

## IT'S OK TO SAY I'M SORRY

*“Anything you say can and will be used against you in a court of law.”*

We are all familiar with this phrase from the Miranda warning. It essentially advises a person accused of a crime to say nothing until he speaks with an attorney. And the attorney will likely advise him to continue his silence. Traditionally, the advice given a doctor who may be a potential defendant in a civil action for medical malpractice is similar. Statements such as “I’m so sorry” or other apologies made by a physician to his patient following a complication or unexpected outcome can be offered as an admission of negligence in an ensuing malpractice trial. But the traditional advice to keep silent in this context is flawed. Significant differences exist between a criminal prosecution and civil medical malpractice. The person who commits a crime *will* be prosecuted. The doctor who makes a mistake will not necessarily be sued. Moreover, the criminal defendant’s adversary is the State to whom he owes no duty. The physician’s potential adversary is his patient to whom he owes ethical and moral obligations.

In recent years, there has been a movement which departs from the traditional advice of silence in favor of encouraging expressions of apology following bad outcomes of medical treatment. In the late 80s, the VA hospital in Lexington Kentucky, which had sustained significant losses from malpractice litigation, completely reversed its strategy of dealing with potential malpractice claims. Rather than encouraging doctors to clam up after an adverse event, full disclosure became the policy. Any errors or mishaps were to be disclosed in a timely manner to patients even if the patient would not otherwise have known of the error. The patients and families were given full information on adverse events and kept fully apprised on the results of ongoing investigations into the cause of the event. If negligence was found to exist, it was admitted and compensation offered. If the investigation found no negligence, the details were fully disclosed and no compensation offered. As a result of this policy change, the Lexington VA significantly reduced its malpractice costs and other VA hospitals have now adopted the full disclosure policy.

In the late 90s, Doug Wojcieszak, a public relations specialist who has worked both for the defense and plaintiff’s bar regarding malpractice tort reform, lost his oldest brother due to negligent medical treatment. The hospital and doctors refused to provide the family with information on what happened to cause his death. The family sued and recovered monetary damages but the main motivation for filing suit was not money but answers. They wanted to know what happened and they needed closure from an acknowledgment of responsibility from the doctors. That acknowledgment was never forthcoming leaving the family angry at the hospital and doctors. This experience motivated Doug to become an advocate for expressions of apology and full disclosure from physicians following adverse outcomes and culminated in his creation of the “Sorry Works Coalition” in February 2005. This coalition is an advocate for apology and full disclosure following medical mishaps, it provides consulting services to organizations seeking to implement an apology/disclosure program, and it assists states seeking to enact laws encouraging physicians to apologize following adverse events. Mr. Wojcieszak testified before a South Carolina Senate committee prior to the enactment of the South Carolina “I’m Sorry” law. (More about the S.C. legislation later.)

An expression of apology and full disclosure following an adverse medical outcome has three types of implications: (1) legal, (2) ethical, and (3) risk management. The legal implications have been the basis for the traditional strategy of silence. An apology can easily be characterized during a trial as an admission of fault. Defense attorneys do not want to have to explain away such an admission during trial so they advise silence following an event. However, the strategy may be overly cautious. While the statement “I’m sorry” may be deemed an admission of responsibility in some contexts, the statement does not necessarily have this connotation. We say “I’m sorry to hear of your father’s death” to express condolences but the statement conveys no expression of responsibility. So a physician does not admit fault when he says to a patient “I’m sorry you have developed this post-op infection.” Also, the defense focus on preventing admissions of fault overlooks another danger at trial – the danger that the jury will perceive silence as an attempt at cover-up. Negating a perception of cover-up is a much more difficult defense task than overcoming a characterization of apology as an admission of fault. Finally, even if an apology might be characterized as an admission of fault, many plaintiff lawyers will avoid trying to use the apology for strategic reasons. Evidence that the defendant doctor apologized following an adverse event makes the doctor sympathetic. The plaintiff’s lawyer wants to demonize the doctor, not make him look sympathetic.

Apology and disclosure also have ethical implications. If a physician makes a mistake which injures his patient, it is his duty to tell that patient. He is not to keep silent and hope the patient doesn’t discover the error. And even if there was no error, the patient needs to be fully informed as to how an adverse outcome occurred. The physician must not treat the patient as a potential legal adversary and couch his statements accordingly. He must be honest and forthright and always act in the patient’s best interests. Moreover, expressions such as “I’m sorry”, whether or not they convey an admission of responsibility, demonstrate caring and empathy. Such a demonstration of concern is an essential part of the physician-patient relationship.

Much of the recent emphasis on apology/disclosure focuses on risk management. Risk management differs from the purely legal facets of apology/disclosure because it deals with avoiding litigation, not winning lawsuits after they are brought. One of the major reasons patients sue their doctors is because they are angry. They are angry when information is not freely given to them. They are angry when physicians don’t answer their questions or return phone calls. They are angry when doctors appear to be unconcerned with their problems. They are angry when physicians are rude and disrespectful. And they are furious when they discover a cover-up. However, studies have shown that patients are less likely to sue when doctors are caring, empathetic, and apologize when they have made a mistake. Good risk management advice is just the opposite of the traditional legal advice of silence. Good risk management stems from good communication. Doctors must keep their patients fully informed, demonstrate that they care about the patient, open all records, and fully explain the circumstances surrounding all complications and unexpected outcomes. When an error is made, it should be admitted. Another risk management benefit from this strategy is full dissemination of facts regarding errors within the facility so that causes of errors are identified and measures taken to prevent their reoccurrence. But irrespective of the risk management benefits of apology/disclosure, the critical thing to remember is that the

apology must be sincere. The apology must be given because it is the right thing to do, not because it is calculated to keep the patient from bringing a lawsuit.

The “I’m Sorry” movement has been embraced by a number of state legislatures and federal “I’m Sorry” legislation has also been introduced. Approximately 30 states have passed legislation encouraging physicians to apologize to patients after unexpected outcomes. These laws often eliminate the traditional reason for the silence strategy by making apologies and similar communications inadmissible in any ensuing malpractice trial. South Carolina is one of those 30 states. In 2006, South Carolina passed the “Unanticipated Medical Outcome Reconciliation Act” which has become known as the “I’m Sorry” law. The legislature described the rationale for the law in some detail as follows:

The General Assembly finds that conduct, statements, or activity constituting voluntary offers of assistance or expressions of benevolence, regret, mistake, error, sympathy, or apology between or among parties or potential parties to a civil action should be encouraged and should not be considered an admission of liability. The General Assembly further finds that such conduct, statements, or activity should be particularly encouraged between health care providers, health care institutions, and patients experiencing an unanticipated outcome resulting from their medical care. Regulatory and accreditation agencies are in some instances requiring health care institutions to discuss the outcomes of their medical care and treatment with their patients, including unanticipated outcomes, and studies have shown such discussions foster improved communications and respect between provider and patient, promote quicker recovery by the patient, and reduce the incidence of claims and lawsuits arising out of such unanticipated outcomes. The General Assembly, therefore, concludes certain steps should be taken to promote such conduct, statements, or activity by limiting their admissibility in civil actions.

As indicated by this preamble, the legislature goes on to specifically protect the “apology” from being admitted into evidence. However, in order to qualify for the evidentiary protection, the “apology” must be made in “a designated meeting to discuss the unanticipated outcome.” This requirement is in accord with an important principle of apology/disclosure practice. Apology following an unanticipated medical outcome should not be made hastily and off the cuff. The facts should be disclosed to patients as they are uncovered but expressions of apology should await the conclusion of the investigation. A doctor should not tell a patient he made a mistake only to have the investigation later reveal that he did not make a mistake. There should be full disclosure, but any statements admitting error and offering compensation should be carefully considered and the words carefully chosen. Statements made by a surgeon to family

members in the waiting room immediately following an operation would likely not be protected under the South Carolina law. This encounter would not be a “designated meeting to discuss the unanticipated outcome.” The designated meeting requirement actually encourages the advisable practice of preparing a sincere apology that will accomplish the desired goal of providing emotional healing to the patient and his family. Michael Woods, M.D. in his book *Healing Words, the Power of Apology in Medicine* lists 4 elements of an effective apology, all of which must be present for the apology to be effective. They are: (1) recognition of the need for an apology, (2) genuine regret, (3) acceptance of responsibility, and (4) the offer of a remedy. The apology to be offered at a “designated meeting” needs to be carefully prepared to insure that all 4 elements of an effective apology will be included. As stated by Dr. Woods:

An apology should be initiated as soon as possible after discovery of the infraction, error or unanticipated outcome. Delays in communication make patients and families suspicious. Still, physicians shouldn't be in such a hurry that they proceed without careful thought and preparation. Even when the doctor has established a good rapport and trust with the patient, a poorly delivered or ill-conceived apology could unravel the relationship, particularly in dealing with severe situations.

The “designated meeting” is not just for apologies where fault is admitted. These meetings are also opportunities to discuss unanticipated outcomes where the circumstances are fully disclosed but the patient and his family are advised that that the unanticipated outcome did not result from any error. Full disclosure is provided and empathy and understanding are expressed but, of course, no compensation is offered. Such a meeting will be productive because a cover-up will not likely be suspected and the patient and his family are often satisfied with the explanation.

The essence of the shift away from the silence strategy is communication. Patients need to be treated as patients and not as potential adversaries when there is an unanticipated outcome and all circumstances surrounding an event need to be fully disclosed. Such communication has always been an ethical mandate. Complying with that mandate will not only foster improved patient-physician relations but it will also decrease the amount of malpractice litigation.

#### References:

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