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A Letter from the Chair of the Board

Dear Colleague:

The issue of disclosure is one that physicians have struggled with over the years (do I disclose, how much do I disclose, etc.). This article, written by James Saxton, Esquire, a health law attorney with the law firm of Stevens and Lee, takes a look at this very difficult subject and provides useful advice to assist you in not only becoming a better communicator, but also focuses attention on the larger picture of patient safety.

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Chair of the Board*

MEDICAL MUTUAL Liability Insurance Society of Maryland

Medical Disclosures

INTRODUCTION

There is much debate about the so-called medical liability crisis. In the July 8, 2002 issue of *The American Medical News*, an article discusses the debate at the Association's latest annual meeting describing it as the AMA's "highest legislative priority." The article goes on to discuss the fact that twelve states are already in a medical liability crisis with thirty states showing signs that they could be headed in that direction because of the lack of companies providing insurance coverage. Setting aside the legislative efforts to obtain tort reform, one point to take home is that it is now more important than ever to focus on ways in which a physician can reduce the potential of a professional liability claim in the first instance. We now know more than ever about the clusters of circumstances that create the risk of a claim. It is time for true risk engineering. Although some of these discussions focus on what is classically referred to as defensive medicine, there are other principles that can be incorporated into a physician's practice which can actually create value. This includes making sure documentation systems are in place, bolstering informed consent, focusing on communication at both the physician and staff level and striving for service



Continued on next page



excellence. These concepts have been shown not only to reduce liability exposure but to enhance staff morale and even efficiency in a physician's practice.

Looking at disclosure of medical errors or complications is yet another way to improve communication, reduce exposure and add a positive benefit for your practice. Hospitals and physicians have long struggled with disclosure of medical errors or complications. Many questions arise, including the following:

- ¶ What if the patient wasn't truly harmed and is not in need of any additional therapy, change of lifestyle or habits?

- ¶ Will disclosure simply add anxiety to the patient and hurt the confidence that they had in their physician?
- ¶ Are we just inviting a lawsuit by disclosing a medical error that has not caused any type of harm to the patient?
- ¶ Whose responsibility is it to disclose this information?
- ¶ When do we do it?
- ¶ To Whom?
- ¶ Can I say I'm sorry?

These are important questions and clearly disclosure or the lack thereof is on the minds of both providers and patients.

WHAT IS THE ISSUE?

In a recent study 42% of patients report that either they or a family or friend had experienced a medical mistake in the last five years. Nearly 60% were concerned they were given the wrong medication. In yet another study much fewer physicians than patients think that patients should in fact be told of an adverse event (60% versus 95%). Further, 50% of residents surveyed would inform an attending of an error. Although a bit dated (1990) a Medical Economics survey of physicians indicated only 45% disclose an adverse event, 45% sometimes disclose and 10% would not.

The AMA Code of Ethics and various laws stress the importance of honesty and candor with patients as part of the physician's fiduciary duty. The AMA Council on Ethical and Judicial Affairs, Code of Medical Ethics, annotated current opinions, 1994 states in part:

Concern regarding legal liability which might result following truthful disclosure should not affect the physician's honesty with a patient.

Doctors RX

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If patients are not told about an error the statute of limitations could be expanded and it could even, under some circumstances, turn into a claim for punitive damages. The purpose of this article is not to set forth all the legal requirements, but to look at, from a practical standpoint, the reasons to disclose, some suggestions on how to disclose and also to review some potential pitfalls.

In recent years, lack of disclosure has been the driver in many of the more significant malpractice verdicts. Nothing can be worse for a physician than evidence coming out at trial that indicates certain information was withheld from the family, even unintentionally. When the family testifies that they were not told what happened intra-operatively and are not even, on the day of the trial, aware of why their son did not make it through surgery, only to then learn from another witness that the very reason was discussed and determined several years prior, has a significant inflammatory effect on the jury which sometimes, as mentioned above, could result in a punitive award. We should never forget that jurors are patients, not doctors! One may think that the peer review discussions they have about an incident will never see "the light of day."

Discussion of medical errors or a complication that occurs is an opportunity to put positive risk engineering and communication principles to work. If appropriate informed consent has been given, it is the next logical step if there has been an unfortunate occurrence. If there has been a complication of surgery, the surgeon can explain in a caring way that unfortunately the risk that was described pre-operatively did occur and quickly move to what is being done in an attempt to treat the complication. In the case of a medical error, once a complete understanding of what occurred has taken place, discussions can begin as to what happened, and why, to the extent one knows what happened, and what is going to be done in the future to reduce the potential of such occurrences.

Disclosure is not simply an apology, though an apology is permitted and should not be considered an admission of negligence or guilt. More often than not, medical errors are due to a breakdown in what can be a complex system. It could be a lack of communication, poor coordination, medications that look similar or documentation that is unclear or may involve sophisticated equipment and medical devices. The apology should be focused on what occurred



and not on blame or guilt. Empathy should be conveyed; the discussion should be organized with a positive plan to get the care that is needed to the one that is harmed and to move forward and obtain more information to be provided to the patient or family. Problems begin when patients feel that the doctor is not being candid, admits to being confused or has no direction. Consider the following examples:

I have no idea what happened. The chance of this occurring was similar to the chance that a Mack truck would hit you when you leave our building and enter our parking lot. As you know, we are nowhere near a highway! I am simply at a total loss for what occurred. I would not be surprised if you get another doctor to take care of your son. I am sorry (Then the doctor leaves the room.)

Although the doctor may indeed feel that way, these discussions are not about the doctor's feelings but about the family's feelings and getting them the information that they need. Their life has changed. They need the doctor more than ever and need information more than ever. When they do not get information, they conjure it up and it is a psychologically known fact that what they make up will be far worse than reality. Getting some information to them promptly is essential and candidly telling them you do not have all the information yet is all right. Contrast the following:

We are not sure what occurred during surgery yet. We are carefully reviewing the facts so we can get a better understanding of what happened and we will immediately get that information to you. Your son is receiving the best of care. We are doing everything we can in an attempt to help him. If you have specific questions now, I am happy to try to answer them based on what information I have. I can tell you how sorry I am about your son. I, together with the other folks here, want to provide you and your son with all of the support we can.

SOME HELPFUL ADVICE

The way disclosure should take place is for the physician to first attempt to obtain all of the information he or she can. Next is to realize that they do not have all the information they need and that it may take time to obtain it. They should get help from their hospital risk manager, their legal counsel or their professional liability insurer. These individuals have dealt with similar situations before and can provide very useful guidance. Further, the doctors will be stressed and a third party can help to work through the rainbow of emotional issues which arise. Next, in speaking to family you should determine who the leader or spokesperson is going to be. If you are not dealing directly with the patient, you should deal with the spouse, the parent or the son or daughter. Importantly, you should find out if others should



be involved in the discussion. If an important individual is left out, that person may be hearing your message in a second-hand fashion and may not even obtain the correct information. You should make clear what information you have and what information you do not. You should show empathy and of course apologize for what has happened. Remember you are not apologizing for any negligence because it is far too early to know whether in fact even negligence occurred or whether there is causation to the damage. You are not apologizing for someone else's behavior or asserting blame with the apology. For example,

- ¥ "I am sorry about the nurses' lack of attention"
- ¥ "I am sorry the anesthesiologist was not able to get here quicker and in time"
- ¥ "I am sorry, I don't know what the residents were thinking"
- ¥ "I am sorry maybe now the hospital will upgrade the equipment"

You should have a plan for what additional information you need, how additional information is going to be obtained and the timetable. You should be careful about your body language, 85% of what you say is non-verbal. Eye contact, sincerity and empathy are key.

Some of the pitfalls to watch out for include the knee-jerk reaction to speak to the family before you truly have any information and then to speculate about what occurred. Be mindful that there will be a great deal of emotion about this issue and a physician should prepare himself or herself for such a meeting. The family could be angry and hostile; the physician could feel defensive and unprotected. Preparing mentally and from an organizational standpoint for these meetings is essential. Families will remember this meeting for years to come, good or bad. Do not promise the patient or family too much, too soon. Sometimes the time lag until one truly understands what has occurred is months, not days. Perhaps pathology slides need to be sent out for a specialized review or films need to be sent to a specialist for interpretation. Meetings have to be scheduled with busy providers so that these details can be analyzed. To let a family know information will be forthcoming and they can anticipate it "soon" sets you up to have their anger and suspicion rise each day they do not receive the information.

Mrs. Smith we are sending the pathology slides out for a special study. We have asked them to expedite the process but I have to tell you it could take weeks or longer. It depends on the lab and this is a lab used by doctors all over the country because they have special expertise. Of course, that is why we want to use them. We feel they can give us the most accurate information. We do not have control over them. I assure you that as soon as I get more information we will be back in touch.

If a statement like this is not made, it is not surprising that the family member you told that you were sending slides out will expect a call the next week. Remember the difference in dynamics. You are trying perhaps not to think about this but they cannot stop thinking about it, focusing on it each and every day!

Remember that there are several different players involved. Physicians have contractual obligations to their insurers and should provide notice to them and should involve their insurers who typically have extremely good resources to help in such situations. When multiple physicians are involved or perhaps a hospital representative as well, care should be taken to coordinate so that mixed signals are not sent. If a meeting is held with the family with

multiple individuals, body language should be watched carefully. Patients will watch you as much as they listen to you. When physicians that are in a room together begin looking at each other before responding, patients or family could conclude there is a conspiracy. If a meeting is going to be held, discuss roles first, who should be there and why. Who is going to take the lead? Who is going to respond to questions? What is going to be the follow up when the meeting ends? Are there people that should be there? Have insurers all been notified? Should appropriate articles be given to the family that may be on point? Is the location private, comfortable? Have you allocated enough time? Nothing is worse than one or more of the doctors having to leave mid-meeting. The family will not understand that there could be anything more important to the doctor than this meeting.

CONCLUSIONS

Having a plan in place and following through is essential. Patients will wait for more information. Sometimes there is no answer but there has to be closure from their standpoint as to what occurred, what is being done about it, what is going to be done in the future. Details such as who is going to pay for the medical expenses or other expenses in many situations also need to be reviewed if in fact it is determined that negligent conduct occurred. It may make sense to discuss a resolution, a very difficult situation under the best of circumstances. However, history has taught us that if there is a complication or medical error that is caused by negligence and causally related to damages, dealing with it at the earliest instance not only reduces the potential settlement amount, but prevents a protracted stressful highly public lawsuit which benefits no one. Why and under what circumstances a discussion concerning disclosures moves to a discussion concerning the settlement of a claim is beyond this article. However, if the disclosure is done right, it goes a long way to helping that process if it became necessary.

Physicians can and should change the liability equation. Their actions after a medical incident, whether it is a complication during surgery, a medical error or a misplaced lab, will drive both the potential of a claim in the first place and chances of success of that claim once filed. Physicians are in the driver's seat more than they realize and using disclosure as an opportunity to impact positively that equation is essential.





New Resources Area Added to Risk Management Section of Web Site

Do you need to understand the potential liability impact of the Internet on your practice? Would you like some guidance on the malpractice risks associated with the failure to diagnose? This information and much more is now available online in the Risk Management Resources section of the MEDICAL MUTUAL web site. The new section includes the above material in the archives of our Risk Management newsletter, Doctors RX. For your convenience, you can also access articles on important practice approach topics in our Reference Library, refer to a new section on HIPAA regulations, and much more. The Risk Management Resources section is available on the MEDICAL MUTUAL web site at www.weinsuredocs.com.



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