional situations, I began to realize the power of forgiveness in my own life as a physician – and how difficult it is for physicians to forgive ourselves in these situations. (It is even difficult to write about it – I want to make it less personal by using the term “themselves” instead of “ourselves”, but have resisted the temptation.)

Organizational Reasons for Forgiveness

The reasons for health care organizations to focus on allowing victims of medical error to forgive are numerous. First and foremost, it is the right thing to do. Medical ethics teaches that *Respect for Persons* includes telling the truth, and *Beneficence* calls for acting with charity and kindness. Telling the truth, apologizing, and expressing remorse uphold the time-honored principles of medical ethics.

Second, if health care organizations are serious about their missions of healing, it is impossible to ignore the healing that must occur after a tragedy if all participants (including health care professionals) are to regain physical and emotional health. Victims tell us consistently that the anger and vengeful feelings that come when truth, apology and remorse are missing is an unhealthy situation. We know from our experiences as physicians that the angry and vengeful heart is an unhealthy heart. The Dalai Lama, in his book “The Wisdom of Forgiveness”, says:

“But revenge.....this creates more unhappiness. So think wider perspective: revenge no good, so forgive. Forgiveness does not mean you just forget about the past. No, you remember the past. Should be aware that these past sufferings happened because of narrow mindedness on both sides. So now, time passed. We feel more wise, more developed. I think that’s the only way.”²

Sister Diane Traffas, a dear friend and former colleague, wrote this about saying “I’m sorry”:

Christ is our model for how we are to behave when confronted with vulnerability. Jesus always illustrated trust by offering hope, courage, and a caring presence to others that said, “I am with you.” We who say we want to be His hands and ears and eyes for the healing profession betray our calling if we do any less.”³

Third, a growing body of evidence suggests that liability costs of health systems can be reduced by full disclosure and apology. The early experience of the Lexington, KY Veterans Hospital outlining reduction in claim costs⁴, and more recent reports from the University of Michigan Health Systems of 50% reductions in claims and more than 50% reduction in attorneys fees are encouraging signs of the power of apology.⁵

Personal Reasons for Forgiveness

But now it’s time to get personal. Why should an individual, particularly a physician, make him/herself vulnerable to a brutal legal system, critical colleagues, or angry patients by asking forgiveness for a mistake? Physicians’ personality characteristics have been studied for years by several authors. Some of the findings make it especially difficult for physicians to acknowledge error, and to express responsibility. For example, physicians typically are very sensitive to criticism, are perfectionistic and compulsive, and often have low self esteem⁶. Many are “alpha males”, who tend to be uncomfortable showing vulnerability, and take high performance for granted⁷.

With this background then, it will be difficult – but not impossible – to change patterns. Based on my own personal experience as a physician – and more importantly as a human being with all my wonderful flaws and imperfections that come with that designation – here is how I see forgiveness applying to each one of us as health care professionals.

1. Think of yourself as a human being first, a physician second. We are no different in our ability to make mistakes than other humans. Forgive yourself for making unintentional mistakes because you are not perfect – and never will be. If necessary, forgive yourself for *being human*. Get off that pedestal that has been built (sometimes with our own sweat) for physicians.
2. Realize that errors are not usually your fault alone. It generally takes a series of circumstances lining up in just the right way for a catastrophe to occur- the “Swiss Cheese” model of error⁸. Don’t personalize the error – look for what can be fixed in the system that allowed the error to occur.
3. Understand that admitting error, and apologizing for it, is a characteristic of great people. It takes strength of character to acknowledge responsibility, and to show compassion for victims of medical misadventure.
4. Trying to keep quiet about our accountability will affect our own health because we know our Hippocratic instinct is to tell the truth. Asking forgiveness for our humanness, and allowing patients or families to forgive us, can begin the healing process for ourselves – as well as for our patients.
5. If we acknowledge our human frailties as physicians, then we should be able to realize that we can create work processes that include communication techniques with other human beings to minimize the opportunity for human error. For example, we can learn from aviation, from deck hands on aircraft carriers, from companies outside of health care that produce products or services with few defects how to build safety into our work. In my case, I learn from my oldest son, a young pilot who is willing to quit his job if his concerns about flight safety are not addressed by his superiors. He has helped me understand the communication techniques that allow dangerous situations to get handled without challenging someone’s competence, or resulting in punitive consequences for the individual raising the concern. Another source of ideas for health care is Toyota, specifically the Toyota Production System, which stresses minimization of errors, and recognizes the creativity and good intentions of the people closest to the problem. Other industries or organizations may be of more interest to you. What is important is that we recognize the vulnerability of our health care system to error, and begin to search for solutions.
6. Finally, I believe it is possible for us to recapture the excitement and promise of a career in medicine by becoming leaders for patient safety improvements in our organizations. We are lifelong learners. The body of knowledge on safety is huge, and just now being explored in health care. We have a sacred responsibility as healers, and as advocates for our patients, to do nothing less on their behalf.

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¹ Alexander Pope. Essay on Criticism. 1711.

² His Holiness the Dalai Lama and Victor Chan. The Wisdom of Forgiveness: Intimate Conversations and Journeys. p. 109.

³ Sr. Diane Traffas, personal communication, June 2005.

⁴ Kraman S, Hamm G. Annals of Internal Medicine, 21 Dec. 1999, pp. 963-967.

⁵ Tanner L. “Doctors Eye Apologies for Medical Mistakes.” AP Medical Writer, Nov. 6, 2004.

⁶ Linney B. American College of Physician Executives, from presentation in June 2004.

⁷ Erlandson E. “Coaching the Alpha Male”, Harvard Business Review. May 2004.

⁸ Reason J. Managing the Risks of Organizational Accidents, p. 9.

<http://www.sorryworks.net/article20.phtml>

SORRY WORKS! INTERVIEW WITH DR. AARON LAZARE, M.D.



The Sorry Works! Coalition is pleased to provide our readers with an un-edited interview with Dr. Aaron Lazare, M.D, Chancellor and Dean of the Massachusetts Medical School, and author of the book, "On Apology." Dr. Lazare's book is available at all major book stores and on-line. Also, contact information for his publisher is available under the Favorite Books section of this website. We hope you find this interview informative and enjoyable.

SW! Tell us in your own words why "On Apology" is an important book.

Dr. Lazare: An apology is one of the most important interchanges between individuals, groups, and nations. It is a communication that many of us long to receive from others and yet struggle to offer.

This book is important for several reasons. (1) It is one of just a few books on the subject of apology. (2) More than a "how to" book, On Apology attempts to understand the psychology of apology. (3) The book is organized into chapters that have relevance to every reader: why apologies are growing in importance, why apologies heal, the structure of successful apologies, the timing of apologies, why apologies are often delayed, motives to apologize, why people avoid apologizing, and why many apologies can be understood as negotiations between two parties. This organization and analysis clarifies why apologies succeed or fail. (4) The meaning and analysis of apologies are illustrated by numerous apologies from current affairs (e.g. recent presidents), history (e.g. Lincoln's Second Inaugural Address), literature (e.g. Homer's Iliad), and personal stories of the author, his friends and acquaintances. (5) The book explains why forgiveness is sometimes offered only in response to an apology. (6) The book's personal and intimate style, enhanced by numerous stories, helps to engage the reader.

SW! You are the Chancellor and Dean of the University of Massachusetts Medical School. How has this book been received by your school?

Dr. Lazare: The book has been well received by students (medical students, graduate nursing students, biologic science PhD students), their faculty, and the parents of students. Its relevance goes beyond patient care and extends to relationships between peers, friends and family.

Having the chancellor/dean as the author of the book is a statement that civility is an

important value of the institution. Other related values that the book advocates in stressing the importance of apologies are honesty, generosity, commitment and courage.

Most people advocate such values but are silent about them. Having the leadership of an institution reinforce them through a concrete piece of work (a book) facilitates their adoption.

The parents of medical students, with whom I become acquainted, commonly become advocates of the book to family, friends and their communities.

It is gratifying that two prestigious universities in Boston (a nearby metropolis) and two equally prestigious educational institutions in Dallas have organized major speaking engagements whose main focus is On Apology.

SW! What important lessons can doctors and health care providers learn from your book?

Dr. Lazare: The most profound lesson that doctors and health care providers can learn from On Apology is that apologizing to patients and their families for medical errors is both an ethical and a psychological remedy for damage to the professional/patient relationship. The apology is an ethical statement because is right to admit to a mistake and express regret and remorse in a relationship in which the patient puts his/her life in the caregiver's hands. The apology further heals the care giver/ patient relationship by the very nature of the acknowledgement, explanation, expression of remorse and offer of reparation. As a result of the apology, the relationship is usually preserved and often enhanced. This outcome is a result of the restoration of the dignity of the patient, the offering of power to the previously powerless patient, the validation to the patient that something went wrong, and restoration of or compensation for some or all of the damage for the harm that was done.

Doctors and health care providers can also learn how apologies resolve some of the offenses that naturally occur between health care professionals at work as well as within families.

SW! Your book has been well received in many different circles (legal, religious, business, etc.) Why are so many different groups of people hungry to learn about apology and forgiveness?

Dr. Lazare: The hunger for apologies applies to most individuals and groups who want to survive and thrive in the global village in which we all live. Certain groups, nevertheless, have a special interest in the apology process.

Religious groups are interested in apologies because of its similarities to repentance. Business groups are interested as they advocate teamwork in the company and customer satisfaction. Law schools are interested in apology as an important part of alternative dispute resolution. Hospice care organizations are interested since clients who are near death often want to apologize before they die. Health care providers are interested in apology in the context of medical mistakes. Conflict resolution groups both in business as well as in international peace seeking use apology as one of their tools. Finally, high schools and colleges use apology to teach civility and conflict resolution as character building. Many of the above groups are beginning to recognize the importance of apology and its application to their work. Equally important, they learn that the skill of apologizing can be taught and learned.

<http://www.sorryworks.net/media41.phtml>

Doctors' disclosure of errors is a win-win situation

By Renie Schapiro
Milwaukee Journal Sentinel
November 20, 2005

No one likes to admit mistakes and for health providers who depend on our trust, it must be harder still.

Add to that the conventional wisdom that confessing to a patient is a gold-plated invitation to a malpractice suit, and it's no surprise that many mistakes have traditionally been swept under the rug.

Angry and anguished patients who suspect malpractice have had little recourse other than pursuing costly and unpredictable litigation to understand what happened, vent their outrage and perhaps get compensated. Only an estimated 2% of patients who may have been harmed go to the trouble.

But some remarkable changes have been taking place.

More and more hospitals and bioethicists are instructing providers to tell patients when an error has occurred - explain what happened, apologize or express regret and tell them what is being done to make sure it won't happen again. Compensation is sometimes being negotiated, avoiding the need for litigation.

Nineteen states - not including Wisconsin - have passed "apology laws" that allow doctors to say "I'm sorry" without it being used against them in malpractice suits.

This openness is seen not only as the right thing to do to maintain an honest doctor-patient relationship; it also reduces the worrisome number of preventable hospital errors. And some evidence suggests it actually reduces malpractice litigation.

"The culture of the hospital is changing from deny and defend to openness and transparency," says Doug Wojcieszak. After his brother died from a medical error, he founded "Sorry Works!", an Illinois-based coalition to promote a protocol for disclosure and apology at all hospitals.

The approach was tested in the Veterans Affairs Medical Center in Lexington, Ky.

There and in other hospitals, including the University of Michigan Health System, lawsuits dropped significantly.

At the Michigan hospitals, lawsuits and malpractice claims were cut almost in half between 2001 and 2004.

The drop in litigation does not surprise experts, who note that anger and poor communication are prime reasons patients sue.

More openness and a focus on patient needs reduce the motive for litigation.

Last month, the Veterans' Administration made it official policy that all its hospitals and providers are obligated to disclose adverse events to patients who have been harmed.

Some of Wisconsin's hospitals - including Froedtert and University of Wisconsin Hospitals and Clinics - have impressive programs to work with providers and patients to ensure effective disclosure. For the first time, UW medical students are being taught about disclosing.

Disclosure is also key to reducing mistakes - according to a 1999 Institute of Medicine report, as many as 98,000 people a year may die from preventable hospital errors. About two years after the report, the hospital accreditation agency JCAHO called for practitioners to disclose errors.

When mistakes are kept secret, they are less likely to be fixed and more likely to be repeated.

As the Urban Institute's Robert Berenson points out in an article last month in The New Republic, the current malpractice system perpetuates secrecy.

More than 90% of malpractice suits are dropped or settled out of court. Typically, documents are sealed and with them the information needed to prevent future errors.

Surveys show that patients overwhelmingly want to be informed when a mistake is made and told what is being done to keep it from happening again. Even though the disclosure can be emotionally difficult - for the patient and providers - experience shows that patients are grateful that the medical team has shared the facts and expressed regret.

"In general this is not something people leap to the table to do," says Robyn Shapiro, director of the Center for the Study of Bioethics at the Medical College of Wisconsin. "But in my experience, when disclosure occurs, the experience has never been negative."

Norman Jensen, vice chairman of the University Hospital ethics committee in Madison, has been interested in disclosure since 1976 when, as a young physician, he privately agonized over whether to tell a patient that he prescribed 10 times too high a dose of blood thinner. No one was talking about medical errors then, he recalls.

He told her and now he helps guides other doctors through the process. Some doctors' "near hysteria" about malpractice makes them resist disclosure, he says. But whether to disclose is not a serious debate. Now, he says, the attention is on how to do it well.

Renie Schapiro is a consultant to the University of Wisconsin Medical School and the Institute of Medicine. She can be reached at renieschapiro@hotmail.com.

Appeared in the Milwaukee Journal Sentinel on Nov. 21, 2005.
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<http://www.sorryworks.net/article18.phtml>

SORRY WORKS! LEGISLATIVE TOOL KIT

We have received many inquiries from state legislators and legislative staff people looking for ideas and advice on how to introduce Sorry Works! legislation. This kit contains all the essentials for comprehensive Sorry Works! legislation:

- **Colorado apology immunity law** (Colorado Rev. State 13-25- 135). Provides immunity for all apologies and admissions of fault. Though legally unnecessary in many cases, having this law in place removes doctors' excuses for not apologizing and doing the right thing.

- **Pennsylvania mandatory disclosure law** (Medical Care Availability and Reduction of Error Act (MCARE), 2002 Penn Law Act 13, Sec. 302, 40 Pa Cons. Stat. Sec. 1303.301 et seq. (2003); MCARE Reporting and Notification, 40 Pa. Cons. Stat. Sec. 1303.308 (2003). Hospitals and healthcare organizations are required by law to disclose adverse events in writing to patients and/or families within 7 days of the incident.

- **Sorry Works! grants (S. 1785 - Clinton/Obama)**. Provide grants and financial assistance for hospitals and healthcare organizations to implement Sorry Works! and train staff on how to properly do full-disclosure.

- **Mandate Sorry Works! training for all medical students**. Also, mandate Sorry Works! training as a continuing education requirement for all physicians and all healthcare professionals. The more doctors and healthcare professionals that learn about Sorry Works!, the sooner full-disclosure will be the norm, not the exception. Make Sorry Works! a standard offering for all ethics training requirements for healthcare professionals.

WORD OF CAUTION TO HEALTHCARE PROFESSIONALS: While Sorry Works! legislative programs are great because they provide incentives and take away excuses, you don't have to wait for legislation to pass. Almost all existing Sorry Works! hospitals and healthcare organizations adopted full-disclosure without any legislative initiative or prompting. These facilities simply took the initiative and began Sorry Works! on their own because it was the right thing to do ethically and economically. You can do the same in your organization or office. This is the beauty of Sorry Works! and what makes it so empowering for healthcare professionals: You take control of your liability exposure and stop counting on politicians and judges to fix the problem for you. Fix it yourself today with Sorry Works!

<http://www.sorryworks.net/article19.phtml>

SORRY WORKS NOW THE RULE IN ALL VA HOSPITALS

The Sorry Works! protocol, which was initially developed at the Lexington, Kentucky VA hospital and has spread to many other government and private hospitals, is now the rule in all VA hospitals nationwide as of last week. This is a major development in the Sorry Works! movement. More doctors and more patients are going to be exposed to Sorry Works!, and it's just a matter of time before Sorry Works! is the rule in all hospitals - government and private.

The new VA disclosure policy is freely available on the VA website or by clicking on this [link](#). The document will download as a PDF file.

<http://www.sorryworks.net/article17.phtml>

SORRY WORKS! INTERVIEW WITH FORMER HOSPITAL DEFENSE ATTORNEY



We are pleased to share an important and compelling interview Jane Ruddell, a former hospital defense attorney. Please share this important interview with friends and colleagues by forwarding this free newsletter.

What makes Jane's story and this interview so important and compelling is her instant credibility with healthcare and insurance professionals. She has spent the better part of her legal career defending hospitals and insurers from lawsuits. Like many defense attorneys, Jane initially believed the best way to thwart a lawsuit was to limit and even break off communication with patients and families after bad outcomes. But her feelings have changed.

Ms. Ruddell began her health law career in 1984 as the first General Counsel for the Lankenau Hospital in Wynnewood, Pennsylvania. She capped her 20 year in-house counsel career with 8 years of service as Senior Vice President and General Counsel of the Jefferson Health System, the largest system of health care providers in the greater Philadelphia region.

Jane currently owns a consulting company - Healthcare Resolutions - and she advises and instructs healthcare and insurance professionals on the importance of full-disclosure and Sorry Works!

Below are questions we asked Ms. Ruddell and her unedited responses. Again, please share this important interview with colleagues and friends by forwarding this free e-newsletter.

SW!: Tell us briefly about your career ... you've defended hospitals and doctors in medical malpractice lawsuits throughout your career, correct?

Jane Ruddell: I have for a good part of my career. I had a private practice litigation background before I became the first general counsel for a large hospital system in the Philadelphia area. While with the system I had responsibility for medical claims and litigation for a number of years before moving to a senior management position. My claims work included managing the aftermath of adverse events, coaching physicians and caregivers, working closely with outside defense counsel on trial strategy, negotiating settlements and preparing physicians, nurses and other caregivers as witnesses.

SW!: You used to advise "deny and defend" to your physician and hospital clients, correct?

Jane Ruddell: Yes, initially I did. In the aftermath of adverse events, I advised physicians to be extremely careful, giving out only controlled and coached information. And, for sure, I did not advise them to talk to families freely and openly. Rather, I invoked an old litigation motto: "What you don't say can't hurt you." Just when the patient and physicians were most in need

of contact and connection, I advised our hospitals and physicians to withdraw behind a wall of silence.

SW!: What made you change your mind about deny and defend?

Jane Ruddell: Observation and experience. One incident in particular stays with me. We inexplicably lost a mother following a routine C- section in one of our hospitals. The look of utter devastation on the face of the attending OB/GYN as he told me about it spoke volumes. I realized then how important it was to recognize and address the human, not just the legal, concerns when counseling my clients. Over time, I have watched the emotional toll these situations take on physicians and nurses. They experience anxiety, sadness, guilt, remorse, fear, and self-doubt. Litigation adds anger, frustration and hostility and, often by the time of trial, full blown vilification. At some point, it just struck me that a non- communicative, dehumanizing, adversarial process was at complete odds with the mission of healing, delivering compassionate care and treating patients with dignity and respect. Coupling that with the high cost and unpredictability of litigation, I began to think about ways to reduce its emotional, financial and time-consuming costs. This led me to focus more on why patients pursue legal action in the first place and to find ways to handle adverse events differently.

SW!: Why doesn't defend and deny work and sorry does?

Jane Ruddell: Because it's human. If you are looking for vindication and victory in court, defend and deny does work – if you win. But litigation ignores the underlying reasons patients sue in the first place. Patients want information, an explanation of what happened, provider accountability and to be sure someone else doesn't have to go through what they did. Patients turn to lawyers because doctors and hospitals stop talking to them. Full disclosure, apologies and open communication pre- empt the fundamental reasons patients sue, allow for human expression of compassion and concern and create a foundation for physicians and hospitals to work with patients to address their needs. Litigation offers only money, but these other issues are often more important to patients than dollars.

SW!: Tell us about your business now and how you promote full-disclosure/SorryWorks! with your clients.

Jane Ruddell: I founded HCR because I believe that our health care industry needs better ways to prevent and resolve conflicts – of all kinds.

We talk about HCR's work in the medical liability and claims field as "Restoring the Human Connection." Our programs help organizations and individuals recognize and respond to the core human dimension inherent in every adverse outcome and prevent costly litigation. We design our early intervention programs around communication training and coaching, accepting accountability, bringing patients into the process and keeping them fully informed, listening to them, and changing policies and practices based on what we learn from them. While customizing our models for each client, these components are central to all.

One of our most exciting projects is working with the Pennsylvania Medical Society on an innovative 7 Point Mediation Initiative. Roger Mecum, the Executive Director of PMS, designed the initiative to use mediation as a way to change Pennsylvania's difficult litigation climate for physicians. We are working with PMS on education and training, creating a Mediation Kit for physicians, and starting a cutting edge pilot early intervention program. The Pilot will be led by one of the county medical societies in cooperation with the courts, the county bar association and a non-profit hospital and will be consistent with the philosophy of SorryWorks! To my knowledge, a cross- disciplinary, collaborative program like this Pilot will be the first of its kind anywhere.

HCR is pleased to be a part of the SorryWorks! Coalition. It is heartening to know that so many like-minded people are all working in many ways to improve the human experience in healthcare.

<http://www.sorryworks.net/media40.phtml>

Proposed Legislation Encourages Hospital Disclosure Initiatives

By Christina Orlovsky, senior staff write

NurseZone.com

October 7, 2005

As hospitals across the country begin to realize the value of full disclosure about medical errors, new legislation has been proposed to encourage physicians, hospitals and health systems to take extra steps toward fair negotiations with patients and their families with the help of two little words: I'm sorry.

On Sept. 28, Democratic Sen. Hillary Rodham Clinton, of New York, and Democratic Sen. Barack Obama, of Illinois, introduced the National Medical Error Disclosure and Compensation (MEDiC) Act, designed to propel the medical community to universally adopt a policy of disclosure of medical errors, apologies for these errors and early compensation for patient injury. Further, the MEDiC program would provide grant money and technical assistance to help doctors, hospitals and health systems implement these policies.

In a statement introducing the legislation, Clinton spoke of the relationship between full disclosure of medical errors and improved patient safety.

"Patients and physicians are paying the price for a health care system that discourages the kind of communication needed to find and correct the conditions that lead to medical errors," she said. "We need to do everything we can to put patient safety first and bring a fresh idea to the table. I am introducing legislation that will provide incentives for doctors, hospitals and health systems to create a culture of safety that will reduce medical errors and lower malpractice costs."

The MEDiC Act was modeled after several policy changes that have already been implemented across the country. One initiative, the Sorry Works! Coalition, is leading the charge in the promotion of full disclosure.

"We are a group of doctors, lawyers and insurance industry representatives—all the players in the medical malpractice crisis—who have come together to advocate the middle ground solution: Apologies for medical errors and quick, up-front compensation reduce lawsuits for doctors while providing swift resolutions for attorneys," explained Doug Wojcieszak, spokesperson for Sorry Works! "By infusing honesty into hospital systems, you have a better chance of reducing errors and medical malpractice lawsuits."

The Sorry Works! protocol works by practicing full disclosure immediately after a medical error occurs. The patient and/or family is contacted and encouraged to retain counsel and a meeting with the doctor and hospital is scheduled. An apology and explanation is provided and a settlement offered. If it is determined that a medical error was not to blame for a bad outcome, open communication is still practiced through the provision of medical records and answering of questions or concerns from a patient and their family.

According to Wojcieszak, the benefits of Sorry Works! for doctors, hospitals and insurers include fewer lawsuits, lower settlement and defense litigation costs, overall savings, better control over liability exposure and a maintenance of relationships with patients and families. Patients, plaintiffs and plaintiffs' attorneys benefit from quicker justice, maintenance of their constitutional rights and a reduction of medical errors.

Since its creation in Feb. 2005, Sorry Works! has garnered interest from numerous states that are eager to get involved in implementing new policy. A bill was passed in Illinois for a pilot program that allows two hospitals to take a risk-free approach to full disclosure and report costs differences between the Sorry Works! efforts and the traditional defense method after a two-year period.

Wojcieszak is hopeful that the proposed legislation will encourage similar efforts in a greater number of health systems nationwide. Still, he pointed out, legislation is not necessary for hospitals to initiate these positive changes.

"We applaud the legislation, but our message is that you don't have to wait for legislation to pass," he said. "All of the hospitals that have done this successfully have done so without a mandate from Washington—that's from government hospitals and university health systems to private hospitals. It has worked very well."

One hospital system that has had success with its full disclosure policy is the University of Michigan Health System, in Ann Arbor, Michigan. Under the direction of Rick Boothman, J.D., chief risk officer, the hospital has implemented numerous changes in the way the staff addresses medical errors and their consequences.

"The first thing we did was establish a benchmark to compensate fairly and quickly any patient who was harmed through medical care; to vigorously defend our staff when we were convinced the care was reasonable regardless of the outcome; and to learn from patients' experiences and complaints, regardless of whether or not we thought our care was reasonable," Boothman explained.

Boothman also visited with plaintiff firms and explained to them that if they had a medically supported case, they wouldn't need to sue the hospital. They simply had to sit down with the hospital and share the situation, and the hospital would promise them "a fair shake." Boothman then created a committee comprised of nurses and doctors to help determine what cases involved reasonable and unreasonable medical care.

"It gave me the credibility to move forward and resolve cases that we could resolve and defend those we needed to defend," Boothman said.

"We've also reformed our risk management department to include all experienced nurses, reasoning that I needed people in my department who are intimately familiar with how care is delivered," he added.

Since the implementation of the new policy in 2001, the University of Michigan Health System has seen the number of malpractice claims fall from roughly 265 per year to 114, levels Boothman said the hospital hasn't seen since the 1980s.

What pleases Boothman further is the change in culture among the doctors and nurses, who had learned through the years to keep quiet about errors.

"Our staff has really embraced something that all along they have wanted to do," he said.

"Caregivers have the natural tendency to identify with patients, even when bad things happen. It's only been the legal system that has prevented it," Boothman added. "We have gotten so defensive that we forgot what it was to do the right thing. Now, we have lots of support—we need to be open and honest with our patients to keep them on board."

For more information, visit the [Sorry Works! Coalition Web site](#).

<http://www.sorryworks.net/media39.phtml>

Senators Clinton and Obama Introduce Sorry Works! Legislation



United States Senators Hillary Clinton and Barack Obama have introduced Sorry Works! legislation that will provide grants and other incentives for hospitals and doctors to implement Sorry Works! programs. Clinton and Obama were joined by Sorry Works! spokesperson Doug Wojcieszak and Rick Boothman of the University of Michigan Hospital System at a press conference in Washington, D.C.

To learn more about the Clinton-Obama legislation visit the following link: [Clinton-Obama pdf](#)

<http://www.sorryworks.net/media38.phtml>

ANOTHER POINT OF VIEW: Malpractice suits? Say 'sorry'

September 4, 2005
Detroit Free Press

The first words out of the mouth of a doctor who has made a mistake in treating a patient should be: "I'm sorry."

Unfortunately, many factors, especially the risk of a malpractice lawsuit, make it difficult for doctors and other health care workers to apologize. Now, however, South Carolina may be joining a number of other states in doing something about that.

A state Senate subcommittee is holding a series of public meetings to discuss changes that would encourage doctors to apologize and offer settlements before cases go to court. This effort comes just months after the state passed sweeping malpractice changes, capping the amount litigants can win in lawsuits.

A group known as Sorry Works, which is made up of doctors, lawyers and patients, has launched a nationwide campaign to reduce the number of lawsuits stemming from medical errors.

The group claims -- with ample evidence to back it up -- that an apology from a medical provider and an offer of a reasonable settlement can help curb malpractice suits and reduce overall cost to hospitals. Ultimately, it also might help reduce the cost of malpractice insurance as well.

Under current conditions, doctors, nurses and hospital administrators are constrained from apologizing because it could be construed as an admission of guilt and used against them in a trial. But Sorry Works contends that most people sue out of anger, not greed, and an apology can defuse that anger.

Seventeen states have passed so-called "I'm sorry" laws. The system requires hospitals to investigate every unexpected death with the expectation that anyone involved in the case will cooperate with investigators. If negligence is found, those responsible meet with the family and apologize. Family members are then offered a settlement and told that if they decide not to accept it, they can expect a lengthy and hard-fought lawsuit. ...

Medical malpractice suits are, in effect, one way to make those who are negligent or careless say they're sorry with money.

Sorry Works thinks that a simple apology up front and a reasonable settlement offer can make many such trials unnecessary.

We hope state lawmakers give that idea serious consideration.

<http://www.sorryworks.net/media36.phtml>

When doctors say they're sorry

By Doug Wojcieszak

Boston Globe

August 25, 2005

RECENT NEWS stories report that Harvard Medical School's major teaching hospitals are actually encouraging their doctors to apologize for medical errors. Given our litigious culture, this unusual move looks like a ready-made gift for greedy trial lawyers -- or is it?

Actually not. In fact, apologizing for medical errors has been shown to reduce lawsuits and liability costs in hospitals across America.

The first hospital to implement apologies for errors was the Lexington, Ky., Veterans Administration Hospital. After being stung by two multimillion-dollar lawsuits in the mid-'80s, hospital leaders instituted a policy of apologizing for all medical errors and offering fair, upfront compensation to patients, families, and their attorneys.

Conventional wisdom said they were crazy, but the Lexington staff happily reported in the December 1999 edition of *Annals of Internal Medicine* that their facility ranked in the lowest quartile of VA facilities for malpractice payouts; their average settlement per case was \$16,000 compared with the national VA average of \$98,000. The Lexington approach spread to VA hospitals in Los Angeles and Las Vegas and then to the University of Michigan's hospital system, which has cut its lawsuits in half. Michigan also reports saving \$2 million in defense litigation expenses annually because cases are being settled in months instead of dragging out for years. Similar positive results have been reported at 28 Kaiser hospitals and 39 hospitals in the Catholic Healthcare West System.

Honesty programs vary from hospital to hospital, but they usually follow a similar protocol.

After a bad outcome (unanticipated death, unsuccessful surgery), hospital administrators and doctors determine whether the standard of care was met.

If the investigation shows that the standard of care was not met (i.e., error or negligence), the hospital schedules a meeting with the patient and family at which time the doctors apologize, provide explanations, and offer fair, upfront compensation for the injuries.

If, however, the investigation determines that the bad outcome was not caused by error (i.e., the patient was simply too sick), the hospital staff still meets with the patient/family and their legal counsel. They explain what happened, open medical charts, and answer all questions. Simply put, they prove their innocence, which reduces the nonmeritorious cases that account for 60 to 80 percent of all medical malpractice lawsuits.

Dealing with patients and families honestly turns litigation strategy on its head, and doctors are perhaps the greatest beneficiaries. How often have we heard doctors complain about being forced to settle a case where they had not committed an error but the insurance company insisted settling was cheaper than fighting the charges? Yet how many times have we wondered why a hospital was fighting a case of obvious gross negligence, such as amputating the wrong foot?

Everything works in opposite with apologies and honesty. Cases of gross negligence are settled quickly and fairly, while bad outcomes with no error are appropriately denied compensation. Those denials are defended in court if necessary. Hospitals save money both ways.

Patients, too, benefit from honesty. They are provided a quick and fair alternative to litigation, and their safety is enhanced. Michigan says that honesty has helped its doctors improve medical care because they can learn from their mistakes.

Honesty and apologies for medical errors has grown into a movement; doctors, lawyers, and patient advocates have formed a group which advocates apologies and upfront compensation for medical errors. The coalition is positioning the honesty approach as a middle-ground solution to the medical malpractice crisis and has already caught the attention of legislators in Illinois, Kentucky, Vermont, South Carolina, Tennessee, and New Jersey.

The addition of Harvard Medical School's teaching hospitals to the movement will only fuel the fire and teach more people that sorry really does work.

Doug Wojcieszak is spokesman for the Sorry Works! Coalition.

<http://www.sorryworks.net/media37.phtml>

WHEN DOCTORS SAY `I'M SORRY'

Sep 2, 2005
Hartford Courant

The Friday editorial "When Doctors Say `I'm Sorry'" urged Connecticut to adopt a law providing that doctors' apologies to patients may not be used against the doctors in court. Such a provision was included in medical malpractice legislation adopted this year.

Skyrocketing malpractice premiums are driving some doctors out of medicine, but a promising new approach could offer relief.

Patients often sue not out of greed, but because they are angry at a physician's brusque manner and failure to apologize for a medical mistake or bad outcome. What if doctors, instead, met with patients and families after an adverse event, explained what happened, apologized and offered compensation?

That humane strategy is being promoted by The Sorry Works! Coalition, a national educational and lobbying group. It argues reasonably that a heartfelt apology substantially reduces the likelihood that a patient will sue.

A number of medical centers have adopted the approach, with encouraging results. After the University of Michigan Health System trained physicians to apologize for mistakes, malpractice claims plummeted 45 percent between 2001 and 2004. Harvard Medical School's teaching hospitals are now weighing use of a similar strategy.

Some doctors understandably worry that if they express sorrow, their apology would backfire in court. In response, at least 15 states, including Massachusetts, have passed legislation saying that doctors' apologies may not be used against them in court. Connecticut ought to pass similar legislation.

After bad medical outcomes, physicians often clam up -- sometimes on a lawyer's advice -- which only increases the possibility that frustrated patients will sue. Some doctors remain secretive to foster the illusion of medical omnipotence.

After one malpractice insurer in Denver promoted apologies and quick settlements among a group of physicians, average payments to aggrieved patients were under \$6,000, compared with about \$284,000 for doctors not in the program. That's a remarkable difference that ought to catch the attention of doctors, hospitals and insurers everywhere.

Connecticut lawmakers have held numerous hearings, conducted studies and debated a range of ways to reduce medical malpractice premiums.

Perhaps they've overlooked a deceptively simple and proven approach that can save money, lower insurance premiums and, perhaps most important, strengthen doctor-patient relationships. Illinois is introducing a pilot program to test the impact of such a strategy.

Why not Connecticut?

<http://www.sorryworks.net/media35.phtml>

"Sorry" Works
A prescription for fewer medical-malpractice suits.

By Deroy Murdock

August 29, 2005

National Review

Across the years and through the morphine, I recall an anesthesiologist explaining how he goofed during major surgery — on me. I was in a dreadful car crash in 1986. While trying to insert a small antibiotic tube near my heart, a Tucson Medical Center anesthetist accidentally slipped and punctured my lung, making it collapse. As I recovered from that morning's incisions, he detailed his mistake and said he was sorry.

"I have two questions," I groggily declared. "Did you intentionally collapse my lung?"

"No," the doctor replied.

"Were you trying to make me better?"

"Yes," he said.

"Well, then I forgive you. Thank you for putting me back together."

Absent that apology, a gurney-chasing attorney could have convinced me to sue this physician for malpractice. Instead, I was touched by his honesty and felt no malice towards him. As I recuperated, litigation was the last thing on my mind.

Along these lines, a new organization called "The Sorry Works! Coalition" hopes to curb lawsuits stemming from medical errors. It encourages doctors and hospitals to 'fess up when they screw up and offer fair compensation to those they have harmed. This simple idea should brighten the climate wherein doctors often fear the sick as potential litigants, while too many patients treat practitioners like unguarded pots of gold.

Sorry Works! cites several apologies that have vaccinated physicians against lawsuits:

Linda Kenney had ankle surgery in 1999, but nearly died after accidentally receiving anesthesia in her heart. The anesthetist ignored the hospital's advice and apologized for his gaffe. She never sued, and the two have become friends.

"For him, it was like a great weight was lifted from his shoulders," Kenney told Boston's CBS-4 TV. "For me, it was like freedom to move on."

A mis-programmed pump gave a child a fatal dose of painkillers at a University of Michigan hospital. Its medical director apologized to the grieving mother. Despite capturing his words on tape, she refused to sue and accepted an undisclosed settlement.

When another Michigan patient suffered blurry vision after lasik eye surgery, he prepared to sue. The doctor explained that corneal wrinkling is a standard risk in such procedures, and that he did nothing wrong. The patient dropped his suit and let that physician correct the damage.

Lexington, Kentucky's Veterans Administration Medical Center launched an apology policy in 1987. By 2000, it had settled with 170 patients and only thrice went to trial. Its average payment across all claims was \$16,000 compared to the VA system's \$98,000 average in 2000.

University of Michigan's hospitals have cut routine caseloads from 260-275 claims in 2002 to 120-140 today. Concluding a typical case required 1,160 days (about three years and two months) then, versus 320 days (ten and a half months) now, a 72.4-percent savings. Per-case legal costs have plunged from \$65,000 to \$35,000. Annual legal-defense expenses have dropped from roughly \$3 million to \$1 million.

Denver-based COPIC Insurance Companies covers some 5,800 Colorado physicians, of whom 1,942 participate in its 3-R's Program. Since late 2000, this initiative has sought to "Recognize, Respond [to], and Resolve" medical errors.

"Through last March 31, we have had 1,187 documented discussions among patients, families, and providers," says COPIC's George Dikeou. "Of these, 807 were resolved through enhanced communication. We often find that patients just want to know what happened and that their doctors care about them. In 352 cases, some payment was made. Finally, 28 went to the claims department as regular cases, of which 11 were settled without attorneys. The remaining 17 remain open."

Dikeou added that "the average payment in 3-R's cases is \$5,586, while the average outside the program is about \$284,000."

"We do not ask patients for releases in the 3-R's program," Dikeou notes. "So, they still have the right to sue, but that has not happened."

"The majority of people who file medical lawsuits file out of anger, not greed," says Sorry Works! founder Doug Wojcieszak. "That anger is driven by lack of communication, being abandoned by doctors, and no one taking responsibility for his mistakes. Apologizing and offering some up-front compensation reduces this anger. Also, if doctors learn from their mistakes, they have a better chance of fixing them and not repeating them."

As Wojcieszak suggests, beyond legal and economic benefits, apology policies have clinical advantages. They preserve doctor-patient relationships, boost physician morale, and help correct errors.

"If you sue your doctor or hospital, that is the last time you walk in there as a patient," says Steve Kraman, MD, a pulmonary critical-care specialist, University of Kentucky professor, and former chief of staff at Lexington, Kentucky's VA hospital. "They're the enemy, you're the enemy, and you go elsewhere for health care. By treating people decently up front," Kraman found, "not only did they remain within the system, they felt even better about us than they did before. Some people felt so good about the way they were treated, they wanted to get even closer to the hospital. We had people who signed up as hospital volunteers."

In terms of morale, "Doctors already beat themselves up about making medical errors," Kraman adds. "Now they can get involved in the process of trying to correct the situation. Doctors and nurses feel better about being able to make things right."

As for fixing errors, the apology approach "allows you to talk about these things in the open. What frequently happens in medical malpractice is that you don't want the other side to get any of your information. So, if you look at an error, you don't want memos and e-mails flying around about this. If you discuss this at a morbidity and mortality conference, participants may be reluctant to leave paper trails for fear of having plaintiffs' attorneys exploit their words."

"Since we attacked problems up front," Kraman continues, "there was no need to hide anything. We had a nice paper trail. In most cases, these were system errors or personal errors that were the result of a system that was difficult to negotiate. When we identified an error, we sent in a team to see what happened and what we could do to keep it from happening again."

Seventeen states have enacted apology laws; some make remorseful words inadmissible in court if uttered soon after mishaps occur. U.S. Senators Max Baucus (D., Mont.) and Mike Enzi (R., Wyo.) introduced the Reliable Medical Justice Act on June 29 to provide federal funding for apology pilot projects around the nation. While the need for federal grants here is a mystery, Washington should encourage this concept without reflexively whipping out the checkbook. Implementing it in VA hospitals would be a solid start.

After all, when trying to cure medical-malpractice lawsuits, "sorry" shouldn't be the hardest word.

— Deroy Murdock is a New York-based columnist with the Scripps Howard News Service and a senior fellow with the Atlas Economic Research Foundation in Fairfax, Virginia.

<http://www.sorryworks.net/media34.phtml>

Sorry Works! Testimony before the South Carolina Senate

August 16, 2005

For the record: My name is Doug Wojcieszak (pro-nounced Woe-ches-zak) and I am the spokesperson for The Sorry Works! Coalition. We are a national non-profit group based in Illinois. Our membership is comprised of doctors, healthcare providers, lawyers, and patient advocates.

Mr. Chairman and members of the committee - I want to thank you for inviting me here today to testify. I consider this an honor and a privilege, and I hope my comments can add value to your upcoming discussions and work. Furthermore, I applaud your efforts in exploring alternative ideas to medical malpractice reform.

As a former legislative staff member for the Illinois House Republicans, I am going to take a slightly different approach with my testimony today. Instead of overwhelming you with a power point presentation and charts and graphs full of data, I am going to speak to you from the heart. I am going to look each of you in the eyes and explain why Sorry Works, apologies for medical errors, and full-disclosure is not only a middle ground solution to the medical malpractice crisis, but also the most comprehensive solution to the problem.

I am going to talk to you as a person who lost his oldest brother to medical errors, and as a person who has worked for both tort reformers and the plaintiff's bar in the fight over medical liability reform. From a personal and professional perspective, I believe Sorry Works! to be the best solution all-around solution for the med-mal crisis.

I will show how Sorry Works! addresses the root causes of medical malpractice and treats all stakeholders in the crisis - doctors, hospitals, lawyers, insurance companies, and patients - fairly.

And I will demonstrate how Sorry Works! lowers lawsuits and liability costs for doctors and insurance companies while providing swift justice for victims and their attorneys without constitutional limits. Furthermore, by infusing honesty in hospital systems, doctors learn better from errors, thus increasing patient safety and further reducing liability exposure.

Finally, I want everyone to understand that what I am advocating to you is more than doctors simply saying, "I'm sorry." While offering an apology is very, very important, there is much more to this than apologies...it's about accepting responsibility for problems, fixing the processes so those errors don't happen again, and also fixing problems of injured patients and families.

Sorry Works! is a comprehensive process, not just a few words.

The story of Sorry Works! begins in Lexington, Kentucky at the Veterans Administration Hospital.

In the mid-80's, the hospital had lost two multi-million dollar lawsuits. Not only did these lawsuits cost large sums of money, but they also turned doctors and patients into enemies. It wasn't the way they wanted to practice medicine.

So, they implemented a new, unconventional policy: apologies and upfront compensation for medical errors.

Here's how their program works:

After an adverse medical event - i.e, a bad outcome, unanticipated death, unsuccessful surgery, etc - doctors and hospital staff perform a root cause analysis. The analysis seeks to determine if the acceptable standard of care was met. The analyses sometimes involve the assistance of outside experts and usually take a few weeks to a couple months to complete.

During the analysis the hospital staff stays in close contact with the patient and/or family so they don't suspect a cover up or feel abandoned.

If the root cause analysis shows that the standard of care was not met, the doctors and medical staff meet with the family and their attorney, apologize, provide explanations of what happened, tell how they will fix the processes so the error doesn't happen again, and offer fair, upfront compensation.

However, if the standard of care was met (i.e, no error or negligence), the doctors and hospital staff still meet with the patient, family, and their attorney to provide explanations, open medical charts, answers questions, and basically prove their innocence. The hospital will empathize with the patient, but no settlement will be offered under any circumstances. Furthermore, the hospital will defend itself and their doctors to the death if a lawsuit develops - no settlements will be offered!

Conventional wisdom said they were crazy, but the Lexington staff happily reported in the December 1999 edition of *Annals of Internal Medicine* that their facility ranked in the lowest quartile of VA facilities for malpractice payouts; their average settlement per case was \$16,000 versus the national VA average of \$98,000. The Lexington approach spread to other VA hospitals in Los Angeles and Las Vegas with similar positive results.

The University of Michigan Hospital system adopted the Lexington program and has cut their lawsuits in half. Michigan also reports saving \$2 million in defense litigation expenses annually - or 2/3 of their defense litigation budget - because cases are being settled in months instead of dragging out for years. Similar positive results have been reported at 28 Kaiser hospitals and 39 hospitals in the Catholic Healthcare West System.

COPIC insurance of Colorado reports similar results. Malpractice claims against their 1,800 doctors have dropped by 50 percent since 2000 and settlement costs have fallen 23 percent.

So, how does this honesty program work? Why has it produced these results?

Reason #1: Anger Reduction

Forget everything you have heard about greedy lawyers and greedy plaintiffs being the cause of medical malpractice lawsuits. It's anger - not greed - that is the root cause of most medical malpractice lawsuits. Anger literally forces people to call a plaintiffs attorney.

Patients and families become angry when doctors and medical staff clam up and cut off communication after a bad outcome. They become angry when questions are not answered. And they become really, really angry when doctors try to cover-up mistakes and lie about it. Indeed, the cover up is always worse than the crime.

The traditional risk management approach to medical errors is usually called "deny and defend." This is where defense lawyers sweep in tell doctors and medical staff to keep quiet. I'm here to tell you today that deny and defend is a tried and failed risk management strategy. It produces anger and it's a big part of the reason we have a medical liability crisis.

As legislators grappling with this thorny public policy issue you must look for ways to encourage hospitals, doctors, and insurance companies to steer away from deny and defend and move toward the approach originally developed in Lexington, KY.

Dealing with people with honesty and fixing their problems removes anger, and in most cases the urge to file a medical malpractice lawsuit. When anger is removed, so is the urge to financially punish doctors and hospitals.

It's common sense....imagine having a doctor stand in front of you, apologize, tell you what he or she did wrong, how they are going to fix their processes so the mistake isn't repeated, and offering you upfront compensation. It's hard to imagine being angry at that doctor, and even harder to imagine wanting to file a lawsuit.

If you don't believe me, look at the numbers and data coming out of the hospitals doing this program - they speak for themselves.

Furthermore, look to experts like Dr. Gerald Hickson of Vanderbilt Medical Center and Dr. Michael Woods.

Hickson researched why physicians get sued, and his 2002 paper in the Journal of the American Medical Association - or JAMA - had quite a story to tell. I'll read you a few lines:

"Patients who saw physicians with the highest number of lawsuits were more likely to complain that their physicians would not listen or return telephone calls, were rude, and did not show respect."

Dr. Hickson continued with the following passage:

"Risk (of being sued for malpractice) seems not be predicted by patient characteristics, illness complexity, or even physicians' technical skills. Instead, risk appears related to patients' dissatisfaction with their physicians' ability to establish rapport, provide access, administer care and treatment consistent with expectations, and communicate effectively.

To summarize Dr. Hickinson's findings, the doctors who are poor communicators, arrogant, and make their patients angry are more likely to get sued.

Also, consider the following from Dr. Michael Woods' book, "Healing Words." In his book, Dr. Woods cites a study which looks at male and female doctors of similar training and practices. The study found that male physicians are three times more likely to be sued than their female colleagues.

Why? If you believe our societal norms that females are better communicators than males and value relationships more, than it follows that female doctors are better at keeping their patients from getting angry because they are better at preserving relationships.

Anger is the key - it's the root cause of the litigation "disease." Treat the root cause - especially after a bad outcome or adverse medical event - you can realize success versus dealing with the symptoms, which tort reform is predicated upon.

If you can reduce anger, you have a better chance of reducing lawsuits, settlement costs, and liability expenses. Sorry Works! provides the mechanism to effectively reduce anger.

Reason #2: Reduction of non-meritorious lawsuits

Hospitals that practice Sorry Works! are known as "straight shooters." They call it straight when they make a mistake, and because of it are more likely to be believed when they say a bad outcome wasn't their fault.

Sorry Works! hospitals report that if a person contacts a plaintiff's attorney demanding to file a lawsuit, the first thing the plaintiff's attorney will do is call the hospital and ask if they are apologizing and settling or fighting the charges. If the hospital says they are contesting the case, the plaintiff's attorney will usually take a pass because they know the hospital is probably on solid ground.

Compare the honesty approach to "deny and defend" where all cases are fought and contested.

By claming up and breaking off communication, deny and defend makes doctors look guilty 100% of the time after all bad outcomes - whether an error was committed or not. Deny and defend invites lawsuits which, after large sums of defense dollars have been spent, do we learn that no error was committed, or that not all doctors named in the lawsuit were at fault.

As legislators, if you want to reduce non-meritorious lawsuits - or frivolous lawsuits as they are sometimes called - you must again encourage hospitals, doctors, and insurance companies to abandon deny and defend practices and move towards honesty and transparency.

Honesty and transparency restores the reputation of hospitals and doctors and literally immunizes them against non-meritorious lawsuits.

Reason #3: Turning litigation logic on its head

As legislators I'm sure you heard doctors complain about being forced to settle a lawsuit where they did not commit an error but the insurance company insisted on settling because it was cheaper than defending the charges. And I'm also sure you've wondered why hospitals and insurance companies sometimes fight cases of clear, gross negligence, such as a wrong-side surgery.

With Sorry Works, everything is in reverse. Cases of clear negligence are settled quickly and fairly, which saves large sums of money on defense litigation expenses and also lowers settlement costs because patients and families aren't trying to financially punish doctors. Conversely, when the doctor and hospital feels they have not committed an error, they will defend the case to the death with no settlement, which sends a strong signal that further reduces the filing of non-meritorious or frivolous lawsuits.

Reason #4: Reducing medical errors

Infusing honesty in hospital systems helps doctors learn better from errors, which increases patient safety and further reduce liability exposure. Hospitals that practice Sorry Works! report that their physicians become better at doing medicine.

Here's a classic story from the Lexington VA hospital: An elderly gentlemen had been visiting their hospital for blood clots, and one day they gave him the wrong dosage level of his medication. The man developed blood clots that broke off and went to his lungs, at which time he died. The root cause analysis showed the error, the hospital apologized and settled quickly and fairly with the family....but they also learned from their mistake.

Hospital leadership learned that the medicine in question came in many different dosage levels, yet the different dosage levels were all in bottles with white labels and lined up next to one another in the hospital pharmacy. On a busy day, it was easy for the pharmacist to grab the wrong bottle.

Now the different dosage levels are in different colored bottles and stocked on different shelves.

Dr. Steve Kraman, the former director of the Lexington VA says that with deny and defend they never would have learned about this problem and would probably still be making the same mistake today which would cost more lives and more money.

Another story of learning, from the University of Michigan Hospital System.

A woman underwent elective surgery and bled to death during the procedure. In their review after wards, Michigan administrators learned some startling things.

The surgeon who operated on the woman had been considered "a living legend" in his prime, however, in recent years the nursing pool said they always stocked extra blood when he operated because his patients bled so much.

The anesthesiology department also booked their best people with the surgeon to compensate for his mistakes.

So, Michigan staff learned that no one confronted the "living legend"...they just compensated for his dwindling skills until one day it killed a patient.

Michigan learned all of these things and they are now able to prevent another catastrophic error because they are honest with themselves.

The surgeon will either receive refresher training or retire....either way, the mistakes won't happen again.

Now there many emotional knee-jerk responses to Sorry Works! Without question, what we are proposing with Sorry Works! goes against conventional wisdom, but it makes all the sense in the world. The data is there to support it, and common sense says it works too. However, the doubters continually offer up knee-jerk emotional responses to Sorry Works! and I want to address some of the most common ones today:

Challenge: Doctors will become sitting ducks with Sorry Works! They'll get their pants sued off.

Response: The current system of deny and defend makes doctors sitting ducks. Doctors and hospital administrators are left to wonder if an unanticipated outcome will be followed by a process server bringing bad news. That's no way to live. If a mistake occurs, doctors have to ask themselves one question: "Would it be better to handle this situation on my terms or have it fought out by high-priced attorneys in front of a jury of strangers?" Sorry Works! provides the protocol to constructively and positively handle errors and bad outcomes.

Challenge: What if sorry doesn't work? A doctor has just admitted guilt.

Response: A doctor apologizes for an error and offers compensation, but the compensation is rejected and a lawsuit is initiated. So, the doctor will go to court looking like the person who tried to do the right thing by apologizing and making a fair offer, but was rebuffed. The doctor will be the sympathetic defendants and the plaintiff will look greedy, which is not the formula for success in the courtroom if you're a trial lawyer.

Classic story from the University of Michigan hospital system: They gave the wrong type blood to a patient, and the patient went into shock. Fortunately, they caught the mistake quickly and corrected the situation, but the patient did have to endure some pain and suffering and extra time in the hospital.

The Michigan staff apologized and offered \$10,000 in upfront compensation. The patient and his attorney thought they should get \$250,000. They went back and forth, and Michigan's final offer was \$40,000, which the patient and attorney rejected.

The case went to trial and the patient won, but he was only given \$10,000.

Challenge: Lawyers simply file too many lawsuits in my hometown for Sorry Works! to be successful here.

Response: If a region or county is considered to be friendly to plaintiffs' attorneys all the more reason for doctors to implement Sorry Works. Doctors, hospital administrators, and insurers should do everything possible to make sure that patients and families don't leave their offices angry in litigious regions. Sorry Works! provides the protocol and methods to alleviate anger and significantly diminish the chances lawsuits being filed, especially in the most litigious areas. An overly aggressive trial attorney is powerless without an angry, yet sympathetic plaintiff.

Another way to look at this situation....when things go wrong, hospitals and doctors should not want to push people away as they told to do with deny and defend...because they literally push them into the arms of plaintiff's attorneys....they should work to draw them closer and fix their problems.

Challenge: But not all bad medical outcomes are the result of errors. Sometimes people just die or are injured despite the best efforts of a medical staff. We can't be handing out checks every time someone dies or doesn't heal completely.

Response: People die from medical errors, but not all deaths are caused by medical errors. Many times the standard of care is met, but people still die or do not completely heal. Doctors and hospitals certainly should not be expected to "hand out checks" under these circumstances. However, they still need to communicate with patients and families. This lack of communication and a perception of a cover up causes lawsuits even when the standard of care is met.

Sorry Works! stresses communication with patients and families, including in circumstances when an error did NOT occur. Medical records and charts should be quickly provided to patients, families, and their attorneys. Medical staff and administrators should make themselves available to answer questions, provide insight, and empathize with the patient and family, but a settlement is not required.

If the patient or family attempts to file a lawsuit, the hospital must be clear that it will defend itself vigorously and not settle. This is where Sorry Works! pays dividends. Hospitals that practice Sorry Works! develop a reputation for honesty with local plaintiffs' attorneys. If the hospital plans to contest a case (no apology or settlement), local attorneys learn that such cases are probably without merit and not worth pursuing. We call this effect "The Honesty Dividend."

Challenge: Dr. Kraman developed Sorry Works! in a VA hospital. It will never work in a private hospital.

Response: Kaiser Hospitals and Catholic Healthcare West show this to be untrue. Furthermore, as more and more hospitals become captive insurers, Sorry Works! will become easier to implement. Insurance companies are also starting to seriously study Sorry Works! too.

Challenge: Aren't you asking patients to give up their rights to file a lawsuit?

Response: No, Sorry Works! is not binding arbitration - people still maintain their right to file a lawsuit if they are not happy with the process. Here's the difference: Tort reform makes it more difficult for people to file lawsuits, whereas Sorry Works! makes it unnecessary to pursue litigation.

I understand there is some talk of implementing binding arbitration here in South Carolina. And I know some people like to try to tie binding arbitration to a Sorry Works! protocol.

If I may be blunt with you, don't touch binding arbitration with a ten-foot pole. If you want the positive results of Sorry Works, you can't mix in binding arbitration.

Why? Trust and mutual respect are the foundation of Sorry Works! Under Sorry Works! people maintain their right to file a lawsuit, but very few exercise because they are treated fairly and humanely.

If you add binding arbitration to the mix, you break the bond of trust between patients and doctors, build walls, provide reasons to suspect cover-ups and lies, and then litigation becomes the only feasible alternative for people.

I know there is a temptation to monkey with Sorry Works! and try to tweak here and there and make it a little more comfortable for doctors or hospitals, but don't disrupts the fundamentals of the program or it won't work.

As I close my presentation, I want to leave you with legislative suggestions.

As legislators you can provide incentives for Sorry Works! to speed the implementation of full-disclosure programs:

1) Require Sorry Works!/full-disclosure training in South Carolina medical and nursing schools. Also, require that physicians and nurses already licensed receive full-disclosure training as part of their continuing education requirements. Sorry Works! has a powerful, compelling message, and the more doctors and healthcare providers that hear this message, the more that will ask themselves, "Why aren't we already doing Sorry Works?"

2) Pass apology immunity laws similar to Colorado, Georgia, and Arizona. Physicians will swear they need immunity from apologies and admissions of guilt should a lawsuit arise from a full-disclosure event. Despite stories like the one I told you about from Michigan where the man received the \$10,000 original offer, some doctors won't budge until they have such a law in place. Politically speaking, you should probably pass this legislation because it will be easier to pass the law then trying to explain that it's really unnecessary.

Here's the reason....we're changing a "deny and defend" culture that has been in place for decades and has scarred physicians out their wits for the wrong reasons. Give physicians an immunity law to soothe their fears, but put a caveat in it....allow doctors to decide if they want to bring an apology and previous offer of fair compensation into court. Doctors will learn over time that apologies strengthen - not weaken - their position, and giving up that advantage in court is a foolish move.

And a special message to doctors and healthcare executives here today - if you have a defense attorney who tells you not to mention a full-disclosure event in a courtroom....to make believe like it didn't happen... fire that person immediately. They are not working in your best interest....they are only interested in raking up billable hours at your expense. Sorry Works! and full-disclosure empower physicians and don't ever let some defense attorney hungry for your money take away your best defense in court.

3) Pass a Sorry Works! pilot program similar to Illinois

Illinois became the first state in the Union to pass a Sorry Works! pilot program this spring whereby two hospitals and their doctors and insurance companies get a risk free try at Sorry Works! Under the program, a panel of medical, legal, and insurance experts determines the liability costs (settlements, defense litigation expenses, etc) incurred by a pilot hospital over the last five years. The committee will then look to see if costs go up, remain the same, or go down under Sorry Works! for a pilot hospital. If costs go up, the state picks up the difference between the old norm and the new norm. If, however, cost go down - as they should - the hospital saves money and state doesn't pay a penny. The beauty of the pilot program

approach is that it removes the doubters excuses for trying Sorry Works, and it provides important exposure for the program.

I'm told the State of South Carolina has some management over the medical malpractice insurance company that provides coverage for most doctors....so you may be able to implement a Sorry Works! type initiative even faster and quicker than Illinois or other states.

For sure, there will be resistance from some physicians and defense attorneys, but that is where you can provide some help to get them over the emotional hurdle of saying, "I'm sorry."

I want to close with a special message for the doctors, healthcare providers, and insurance professionals here today. While I hope your legislators will enact Sorry Works! legislation to encourage apologies and full-disclosure, you don't have to wait. Unlike tort reform, the beauty of Sorry Works! and apologies for errors is no legislative solution is required. Doctors and hospitals can implement Sorry Works! and honesty programs on their own right now....without waiting for legislators to vote or judges to rule on issues of constitutionality.

Look at the University of Michigan hospital system...look at Children's Hospital of Minnesota which was featured in Time Magazine last week....neither state has apology immunity laws or Sorry Works! pilot programs, and both hospitals have successful disclosure programs. It works for them...it can work for you too.

You can get up out of your chairs today, go back to your hospital, and do it right now. I will stick around afterwards if you interested in different training programs that are available.

Thank you for your time attention today....again, I appreciate the opportunity to testify before you today and I would welcome questions and comments. Thank you.

<http://www.sorryworks.net/media30.phtml>

Sorry Works! in Time Magazine

When Doctors Say, "We're Sorry": Aggrieved patients often just want an apology, but will admitting a mistake increase the risk of a lawsuit?

By DANIEL EISENBERG

Time Magazine

August 15, 2005

It's easy to understand why Trish and Andy Olson initially considered suing. But more than money, what the suburban St. Paul, Minn., couple wanted from the hospital was a genuine apology. Their son Owen, 7, born with spina bifida and a range of other birth defects, had already endured more than 40 operations by the time he was taken to the Children's Hospitals and Clinics of Minnesota for treatment of a suspected infection last fall. Because the staff on duty that night forgot to attach a catheter to Owen, doctors ended up having to take emergency action several hours later, first using a needle to drain his dangerously full bladder and then, after his bowel was punctured during the procedure--a known risk--surgically repairing the damage.

Although the little boy escaped with no permanent damage, his parents' faith in the hospital was not easily restored. But then something unusual happened: the administrators and the family's doctors said they were sorry, explained how the error happened and offered to help with Owen's growing medical bills. The Olsons soon gave up thoughts of legal action. "They have been wonderful about everything," says Trish. "We were angry, but we're not anymore." Dr. Phil Kibort, the hospital's vice president of medical affairs, says, "When I went to medical school, I didn't plan on doing this. But I want [patients] to feel they can trust us."

At a time when hospitals and doctors are desperate to reduce the rising costs of malpractice insurance and litigation, apologizing for medical mistakes may seem to some like legal suicide. But to a widening coalition of players on all sides of the issue--from doctors, hospital administrators and insurance executives to patient advocates, politicians and even trial lawyers--it may actually be a step in the right direction. Since many of these players believe malpractice lawsuits are motivated as much by feelings of frustration as by the almighty dollar, in their view, honesty may indeed be the best policy.

To help encourage openness, over the past few years, such states as Florida, North Carolina, Missouri, Illinois, Colorado, Arizona and Oregon have passed bills under which a doctor's apology for a medical mistake or expression of sympathy is inadmissible in civil court. A few like Pennsylvania are even mandating the prompt, formal disclosure of any such errors to patients and state authorities. Legislation has been introduced in Congress to help set up similar pilot programs in other states, and President Bush recently signed a bill establishing a confidential and voluntary system for reporting medical errors. In addition to giving people less motivation to sue, supporters argue, fuller disclosure will help reduce malpractice in a more fundamental way by helping health-care professionals learn from mistakes so fewer preventable errors occur.

Not everyone is waiting for the law to change. More and more hospitals are following the lead of pioneers like the Veterans Affairs Medical Center in Lexington, Ky., and Johns Hopkins in Baltimore, Md., in establishing formal policies requiring medical staff to promptly admit and apologize for mistakes. Having adopted that approach, the University of Michigan Health System in Ann Arbor, which encompasses the university medical school, three hospitals and numerous other health facilities, has seen its annual number of malpractice claims and lawsuits drop almost 50%, from 260 in 2001 to 140 in 2004, and its average legal expense per case fall at virtually the same rate, to \$35,000. Dr. Darrell (Skip) Campbell, a transplant

surgeon and the chief of staff, says the new openness has the added advantage of allowing doctors to explore what happened. "The natural reaction when something goes awry," he says, "is to sweep it under the rug. [But then] you don't find out what the problems are."

Proponents say an apology may take some of the bitterness out of what has become an all too adversarial relationship between doctors and patients, making malpractice victims more amenable to a negotiated settlement, which is typically less costly and time consuming than a lawsuit. On a broader level, having a policy of apologizing may help a hospital's reputation or credibility. Says Robert Lord, chief legal officer for Martin Memorial Health Systems in Stuart, Fla.: "When we go into litigation and deny liability, people tend to take that more seriously."

When it comes to malpractice, the medical community seems open to experimentation. Limits on damages for pain and suffering, like the \$250,000 federal cap that President George W. Bush has tried in vain to get through Congress, are increasingly seen as little more than a Band-Aid: recent studies cast serious doubt that such caps would make malpractice-insurance premiums cheaper. Meanwhile, long-term options, like a no-fault system with specialized medical courts and expert judges, are still largely in the theoretical stage.

Skeptics may think malpractice litigants are interested in just money, but there is at least some evidence to support the notion that it's also about emotional redemption. A series of academic studies over the past decade have shown that in many cases, victims are more likely to sue their medical provider if they feel he or she has not been sufficiently compassionate and communicative. Although she's not a scientific researcher, Jennifer Dingman of Pueblo, Colo., knows that firsthand. Soon after her mother died in 1995 at age 78 as a result of a series of misdiagnoses and medication errors, Dingman started a patient-advocacy organization called PULSE, or Persons United Limiting Substandards and Errors in health care. "In every scenario, people who have filed lawsuits wish they hadn't had to go through this," she says. "One hundred percent of the time, we hear, 'If only the doctor had apologized.'"

For many patients, legal action is also the only way to find out what really went wrong. "Most people don't want to sue, but they feel pushed into it," says Doug Wojcieszak, an activist who helped promote what's called the Sorry Works! legislation in Illinois; Doug's brother Jim died in 1998 of multiple heart attacks after a Cincinnati, Ohio, hospital mixed up his records with those of his father, who had been there six months earlier, and misdiagnosed Jim's heart condition.

Only an estimated 2% of negligent events in hospitals result in malpractice cases, so it is entirely possible that if more medical professionals admit errors, the number of potential litigants could skyrocket. David Studdert, a professor at the Harvard School of Public Health, firmly supports increased transparency but nonetheless thinks it will increase litigation, for the simple reason that "now most people don't even understand that they have been injured due to an error."

And not everyone believes shielding doctors after they say sorry is a fair outcome. In many critics' minds, an apology isn't worth much if the person doesn't have to worry about or suffer the consequences. Apology laws, they complain, could just usher in an epidemic of playacting. "To think I should give up my rights so that you can say you're sorry is insulting," says Patti O'Regan, a nurse practitioner in Port Richey, Fla., whose mother died in 1999 from a reaction to pain medication. Many of the states that have passed laws have tried to deal with that issue by providing protection only for general apologies that express sympathy, not for outright admissions of guilt. Colorado's two-year-old statute is a notable exception, covering outright admissions of fault or liability as well--which doesn't sit well with some of the state's malpractice attorneys. One of them, Natalie Brown, says she is waiting for a test case to challenge the law's constitutionality in the Colorado supreme court.

Regardless of the law, it is still no small feat to persuade doctors to give up the defensive mind-set that anything they say will be used against them. No matter how many times doctors, hospital administrators, attorneys and malpractice insurers are told so, they still have a hard time believing that there has yet to be a case in which an apology was used as

evidence and made a difference in the outcome, as many supporters of the movement point out. Even if they are sold on the idea, many doctors still have to work on their bedside manner. That's why medical schools like Vanderbilt are increasingly requiring communication classes that include lessons in how best to express regret, and why similar seminars for more seasoned physicians are drawing crowds. At the recent graduation ceremonies for the State University of New York's Downstate Medical Center, its president, John LaRosa, offered some parting advice to the graduates: "'I'm sorry.' Say the words. Mean them. And move on." For now, at least, it's clearly not that simple. --Reported by Massimo Calabresi/ Washington, Elizabeth Coady and Leslie Whitaker/Chicago, Rita Healy/Denver and Michael Peltier/Tallahassee

<http://www.sorryworks.net/media33.phtml>

MEDICAL MALPRACTICE: There really is middle ground for a solution

By Doug Wojcieszak

St. Louis Post Dispatch
Thursday, Aug. 04 2005

Conventional wisdom: The on-going political battle over the medical liability crisis is a polarized fight with no middle-ground solution in sight.

Actually, Illinois doctors, lawyers, and patients may find some middle ground with a program called "Sorry Works!" This spring, Illinois lawmakers passed legislation authorizing a pilot program providing incentives for doctors to try it.

"Sorry Works" operates on the premise that openness, sincere apologies and prompt compensation for medical mistakes actually reduce lawsuits and liability expenses for doctors and insurance companies while providing swift justice for victims. And by infusing the process with honesty, doctors learn from errors and reduce recurrences, which further reduces liability exposure.

Legislators from Kentucky, Vermont, New Jersey, South Carolina, and Tennessee have expressed interest in replicating the Illinois legislation. Federal legislators are interested, too, having already introduced one bill (S. 1337), with more "Sorry Works" legislation expected in the fall.

Here's how the approach works:

After a bad medical outcome (unanticipated death, unsuccessful surgery), hospital administrators and doctors investigate the case to determine if their medical treatment met the standard of care. The analysis may take from a few weeks to a couple months, but hospital staff stays in close contact with the patient or family throughout the process so they don't feel abandoned or suspect a cover-up.

If the analysis shows that the standard of care was not met - if there was error or negligence - the hospital schedules a face-to-face meeting with the patient and family at which time the doctors apologize, provide explanations, discuss how they will address the problem and offer fair, upfront compensation for the consequences.

If, however, the investigation determines the bad outcome was not caused by error (i.e, the patient was simply too sick), the hospital staff still meets with the patient and family and their lawyer. Hospital officials explain what happened, open medical charts and answer all questions. Simply put, they prove their innocence, which reduces the non-meritorious cases that account for 60-to-80 percent of all medical malpractice lawsuits.

This forthright approach removes anger from patients and families, which is the driving force behind most medical malpractice lawsuits; patients and families simply want doctors to acknowledge mistakes and make amends.

The University of Michigan Hospital System says honesty has cut their lawsuits in half. Furthermore, Michigan has saved \$2 million in legal expenses annually because cases are closed in months instead of dragging on for years. And Michigan administrators report that because their doctors honestly review errors, they have been able to improve medical care.

Twenty-eight hospitals in the Kaiser hospital system and 39 hospitals in the Catholic Healthcare West system have gained reputations for being "straight shooters" using this approach. When they say something wasn't their fault, they are more likely to be believed by patients and lawyers.

COPIC insurance of Colorado reports similar results with a "Sorry Works" approach. Malpractice claims against their 1,800 doctors have dropped by 50 percent since 2000 and settlement costs have fallen 23 percent.

Equally positive results are being reported at Children's Hospital of Minnesota and at three Veterans Administration hospitals in Lexington, Los Angeles and Las Vegas. The Lexington institution reports average settlement costs of \$16,000 per case versus the national VA average of \$98,000 per case.

"Sorry Works" works because it addresses the root causes of the medical liability crisis. "Sorry Works" improves the "inside culture" of hospitals, while efforts at so-called tort reform - the more often prescribed cure for the med-mal mess - focus on the "outside culture" of judges, juries and lawyers. Tort reform tries to make it harder for people to file a lawsuit; "Sorry Works" tries to make lawsuits unnecessary.

Finding middle ground in the medical malpractice crisis starts with one word: "Sorry."

Doug Wojcieszak of Glen Carbon is a spokesman for The Sorry Works! Coalition. He is a political activist and a former downstate director for the Illinois House Republicans.

<http://www.sorryworks.net/media32.phtml>

HARVARD HOSPITALS JUMPING ON SORRY WORKS! BANDWAGON Hospitals study when to apologize to patients

By Liz Kowalczyk

Boston Globe

July 24, 2005

Harvard Medical School's major teaching hospitals are considering adopting a sweeping disclosure policy that would establish detailed procedures for physicians to openly acknowledge medical errors and other bad results to their patients, and provide for training in apologizing.

A group of physicians, patients, and executives from the hospitals, led by Dr. Lucian Leape, a national specialist on patient safety, began drafting the policy last year. In recent months, the group circulated a 50-page first draft among hospital leaders, who responded favorably to its broad goals but have suggested numerous revisions, which the group is now implementing.

If Harvard's largest teaching hospitals -- Massachusetts General Hospital, Brigham and Women's Hospital, Beth Israel Deaconess Medical Center, Dana-Farber Cancer Institute, and Children's Hospital Boston -- adopt the policy, it would create a uniform response across the Harvard system to some of medicine's most difficult situations. The Harvard hospitals also would join a growing number of US medical centers and malpractice insurers that are embracing immediate and open disclosure and apology to patients when medical care goes wrong.

"I'm trying to get all the Harvard hospitals to adopt the policy," said Leape, a professor at the Harvard School of Public Health. "The time has come to be open with our patients."

The policy states that patients should be compensated for expenses related to medical injuries, said doctors who have read it. But those involved in the project said they don't believe they can work out soon an agreement about who should pay such expenses, and which expenses are covered, so the group plans to leave out those details until after further discussions.

The Harvard hospitals, as do most hospitals, already have their own policies on dealing with unanticipated medical outcomes. The Joint Commission on Accreditation of Healthcare Organizations, a national group that reviews and accredits hospitals, requires hospital caregivers to tell patients about the most serious of these situations, but doesn't spell out requirements beyond that.

In Boston, Dana-Farber has one of the most detailed disclosure policies, and requires doctors to apologize for errors. But the ingredients of the Harvard hospitals' policies vary tremendously. And implementation of the policies and training is spotty, said Robert Hanscom, director of loss prevention for the Risk Management Foundation, which insures Harvard hospital doctors.

"We have some hospitals that have moved forward very progressively, but we've seen a couple of cases recently where there's been a real hesitancy on the part of providers to have that conversation with patients. It should happen within hours. We've seen delays of several days," said Hanscom, who is a member of Leape's group.

Leape and other physicians developing the policy said disclosure is "the right thing to do," but there also is growing belief among malpractice insurers that such disclosure and open expression of sympathy and remorse could head off malpractice lawsuits in a system reeling from skyrocketing premiums.

"Doctors worry that if they talk to the patient, they're more likely to be sued," Hanscom said. "Our feeling is just the opposite. It's the shutting down that angers patients. We've heard from patients in this situation that everyone almost shuns them."

Colorado's largest malpractice insurer, COPIC, for example, has enrolled 1,800 physicians in a disclosure program under which they immediately express remorse to patients when medical care goes wrong and describe in detail what happened. The insurer compensates patients for related expenses, including insurance deductibles for follow-up medical care; lost time at work; and baby sitters, said Dr. Jerome Buckley, who helped develop the program. Patients cannot participate in the program if they have filed a lawsuit, but they do not waive their right to sue later, he said.

Cases in which an obvious error occurred, such as a surgeon amputating the wrong leg, do not qualify for this program, Buckley said, because they must by law be reported to regulatory boards and investigated through traditional channels. But it does cover cases where patients experience a known potential complication or poor outcome, or when it's unclear that a bad outcome was caused by a physician's error.

Since 2000, COPIC has reimbursed more than 400 patients an average \$5,300 each for bad medical outcomes, or a total of about \$2 million.

Buckley said malpractice claims against these 1,800 doctors have dropped 50 percent since 2000, while the cost of settling these doctors' claims has fallen 23 percent. The University of Michigan Health System has cut claims in half and reduced settlements to \$1.25 million from \$3 million a year since developing a disclosure policy in 2002, said Richard Boothman, chief risk officer.

Last month, Buckley flew to Boston to speak to Risk Management Foundation executives as part of development of the proposed Harvard policy, and to executives from ProMutual Group, the state's largest malpractice insurer.

Leape said he did not want to discuss his proposal in detail until it's final.

But doctors who have reviewed it said that it addresses all aspects of a poor medical outcome: the impact on the patient and family; the impact on doctors and nurses; training for caregivers in handling these events, including immediate response teams that would provide immediate guidance on talking to patients and families; and the investigation of such events and making changes to prevent future problems.

"Yes, we're recommending that doctors say they're sorry," said Dr. Thomas Delbanco, of Beth Israel Deaconess and a member of Leape's group. "Be a human being. Don't just say it; mean it."

The policy would require approval from the hospitals' top executives and in some cases trustees. "A lot of details need to be worked out before we could sign off on it," said Dr. Britain Nicholson, Mass. General's chief medical officer. "This would dramatically expand on our policy."

Nicholson and leaders at other hospitals said they want language clarified. For example, many bad outcomes are not errors; they are known but rare complications. Do doctors apologize in these cases? Should patients be compensated financially?

"If I am doing a colonoscopy and there is a perforation at a weak area in the bowel wall, a physician would take umbrage if he or she had to say 'I am sorry I made this error,' " said Nicholson.

He said doctors who reviewed the policy also want the section on support for physicians and nurses involved in medical mishaps expanded; possibilities are allowing these doctors paid time off and expanded counseling and mental health benefits.

Nicholson said that at Mass. General disclosure of medical errors is routine. But he said whether a doctor explicitly expresses remorse varies. "Part of it depends on when you went through training," he said. "Fifteen to 20 years ago coming through medical school and residency, we were implicitly, if not explicitly, told, 'Don't ever admit a mistake,' because it will come back to haunt you if you get sued."

<http://www.sorryworks.net/media31.phtml>

Standards, Audits, and Saying I'm Sorry: An Engineer's Family Proposes Solutions

By Doug Wojcieszak

Patient Safety & Quality Healthcare
May/June 2005

I dreamed of being an engineer when I was growing up, but algebra and calculus were not my cup of tea, so I pursued a career in politics and public relations. I was a press secretary and policy analyst for the Illinois House Republicans, and then I became the executive director of Illinois Lawsuit Abuse Watch (I-LAW), a tort reform group, in 2000. Like all tort reform groups, we advocated caps on damages and other legal reforms. Working for I-LAW was my first exposure to the politics of medical malpractice, but I was no stranger to the issue on a personal level.

Two years earlier, I had lost my oldest brother, Jim, to medical errors. While the circumstances of his death are unique, the events surrounding his passing are not: A series of medical errors and misdiagnoses compounded until his body quit. Also typical was the hospital and doctors' response to my brother's bad outcome: They refused to talk with my parents, and medical records were not forthcoming. The stonewalling and silence did not sit well with my parents, especially my father, who is an engineer.

My dad holds a PhD in structural and civil engineering and has been involved in the development, design, manufacturing, and service of nuclear power plants for the United States Navy and aircraft engines for military and commercial customers. I can say without bragging that Dad is a great engineer, and his highly specialized training and mindset instinctually kicked in after my brother's death.

My dad wanted to know from the doctors and hospital administrators how Jim died, what system breakdowns contributed to his death, and how the system would be fixed so another person doesn't suffer the same fate. Dad's questions were greeted with a stony silence and a canned response: "We're sorry, but we can't discuss these issues with you." Maddening.

Here sat my father who made a career out of designing, implementing, and fixing processes so that nuclear ships and aircraft engines would be safe, and he was impolitely told to butt out of the death of his own son. Absolutely maddening.

My family turned to the courts for redress and received a monetary settlement, but the hospital and doctors never admitted fault. Our attorney said the doctors would have a "black mark" on their record; however, we still have lingering questions: Has the hospital truly learned from Jim's death? Have they improved their processes? Have other families suffered our fate?

These lingering questions continue to haunt our family, especially during the current tort reform debate over capping damages and attorneys' fees and insurance reform. Whenever I speak with Dad about the tort reform battle, he poses the same frustrated, rhetorical question: "Why aren't the politicians and the media talking about fixing medical processes to reduce all these errors?"

He also makes another interesting point: "When engineers make a mistake, the plane crashes or the ship sinks, hundreds if not thousands die, and there is an outcry from the media, legislators, and the public for heightened safety standards. Furthermore, there is no talk of limiting lawsuits. However, the Institute of Medicine says medical errors kill between 44,000 and 98,000 Americans annually, and all we're talking about is capping damages and making it

tougher for people to file a lawsuit. There is no serious public discussion about increasing safety standards and reducing medical errors."

Indeed, maddening.

Engineering: A Culture of Safety Driven by Accountability
To be fair, engineers and doctors work under much different conditions.

I've pointed out to my father that he could pick and choose the time and place he worked on a nuclear reactor or aircraft engine, whereas a doctor doesn't know who or what is coming through the emergency room doors in the next 10 minutes. Dad agreed with this point, but he was quick to retort that he believes the stakes for engineers and their companies are much higher. When a plane crashes, it's front-page news, massive lawsuits will be filed that could bankrupt the company, and engineers will lose their jobs; whereas when a doctor makes a mistake it usually affects only a single patient, most often it's not newsworthy, a lawsuit might be initiated, and strong disciplinary measures are rare.

My father believes these heightened stakes have created an unparalleled culture of safety within the engineering profession. The safety culture begins with engineers being trained to work in teams and being able to coordinate complex projects with top to bottom communication from the team leaders to the most junior engineers. A major part of this communication system involves creating written records of all events and producing reams of data to show compliance with procedures and that can be studied to fix processes if something goes wrong. Furthermore, as my father says, "cowboys, gamblers, and risk takers" are generally frowned upon in engineering. If engineers are not sure about something, they run the numbers and do the tests again and again until they are sure. Risks are minimized. "We just don't think something is OK, we prove it's OK with data," says my dad.

Doctors, on the other hand, tend to work independent of each other and other medical providers, which can lead to miscoordination of patient care, and are generally not religious about writing down information and producing data that can be reviewed. Also, due to their independence, doctors can become the risk takers and gamblers scorned by Dad and his engineering colleagues.

The engineering safety culture is further enhanced by the customers, the government, and management.

Customers of engineering products — like a major airline — are highly educated, sophisticated consumers that know how to demand and receive a quality product. These customers have audit power, and if they are not satisfied with their audits they know how to complain to the government and get their auditors involved in the review. Furthermore, there are only so many airlines, and if they cancel a project it can destroy a company's bottom line. Indeed, engineering customers have the ability to inflict consequences.

This stands in stark contrast to patients and families who are usually unsophisticated consumers literally at the mercy of their medical providers. Patients don't have audit power, most don't know how to complain to the government, and if they leave the hospital they'll quickly be replaced by another sick person looking for care. Indeed, patients and families generally don't have the ability to inflict consequences, with the exception of the occasional lawsuit.

The federal government also plays a major role in engineering safety. In addition to actively listening to customer complaints, the federal government has tough oversight and audit powers with engineering companies as well as their customers. The government's job is to make sure engineers, their companies, and their customers are meeting safety standards and codes so the boat doesn't sink or the plane doesn't fall out of the sky. Government's auditors have teeth and are respected — and feared — by engineers. They have the ability to delay or cancel projects, as well as put people in jail.

The medical profession has a much different view and perception of bureaucratic state medical boards and JCAHO. One hospital administrator remarked to me that JCAHO is a "joke." Indeed, JCAHO audits only every three years, while the government audits some military engineering projects on a monthly basis, and corporate projects are reviewed several times a year.

Company managers want to keep the government at bay and customers happy, so they closely manage and monitor their engineering teams and demand quality and constant improvements. Companies institute their own internal audits to make sure their people understand and meet the required specifications and standards. Since many doctors are independent contractors, many hospital administrators generally don't have the same oversight powers.

Finally, when engineering companies and their customers discover problems or deficiencies in processes or products, they are likely to share their findings with the federal government in an effort to develop new industry-wide standards and practices. As my dad says, "Engineers make a real effort to share information and learning, especially after bad outcomes and near misses."

Compare this culture to the medical profession and medical malpractice insurers that require sealed records to be part of most settlement agreements. "How much learning is lost by sealing medical malpractice settlements?" my father wonders.

Indeed, if medical professionals truly wish to improve their processes and reduce errors, they should welcome the establishment of similar outside pressures experienced by engineers. This means better-educated patients who know how to complain to the government and get results, strengthened government oversight and regulatory pressures, and hospital management that is more involved in the day-to-day activities of their doctors.

Much like engineering, these external pressures will produce better team work and communication among doctors and medical providers. Furthermore, it will cause standards to be elevated and audited frequently, and when those standards are not met, meaningful reviews will occur that will produce the necessary system improvements.

Finally, the medical profession must reform by allowing better sharing of information after bad outcomes so doctors can learn from the mistakes of other doctors.

Moving On

Over the past year I continued my education in the politics of medical malpractice, this time working for the plaintiffs' bar. I advocate the typical anti-tort reform messages of enhanced insurance regulation and stronger doctor discipline. However, I have also had the opportunity to promote a unique solution called "Sorry Works!" that encourages apologies and upfront compensation for medical errors. I learned quickly that the Sorry Works! full-disclosure idea appeals not only to plaintiffs, but it also has crossover appeal to doctors, risk managers, and some insurers.

In an effort to gain greater exposure for Sorry Works, I helped start a new group aptly named "The Sorry Works! Coalition" (www.sorryworks.net). We believe that apologies and upfront compensation dissipate anger after bad outcomes, and, thus, lower the number of lawsuits and related liability costs. We also say that full disclosure provides swift, fair justice for victims of medical errors. Finally, we believe full disclosure creates a culture that will lead to a reduction of medical errors, especially repeat medical errors.

Indeed, living in a culture of honesty is the only way doctors can learn from errors and implement changes to reduce the chances of repeat errors. Furthermore, adopting honesty is the first step required to implement the changes recommended in this article.

I penned this article, but most of its insight and substance belongs to my father. Losing Jim was a devastating blow to our family, and the pain of his passing has never left. However, we hope good will come out of our tragedy. Specifically, we want the medical profession to make continuous process improvements so other families will not know our pain. Would you expect anything less from an engineer's family?

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<http://www.sorryworks.net/media29.phtml>

Learning Words They Rarely Teach in Medical School: 'I'm Sorry'

By RICHARD A. FRIEDMAN, M.D.

New York Times

July 26, 2005

There is nothing in the Hippocratic Oath that tells doctors what to do when they make a mistake with a patient. Nor is there much on this subject in medical school curriculums or in residency training programs.

But there should be.

Much was made of the Institute of Medicine's 1999 report that 44,000 to 98,000 people die each year in hospitals from preventable medical errors, many of them presumably made by doctors.

The report spawned many initiatives to address the problem, but there was little discussion about how doctors, when they have made mistakes, should deal with their patients.

Not long ago, a patient called me to complain about the treatment she received from one of the residents I supervise. After starting a new medication, this patient said that she experienced bad side effects, and that her doctor had failed to warn her that this drug might interact adversely with other medications she was taking, something she discovered by herself on the Internet.

What really bothered her was not so much the physical discomfort - headache and dizziness - but the fact that when she confronted her doctor, a psychiatrist, he didn't apologize for his mistake. She asked to be switched to the care of another resident, because she felt her current doctor would resent her for taking him to task.

When I reviewed this case with the resident, he puzzled over why he was reluctant to apologize to the patient. Did he feel his medical authority was threatened? Was he worried about the legal implications of admitting a mistake? Not really.

Instead, it seemed to the resident that acknowledging the mistake would narrow the psychological distance between him and his patient, and that felt uncomfortable.

Everyone assumes that the ever-present threat of litigation has made doctors more anxious about admitting error, and no doubt it has. But doctors have always been tight-lipped about their mistakes, in part to preserve an illusion of medical omnipotence.

Like every doctor, I've made plenty of mistakes along the way.

As a young attending physician, I started a very depressed patient on a type of antidepressant called a monoamine oxidase inhibitor after she failed to respond to Zoloft and then to Prozac, drugs that belong to a different class of antidepressants.

Because the two types of drugs can interact, I waited for what was then considered enough time before prescribing the new drug. But within two days, the patient developed a high fever, confusion and dangerously low blood pressure, a syndrome we now recognize as a result of surging serotonin levels in the brain. She ended up in the intensive care unit and nearly died from a serotonin syndrome.

Needless to say, I was distraught about what had happened. I wasn't sure what went wrong, but I felt that it was my fault, so I apologized to the patient and her family.

They were shaken and angry, and they quite naturally blamed me and the hospital for their daughter's near-death experience. But she recovered rapidly and completely, and in the end, they decided that this was an unfortunate but "honest" medical error and took no legal action.

Studies suggest that patients are less likely to sue when doctors apologize for mistakes, and many hospitals now encourage their physicians to admit their errors. According to an advocacy group called The Sorry Works! Coalition, 16 states have already passed laws giving doctors legal immunity for their apologies to patients.

Of course, there are plenty of doctors with a nice bedside manner who can get away with bad treatment. How else to explain patients who often line up in court to support doctors accused of malpractice?

The surprising truth is that many patients have a hard time knowing whether they are really getting good medical care.

Because so many diseases fluctuate randomly over time, patients sometimes spontaneously improve despite incompetent treatment. On the other hand, a patient who receives exemplary medical care may fare badly simply because the illness is hard to treat. In other words, doctors are often praised or blamed, when the outcome is in fact a chance event.

Many, perhaps even most, medical errors probably have little ill effect and go unnoticed by patients. Many lawyers would disagree, but doctors ought to let their patients know when they've erred; it humanizes them and builds trust.

In the end, most patients will forgive their doctor for an error of the head, but rarely for one of the heart.

<http://www.sorryworks.net/media28.phtml>

Conservative Columnist Praises Sorry Works!

By Deroy Murdock

New Hampshire Union Leader

July 16, 2005

Across the years and through the morphine, I recall an anesthesiologist explaining how he goofed during major surgery — on me. I was in a dreadful car crash in 1986. While trying to insert a small antibiotic tube near my heart, a Tucson Medical Center anesthetist accidentally slipped and punctured my lung, making it collapse. As I recovered from that morning's incisions, he detailed his mistake and said he was sorry.

"I have two questions," I groggily declared: "Did you intentionally collapse my lung?"

"No," the doctor replied.

"Were you trying to make me better?"

"Yes," he said.

"Well, then I forgive you. Thank you for putting me back together."

Absent that apology, a gurney-chasing attorney could have convinced me to sue this physician for malpractice. Instead, I was touched by his honesty and felt no malice toward him. As I recuperated, litigating against him was the last thing on my mind.

Along these lines, a new organization called "The Sorry Works! Coalition" (SorryWorks.net) hopes to curb lawsuits stemming from medical errors. It encourages doctors and hospitals to fess up when they screw up and offer fair compensation to those they have harmed. This simple idea should brighten the climate wherein doctors often fear the sick as potential litigants, while too many patients treat practitioners like unguarded pots of gold.

Sorry Works! cites several apologies that have vaccinated physicians against lawsuits:

- Linda Kenney had ankle surgery in 1999, but nearly died after accidentally receiving anesthesia in her heart. The anesthetist ignored the hospital's advice and apologized for his gaffe. She never sued, and the two have become friends. "For him, it was like a great weight was lifted from his shoulders," Kenney told Boston's CBS-4 TV. "For me, it was like freedom to move on."
- A misprogrammed pump gave a child a fatal dose of painkillers at a University of Michigan hospital. Its medical director apologized to the grieving mother. Despite capturing his words on tape, she refused to sue and accepted an undisclosed settlement.
- When another Michigan patient suffered blurry vision after Lasik eye surgery, he prepared to sue. The doctor explained that corneal wrinkling is a standard risk in such procedures, and that he did nothing wrong. The patient dropped his suit and let that physician correct the damage.

Apologies have saved providers plenty in legal fees and payouts.

- The Veterans Administration Medical Center in Lexington, Ky., launched an apology policy in 1987. By 2000, it had settled with 170 patients and only thrice went to trial. Its average payment across all claims was \$16,000 compared to the VA system's \$98,000 average in 2000.
- University of Michigan hospitals have cut routine caseloads from 260 to 275 claims in 2002 to 120 to 140 today. Concluding a typical case required 1,160 days (about three years and two months) then, vs. 320 days (10 and a half months) now, a 72.4 percent savings. Per-case

legal costs have plunged from \$65,000 to \$35,000. Annual legal defense expenses have dropped from roughly \$3 million to \$1 million.

- Denver-based COPIC Insurance Companies covers some 5,800 Colorado physicians, of whom 1,942 participate in its 3-R's Program. Since late 2000, this initiative has sought to "recognize, respond (to) and resolve" medical errors.

"The average payment in 3-R's cases is \$5,586," says COPIC's George Dikeou, "while the average outside the program is about \$284,000."

"The majority of people who file medical lawsuits file out of anger, not greed," says Sorry Works! founder Doug Wojcieszak. "That anger is driven by lack of communication, being abandoned by doctors and no one taking responsibility for his mistakes. Apologizing and offering some up-front compensation reduces this anger."

Seventeen states have enacted apology laws; some make remorseful words inadmissible in court if uttered soon after mishaps occur. U.S. Sens. Max Baucus, D-Mont., and Michael Enzi, R-Wyo., introduced the Reliable Medical Justice Act on June 29 to provide federal funding for apology projects around the nation. While the need for federal grants here is a mystery, Washington should encourage this concept without reflexively whipping out the checkbook. Implementing it in VA hospitals would be a solid start.

This terrific idea should sweep the nation. To cure medical-malpractice lawsuits, "sorry" shouldn't be the hardest word.

Deroy Murdock is a columnist with Scripps Howard News Service and a senior fellow with the Atlas Economic Research Foundation in Fairfax, Va. E-mail him at deroy.murdock@gmail.com

<http://www.sorryworks.net/media27.phtml>

Sorry Works!/full-disclosure Bi-partisan Federal Legislation Introduced

July 6, 2005

Bi-partisan federal legislation was introduced last week by United States Senators Mike Enzi (R-WY) and Max Baucus (D-MT) that will provide federal grants for full-disclosure/Sorry Works! type pilot programs at the state level. The bill number is S 1337 and can be viewed at this [link](#).

This is yet another exciting development after the recent passage of the Sorry Works! pilot program in Illinois (Illinois Senate Bill 475). Pilot programs at the state level will encourage more hospitals and doctors to try Sorry Works/full-disclosure and learn first hand how this approach reduces lawsuits and liability costs while providing swift justice to more victims and reducing medical errors.

Please call or write your member of Congress and tell them to support S 1337.

Stay tuned to the Sorry Works! website for updates on this legislation and please sign up for our newsletter by hitting this [link](#) to receive bi-weekly updates on the legislation and other important information.

If you have questions call 618-559-8168 or e-mail doug@sorryworks.net. Thank you!

<http://www.sorryworks.net/media26.phtml>

`Sorry' works, if we're brave enough to say it

Chicago Tribune

By Eric Zorn
June 14, 2005

`Sorry" works.

Those words are not only the title of a pilot program soon to be signed into law in Illinois and the name of the organization that promoted it, but they're also just common sense.

Apologies are effective. They cauterize wounds. They smooth ruffled feathers. They help mend fences, turn corners, put out fires and head trouble off at the pass. Pick a metaphor.

Your parents and teachers extolled the virtues of saying "I'm sorry" when you messed up. And, if you were lucky, they forced you into saying it when all you really wanted to do was deny, lie or justify.

Senate Bill 475, the medical malpractice reform bill that has passed in the General Assembly and that Gov. Rod Blagojevich has said he will sign, facilitates the use of apologies in instances of alleged screw-ups by doctors.

It says, "Any expression of grief, apology or explanation provided by a health-care provider, including, but not limited to, a statement that the health care provider is `sorry' for [a medical] outcome ... shall not be admissible as evidence in any [legal] action" as long as that expression comes within 72 hours of that outcome.

Two Illinois hospitals will test the idea under the legislation, though the idea of these so-called apology-immunity laws is working in 19 states, according to Doug Wojcieszak, 34, a former House GOP staffer who directs the national Sorry Works! Coalition from an office in Downstate Glen Carbon, a suburb of St. Louis.

"Anger at doctors drives up the costs of malpractice cases," he said in an interview Monday. Physicians "are told never to say they're sorry, never to explain. So even when they have met the standard of care and a patient dies, they create the perception of a coverup."

Ever since the VA Medical Center in Lexington, Ky., instituted this sort of candor-based approach to doctor error in the late 1980s, health-care institutions that have tried it have seen costs go down, according to Wojcieszak.

The Associated Press reports that the University of Michigan Health System saw annual attorney fees drop from \$3 million to \$1 million and the number of malpractice legal actions drop 50 percent since the system went the "sorry" route in 2002. Wojcieszak refers to such results as an "honesty dividend."

He says his own story illustrates it.

In 1998, he said, his brother Jim went to an emergency room in Cincinnati at 2 a.m. with heart attack symptoms. "They sent him away with a pair of Tums," he said.

His condition worsened and he returned the next day. Tests found he'd suffered several heart attacks, Wojcieszak said, and two days later he died at age 39.

"The hospital slammed the door in our face after that," he said. "They just said he was sick, there was nothing they could do."

Rage fueling their grief and vice versa, the Wojcieszak family sued the hospital, he said.

An apology would not have made things all better, Wojcieszak admitted. "But if they'd have been upfront with us about what went wrong, said they were sorry, told us what they were doing to make sure it didn't happen again and made a fair compensation offer, they would have saved themselves a lot of money" compared with the settlement that concluded the litigation.

So if "sorry" works so well, why does it go against the grain of not just doctors, but most of the rest of us as well?

The answer may lie in human evolution, said bioethics professor John Banja of Emory University, whose work in this area is chronicled in his book "Medical Errors and Medical Narcissism" (Jones and Bartlett, 2005) .

"When you apologize, you essentially humble yourself before another," Banja said. "And it makes bio-evolutionary sense that the more sympathetic a creature feels toward others, the less it's able to survive itself. A species that doesn't have pride, that doesn't have as a defense mechanism confidence in its superiority, isn't well equipped to survive."

Such a sense--Banja rather neutrally calls it arrogance or narcissism--seems to be particularly important for those in high-stress, high-anxiety fields such as medicine.

"Sorry" works, in other words. But so, in its way, does "nuts to you."

But as we've known since childhood, "sorry" is still the way to go.

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<http://www.sorryworks.net/media21.phtml>

BOSTON WOMAN SIMPLY WANTS APOLOGY FROM DOCTOR

JUNE 14, 2005

Boston..... Joanne Brindley wants to hear two little words from an anesthesiologist at a Boston area hospital: "I'm sorry." However, the anesthesiologist has refused to apologize even after the Massachusetts Board of Registration in Medicine issued a Letter of Concern over the incident and Ms. Brindley's state representative wrote a letter to the hospital president asking for the apology.

"We're sharing Joanne's story with the Boston and national media because it typifies what most people want from doctors and hospitals after bad outcomes and adverse events. Despite the popular notion that every patient is a potential plaintiff, most people are like Joanne in that they want their doctors to be honest, contrite, and good communicators," said Doug Wojcieszak, spokesperson for The Sorry Works! Coalition. "Lawsuits are the last thing on their mind, and they only pursue this option after hospitals and doctors abandon them by refusing to communicate and apologize."

Joanne Brindley was scheduled for a mastectomy with local anesthesia on May 13, 2004. Although a local anesthesia is unusual for this type of operation, Joanne and her surgeon agreed to this approach in advance of the operation. However, shortly before the operation, the anesthesiologist introduced herself to Joanne and informed Joanne that she and her assistant were present to provide anesthesia during the surgery. To which Joanne responded that no, she had requested a local. To which the anesthesiologist replied that no, Joanne, was going to sleep. Then it allegedly got ugly.

The anesthesiologist allegedly lost her temper, stomped around the holding room screaming for Joanne's surgeon, said the whole ordeal was a "waste" of her time, and then got into a heated discussion with Joanne's surgeon in earshot of Joanne.

"Here I was scared, alone, and about to undergo a mastectomy, which is hard enough, but then I have to deal with this anesthesiologist screaming that I am a 'waste' of her time. Words mean things. It brought me to tears. Granted, my procedure was unusual and she may have been surprised, but that doesn't give her a right to scream, rant, and rave in my presence and insult me," said Joanne Brindley.

A different anesthesiologist handled the procedure and the surgery was completed without full anesthesia; however, Joanne couldn't let the incident go.

"The doctor was abusive, rude, and unprofessional. I wanted an apology and wanted her to change her behavior so no other patient would have to endure this type of conduct. But she has refused to apologize, and, in fact, she completely denies the incident ever happened," said Brindley.

Joanne complained to the hospital, the state disciplinary board, and her state representative. The state disciplinary board issued a Letter of Concern to the anesthesiologist, and Joanne's state representative (Rep. Thomas P. Kennedy) wrote a letter asking the hospital president for the doctor to apologize for her behavior. Rep. Kennedy's letter also complimented Joanne for not pursuing litigation over the matter.

The hospital president responded by saying the state disciplinary board had looked into the matter, and the chair of the anesthesiology department apologized for an "unpleasant experience," but no apology from the anesthesiologist.

"I just want her to apologize. I just want her to say, 'I'm sorry' and understand how her words hurt so she doesn't do it again. That's all I want. That's all most patients and families want.

We don't expect doctors to be perfect - they're human after all. But doctors need to be accountable for their actions, and own up to mistakes. It's the only way the health care system can improve," said Brindley.

Sorry Works! spokesperson Doug Wojcieszak is urging the hospital and the anesthesiologist to reconsider their position in this case.

"Massachusetts has a law on the books allowing doctors to apologize without it being used against them in court, and Joanne Brindley isn't interested in litigation anyway. She simply wants an apology. She wants accountability and justice. This is what most patients and families want, and when doctors don't provide it patients and families are forced to pursue litigation," said Wojcieszak.

"Doctors need to understand that most patients are like Joanne, in that they don't want to file a lawsuit - they simply want honesty and 'I'm sorry' when things don't go as expected," concluded Wojcieszak

<http://www.sorryworks.net/media20.phtml>

SORRY WORKS! PILOT PROGRAM PASSES ILLINOIS GENERAL ASSEMBLY

JUNE 2, 2005

Springfield....Illinois is set to become the first state to enact a Sorry Works! pilot program as a solution to the medical malpractice crisis with the passage of Illinois Senate Bill 475 this week. Illinois Governor Rod Blagojevich has indicated that he will sign the legislation into law.

The pilot program allows two Illinois hospitals to try Sorry Works! risk-free for a two-year period. The bi-partisan legislation was backed by The Sorry Works! Coalition, a national organization dedicated to educating doctors and hospitals about the value of apologies and upfront compensation in reducing lawsuits, liability costs, and medical errors.

"We're thrilled that Sorry Works! passed the Illinois General Assembly. This provides important exposure for our efforts and extra incentives for doctors and hospitals to try Sorry Works," said Doug Wojcieszak, spokesperson for the Sorry Works! Coalition.

Under SB 475, the State of Illinois will establish a committee of medical, insurance, and legal experts to administer the Sorry Works! pilot program. The committee will determine if lawsuits and liability costs increase, remain the same, or are reduced with Sorry Works! The State of Illinois will cover the difference in costs between the new norm and the old norm if costs rise; however, if lawsuits and costs go down under Sorry Works, the hospitals will enjoy the savings and the State of Illinois won't incur any costs.

"Lawsuits and costs have dropped in every hospital that has tried Sorry Works, so we expect more of the same here in Illinois with our pilot hospitals," added Wojcieszak.

Under Sorry Works, doctors and hospital staff conduct root cause analyses after every bad outcome, and if a medical error caused the bad outcome, the doctors and hospital staff members apologize, provide solutions to fix the problem, and offer upfront compensation to the patient, family and their attorney(s). This approach removes anger and actually reduces the chances of litigation and costly defense litigation bills. The program has worked successfully at hospitals such as the University of Michigan Hospital system, Stanford Medical Center, Children's Hospitals and Clinics of Minnesota, and the VA Hospital in Lexington, Kentucky.

Wojcieszak is careful to caution that hospitals and doctors in Illinois and elsewhere don't need the pilot program to try Sorry Works!

"The pilot program simply provides an extra incentive for hospitals to try this approach and it removes the excuses of the doubters, but the benefits of Sorry Works - lower lawsuits, liability costs, and medical errors - should be incentive enough to try this approach. That is why we have seen several hospital already adopt Sorry Works! on their own, and more can do so without waiting for state or federal legislators," concluded Wojcieszak.

The Sorry Works! Coalition will now target other states to start pilot programs and will also work with federal legislators.

"Illinois was good first step and it has created interest in other states and by leaders at the federal level too. We will continue to work to develop more opportunities to implement Sorry Works! across the country," concluded Wojcieszak.

<http://www.sorryworks.net/media19.phtml>

Doctors Saying "Sorry"

CBS 4 – Boston

May 13, 2005

Hundreds of patients and their families are affected by medical mistakes every year. But Josh Binswanger shows us why more doctors are actually being encouraged to say they're sorry for their errors.

Linda Kenney went in for routine ankle surgery in 1999, but almost died when the anesthesia was accidentally administered to her heart .

"I started to lose consciousness, I went into grand mal seizures and went into full cardiac arrest."

Linda's anesthesiologist went against the hospital's advice and actually apologized to her. And instead of suing, they're actually friends.

Linda Kenney, Patient

"For him, it was like a great weight was lifted from his shoulders. For me it was like freedom to move on."

There is now a growing effort to encourage more doctors to say they're sorry.

Doug Wojcieszak, Sorry Works Coalition:

"What we're encouraging doctors to do is apologize for errors and to apologize for mistakes quickly and also offer compensation up front."

Doug Wojcieszak is trying to get more doctors to apologize for medical mistakes.

He founded "Sorry Works," a coalition that trains doctors how to apologize.

Wojcieszak believes apologies matter and points to research showing hospitals and municipalities that adopt this approach see liability costs drop by a third and lawsuits are cut in half.

"There's a common myth out there that medical malpractice lawsuits are driven by greed. In fact, most medical malpractice lawsuits are driven by anger."

Several Massachusetts hospitals are considering including the apology component as part of a larger effort to prevent medical errors. But they want to make sure that employees would be legally protected so that nothing they said could potentially be used against them in a lawsuit.

Dr. Alan Woodward, Mass Medical Society:

"You want to have an open discussion about what has happened, why it has happened and assure the patient that you're going to make sure that it doesn't happen to another patient."

Linda Kenney has started a support group to help other medical personnel and patients and their families who have been involved in medical traumas called Medically Induced Trauma Support services.

For more information, log onto mitss.org or call 888-36-MITSS.

<http://www.sorryworks.net/media18.phtml>

Sorry Works! pilot program part of final med-mal bill in Illinois

The Illinois Governor and General Assembly have agreed to a final med-mal bill (Illinois Senate Bill 475), and the Sorry Works! pilot program is part of the bill! The bill will be passed this weekend and a signing ceremony is planned this coming Tuesday, May 31. To see the legislation, visit www.ilga.gov, search for Illinois Senate Bill 475 and click on House Amendment 1.

The bill also includes immunity for physician apologies, which can also be a good step. While we believe honesty is its own defense (and a best defense), if this provision helps physicians become more comfortable communicating with their patients, then it's a good thing.

SB 475 contains many other provisions, including comprehensive insurance reform, stricter physician discipline, and caps on non-economic damages (\$500,000 for physicians and \$1 million for hospitals). Indeed, SB 475 is a true compromise bill that all sides gained something and gave something in the process. Still, some members of the Sorry Works! Coalition will not be happy with the caps provision in SB 475. To these members we say this should cause us to re-double our efforts in promoting Sorry Works! as the solution to the medical malpractice crisis. Indeed, Sorry Works! reduces lawsuits and liability costs without limiting constitutional rights, thus making caps (and other tort reform ideas) unnecessary.

It's up to us if Sorry Works! is going to be seen as the med-mal solution or if it's going to be mixed in as part of a grab bag of med-mal fixes.

In conclusion, getting the first Sorry Works! pilot program passed in the United States is a huge accomplishment. We are happy and gratified. However, we have much work to do. Other states should pass pilot programs, but we also need to educate hospitals and doctors that they don't need to wait for legislators to pass pilot programs (or caps)...they can embrace Sorry Works! today and begin experiencing the benefits immediately. The pilot programs are simply a way to publicize the program and provide incentives for people to try Sorry Works. However, the benefits of Sorry Works! should be incentive enough. We need to educate lots of people, and you can do your part by forwarding this e-newsletter to five (5) of your colleagues. Thanks, and cheers!

<http://www.sorryworks.net/media15.phtml>

**Radical Surgery Is Urged for Medical Malpractice:
A growing chorus says the time is right to overhaul the system to encourage
willing disclosure, corrective action and apologies.**

Los Angeles Times

By Ricardo Alonso-Zaldivar, Times Staff Writer
April 05, 2005

WASHINGTON -- After 39-year-old Jim Wojcieszak died of a heart attack that hospital doctors had failed to recognize, his family wanted an explanation. They would have liked an apology too.

Just getting the facts required a long, emotionally painful journey through the world of medical malpractice litigation, and years passed before anyone said they were sorry.

Even though the Wojcieszaks won a financial settlement and could be considered winners in the malpractice system, they have joined a growing number of healthcare organizations, patient advocacy groups and others who think the time has come for fundamental change. They want a system that encourages willing disclosure when medical mistakes are made and insists on corrective action. And for those who have been harmed, an apology and appropriate compensation. They also want to eliminate some of the emotional pain and rancor that are part of the present system.

The Wojcieszaks and others are convinced a window of opportunity has opened for ending decades of stalemate while helping doctors and hospitals learn from their mistakes and avoid repeating them.

The opportunity arises, advocates say, because President Bush's decision to put malpractice reform near the top of his domestic agenda has focused public attention on the problem. The fact that Congress is deadlocked over Bush's specific proposal -- caps on jury awards -- has opened the door for consideration of alternatives.

Although public debate has been dominated by the struggle between trial lawyers and plaintiff groups on the one hand, and the healthcare and insurance industries on the other, alternatives exist.

Some are quietly undergoing field tests around the country.

"There is so much noise around the heated debate over caps that people are not looking beyond their noses to the broader picture," said Dr. Dennis O'Leary, president of the Joint Commission on Accreditation of Healthcare Organizations, a standards-setting body. With the push for caps getting nowhere, O'Leary said "there is a willingness to see how ... other ideas might work around the country. I see a period of experimentation."

One approach that is being tried in several places uses a system of arbitration in which medical care providers acknowledge errors up front, then express regret and try to work out settlements with victims and families. A more far-reaching alternative would replace the present system with special courts in which judges with medical expertise would hear cases and determine awards based on uniform payment guidelines.

Such an approach has the potential to speed up the process, advocates say, to bring greater equity to a system that is subject to the varying judgments of individual juries, and to filter out some of the anger that often drives plaintiffs.

Most important of all, such strategies could make it easier to detect and combat medical errors.

Under the present system, doctors and hospitals are reluctant to admit mistakes because such admissions could be used against them in court. And the Bush proposal, which seeks to hold down malpractice insurance rates by setting dollar limits on jury awards for pain and suffering, does not address this issue.

"Caps are a sort of Band-Aid approach," said David Studdert, a professor of law and public health at Harvard. "They do absolutely nothing about the problem of medical errors and making healthcare safer.

"There are a lot of preventable deaths, and the malpractice system ought to be contributing something to reducing errors," Studdert said. More than almost anything else, that is what bothered Jim Wojcieszak's brother Douglas about his experience with the malpractice system. Jim Wojcieszak was a burly investments salesman who volunteered installing home heating systems for Habitat for Humanity. He lifted weights and he smoked. He had gone to the emergency room of a Cincinnati hospital one night in May 1998 suffering from severe stomach pain and body aches.

Doctors suspected he had a virus and sent him home. Three days later he was dying. A heart surgeon who made a last-ditch effort to keep him alive told Wojcieszak's father, "I could have saved your son" -- if other doctors had not missed the telltale signs of heart attack.

The case soon turned into the type of lawsuit that doctors blame for the rising cost of medical malpractice insurance. Although the Wojcieszaks obtained a settlement in 2000, the amount of which was confidential, there was no guarantee the same medical mistakes would not be repeated with another patient.

"That's something my parents struggle with to this day," Douglas Wojcieszak said. "We got a settlement, but at the end of the day, we don't know if they changed their processes and system to keep this from happening again."

Because of this, Douglas Wojcieszak, a former Republican political operative in Illinois, is lobbying for legislation in his home state that would encourage hospitals to disclose medical mistakes, offer an apology and fair compensation, and follow up with corrective action.

Similar alternatives have been around for more than a decade and have been tried by some Veterans Administration hospitals and other facilities, with promising results. Douglas Wojcieszak is not the only one who has become an advocate of new approaches after having personal experience with the present system. Sue Sheridan has been through malpractice litigation twice, first on behalf of her son and then her husband.

Her son Cal developed kernicterus, a preventable type of brain damage resulting from jaundice that is not treated soon enough after birth. Now 10, Cal cannot walk without help. His speech is impaired and his arms and legs sometimes move uncontrollably.

While Cal's case was pending, his father, Patrick, developed a tumor on his spine. Doctors removed it, but there was a communications breakdown. No one told the Sheridans the tumor was malignant. Patrick died of cancer in 2002, leaving a family with two unresolved malpractice cases.

Sheridan obtained settlements in both lawsuits, but became an outspoken critic of the malpractice litigation system. She was a founder of the Consumers Advancing Patient Safety, based in Chicago, which advocates a range of measures to reduce medical errors.

"I believed and trusted in the tort system, and when I got to see what it was really all about, I was shocked," said Sheridan, who lives in Boise, Idaho.

A jury initially found the doctor and hospital in her son's case were not at fault. But the judge, in a written ruling, termed the testimony of key defense experts "inconsistent," "unintelligible"

and "of no consequence." He then took the highly unusual step of overturning the jury verdict and ordering a new trial.

"I agree that frivolous lawsuits need to be curbed," said Sheridan, who has a master's degree in business administration and was an international banker before she became an advocate for patients.

But she thinks Bush's proposed caps would not solve the real problems.

Research indicates that caps can help tame the rate of increase in malpractice premiums, but that they also disproportionately affect people who have suffered the most serious injuries. One study of California's \$250,000 cap found that people who suffered grave injury had their compensation reduced by an average of seven times as much as people who suffered minor injury.

California's \$250,000 cap, the model for Bush's national proposal, was enacted in the early 1970s. If the California cap had been adjusted for inflation it would now be about \$900,000. Sheridan's experience led her to become interested in special medical courts as an alternative to the tort system. The judges would have the help of an agreed-upon list of mistakes that should not happen in a high-quality medical practice or hospital, and of a compensation schedule that would take into account such factors as the severity of a person's injury. Creating a court system is such a big step that it may not come soon. Although there are specialized tax and patent courts that could serve as models, finding judges with the requisite medical background and setting up processes for handling cases could take several years.

A more manageable experiment is under way at the University of Michigan Health System in Ann Arbor. "Rather than be defensive, we essentially embraced patient complaints," said Richard Boothman, an assistant general counsel who handles malpractice.

Boothman said the philosophy had three parts: to identify and settle "quickly and fairly" cases in which a patient was hurt through medical error; to defend aggressively cases that the hospital considered to be without merit; and to study all incidents to see how staff procedures could be improved.

Such "early offer" programs can satisfy a family's desire for an explanation and an apology, but, critics say, they could also create pressures to reach a settlement. When it adopted the changes in 2002, the Michigan system had 275 to 300 open malpractice cases at any given time. That number has been cut by more than half, Boothman said. The average time it takes to close a case has gone from more than three years to less than one. And legal costs have been cut in half. Payouts have not declined, partly because some cases that predated the new policy have been settled since the changes took effect. But Boothman said insurance experts were recalculating the system's long-term malpractice exposure because of what they saw as positive trends.

"The key question doctors have to ask themselves is not how they can make plaintiffs' lawyers go away," Boothman said. "They have to ask themselves a more difficult question: 'Why would my patient go see a lawyer in the first place?'"

Nearly seven years after Douglas Wojcieszak's brother died, the legislation he is trying to steer through the Illinois Legislature would set up a pilot program similar to the one at the Michigan hospital. The bill is known as "SorryWorks." To entice hospitals to try it, the state would promise to pick up the difference if malpractice costs rise.

"Lawsuits are necessary, given the way things are done now," Wojcieszak said. "But it's a horrible process. My parents had to relive what happened every day for a year and half. My folks thought they would have a heart attack."

<http://www.sorryworks.net/media16.phtml>

**Providing answers to help ease pain:
Program encourages hospitals to be upfront with patients and families about mistakes**

Time Union

By Matt Pacenza, Staff writer
April 7, 2005

Correction: A Capital Region story on Thursday mischaracterized the concerns of David Baker, whose wife died at Samaritan Hospital in 2003. Baker has asked why hospital staff failed to check Lisa Baker's blood sugar in a single four-hour period the night before she fell into a coma, not why the staff didn't check it more often than every four hours throughout her hospital stay.

ALBANY -- David Baker has been trying to get answers from Samaritan Hospital ever since his 42-year-old wife Lisa Baker slipped into a coma and died there in 2003.

He wants to know why hospital staff didn't feed his wife, who was diabetic, even when her blood sugar plummeted. He wants to know why they failed to check Lisa Baker's blood sugar in a single four-hour period the night before she fell into a coma and died three weeks later.

Months of questioning proved fruitless and a state Health Department investigation said Samaritan's care for Baker's wife of 19 years was adequate. Baker, 59, filed a malpractice suit against the hospital last month.

"Someone has to explain what happened," he said. "It's my opinion that something went terribly wrong and someone has to be held accountable for it."

Malpractice is a national issue. Doctors are urging lawmakers to limit the damages that juries can award, arguing that excessive malpractice insurance is driving them out of business. Hospitals are under pressure to reduce errors in order to ward off lawsuits.

Baker's experience offers insight into why many hospitals are trying a new policy called "Sorry Works," communicating openly with patients and families after mistakes.

Baker said Samaritan never tried to explain what happened to his wife -- because, he believes, they know they were negligent.

"Lisa would be alive today if she were not in that hospital," said Cynthia LaFave, Baker's attorney.

In the years before her death, Lisa Baker, once a reporter for the Record in Troy, struggled with her diabetes, which had robbed her of her sight. But, said her husband and attorney, her condition was manageable through monitoring and diet.

Northeast Health, the nonprofit that owns Samaritan, had no comment on Baker's suit, citing a policy against discussing pending litigation.

Many hospitals have sought to improve communication about errors. It's a movement modeled after an experiment that began in a Veterans Affairs hospital in Lexington, Ky., in 1987. Through a policy it named "Sorry Works," staff members promptly tell a patient or family member after a mistake has been made. The number of lawsuits dropped.

Several hospitals in the Capital Region say they are trying Sorry Works, which has the backing of influential bodies like the Joint Commission on Accreditation of Healthcare Organizations.

"If anything goes wrong, we discuss it with the family," said Dr. John Morley, Albany Medical Center's medical director. "Patients are looking for honesty and they're looking for answers."

Northeast Health also has mechanisms in place to deal with concerns about care. Its patient representatives are "unbiased participants who can take the time to speak with a patient about anything," said Jacqueline Priori, Samaritan's assistant chief nurse.

Baker said he spoke to Samaritan's patient representative the day his wife's condition worsened. She said she would look into it. By the time they spoke several days later, the representative's demeanor had changed.

"She was guarded and very defensive," said Baker, well-known in Rensselaer, where he once worked as a reporter.

Baker said his communication with the state Department of Health, which provided him no details when it cleared the hospital, was also negligible.

"After a thorough and comprehensive investigation, which included a review by an independent expert and consultant, we determined there were no violations in the case," said department spokesman Rob Kenny.

Even as hospitals seek to improve communication and avoid litigation, a quick glance at local courthouse records shows malpractice suits remain common.

In Albany County alone in the first quarter of 2005, civil suits seeking damages for injuries have been filed against four hospitals. The suits also often target the doctors who provided care.

A couple is suing St. Mary's Hospital in Troy, alleging that its personnel failed to diagnose a prenatal condition that resulted in the death of twins in utero.

Albany Memorial Hospital and a local cardiology practice and facial surgery center are targets of the estate of a man who died from heart failure the day after he had plastic surgery. A woman is suing St. Peter's Hospital in Albany, alleging that a botched knee replacement left her with permanent foot damage.

The estate of a 53-year-old woman who died at Albany Medical Center a week after undergoing catheterization of several main arteries is suing the hospital and the catheter manufacturer.

In each case, the hospitals declined to discuss the allegations because the litigation is ongoing.

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