Hospitals slow to adopt patient apology policies

By Sabriya Rice | August 15, 2015

A call from a houseguest summoned Jessica Shaw, 38, to her mother's Dallas home the day before Valentine's Day. She panicked upon finding her 59-year-old mom in bed completely unresponsive.

Over the next few days, as her mother's condition worsened in the intensive-care unit at Dallas Regional Medical Center in Mesquite, Texas, Shaw's anxiety turned to frustration. Hospital staffers were rude and condescending, she said, and they repeatedly ignored her questions about treatments.

After her mom, Laura Parker, died on Feb. 20, Shaw wanted to talk with staff about her experience and get clarity about what had happened. She got no response, she said.

In March, she filed a complaint with the hospital's risk management director. After more than two months without a reply, she grew inconsolable and began calling attorneys. "I cannot believe this!" Shaw wailed in a telephone interview. "It's as if they don't care. My mom died in their hospital and they show no sympathy, no nothing."

Hospital officials did not respond to repeated requests for comment.

Deaths, whether inevitable or caused by preventable medical errors, happen daily at most hospitals. But few have adopted best practices for dealing with complaints or even questions when they arise from family members and caregivers, whose first and understandable reaction often starts with the word "why."

Given the ever-present concern about medical malpractice suits, it's an inexplicable oversight for hospital managers. Surveys have shown that patients and their family members are far more likely to pursue legal action when they feel a lack of accountability, disrespect or poor communication from their providers.

In recent years, a few hospitals have developed nontraditional communication-and-resolution models that allow physicians and hospital officials to immediately apologize, investigate and quickly offer financial compensation if a medical mistake has been made. Such initiatives have led to improved transparency and better physician-patient relationships, as well as significant reductions in the frequency of malpractice claims and the amount facilities spend on patient compensation.
The programs have even gained research funding from the Agency for Healthcare Research and Quality and other entities that encourage their use, and their success is documented in the medical literature. Yet despite favorable outcomes, the models have not become widespread.

Experts say they require a culture change that encourages doctors and hospital staff to speak up about potential issues without fear of punishment. Many organizations struggle to create that safety culture. Hospital officials must implement formal processes for investigating complaints and reaching out to patients. And above all, they must abandon the deny-and-defend mentality that has been the status quo for decades.

"I can talk about the common sense of the approach to a roomful of physicians who are nodding in support," said Rick Boothman, chief risk officer for the University of Michigan Health System in Ann Arbor, which launched a lauded communication-and-resolution program in 2001. The program is modeled on a pioneer program begun at Lexington (Ky.) VA Medical Center in 1987. "But the minute I walk out of the room, a risk manager or defense lawyer will say, 'That guy is nuts!' It's not an easy change."

Patient advocates, policymakers and health quality researchers say the programs boost transparency and communication and are key to reducing medical liability claims, which can pose a substantial financial burden to health systems. Such claims totaled $56 billion in direct and defensive medicine costs, equal to about 2.4% of overall healthcare spending, in 2010, according to a study in Health Affairs.

Patients are not asking for anything unrealistic, said Empowered Patient Coalition President Julia Hallisy, co-author of a study in the journal BMJ Quality and Safety that surveyed more than 700 patients and caregivers about medical mistakes. They want honesty and perhaps an apology, she said in an interview. "But the system is not designed to support either." Most often, they are left with "a desperate need for answers that never came," according to the study.

For decades, when something went wrong in a healthcare facility, clinicians were advised to avoid reaching out, expressing condolences or apologizing—the starting point for communication-and-resolution programs such as the one at the University of Michigan. The fear is that their comments could end up being used in court or that they will be seen as incompetent by patients and their peers. Many feared that the programs themselves would lead to more frequent lawsuits and higher payouts.

But early adopters have had the opposite experience. Boothman said that while the number of incidents reported jumped from about 2,400 a year in 2008 to 27,000 last year, they have not translated into more lawsuits. The rate of new claims fell from 7.03 to 4.52 per 100,000 patient encounters between 1995 and 2007, and monthly spending on patient compensation decreased by 59% since the launch of the program.

"Apologies save money, sure. But more importantly, apologies save lives," Boothman said. It is not just about reducing costs associated with expensive trials. The method
also trains practitioners to take a closer look at preventable adverse events and adjust the processes that caused them. In other words, apologizing and resolving complaints helps prevent future errors.

Early adopters continue to tout their successes.

AHRQ is now funding projects to see if the results can be replicated on a larger scale. The Massachusetts Alliance for Communication and Resolution Following Medical Injury launched a project in 2013 at seven hospitals of the Baystate Health and Beth Israel Deaconess Medical Center systems. That study will evaluate use of a policy called Communication, Apology and Resolution, or CARe. Results are expected by next spring, according to participants.

Baystate Health began using a disclosure and apology program in 2006. Leaders there say the system has investigated 600 events, with most eventually deemed unavoidable. All but one of the 20 that led to financial compensation were caused by a system error, which hospital officials quickly fixed.

Dr. Doug Salvador, vice president of medical affairs for healthcare quality at Baystate Medical Center, Springfield, Mass., said the multicenter pilot will provide the rigorous, comparative analysis missing from the literature. "We'll have much better answers to questions that are grounded in scientific fact as opposed to just anecdotes," he said.

While the Obama administration continues to encourage transparency initiatives and use of nontraditional medical error resolution models, many states have adopted tort law changes, which limit the ability of patients to sue, and so-called “I'm sorry” laws, which prevent apologies from being used in courtrooms. Those laws are counterproductive to improving patient safety and tend to encourage "a highly adversarial and stigmatizing process," researchers from Stanford Law School and Harvard Medical School wrote in a JAMA article in November.

MH TAKEAWAYS-Hospitals and physicians have been slow to adopt nontraditional dispute resolution models that demonstrably reduce the frequency of claims. They require culture change that remains a struggle for many.
Still, they appear to be having a dampening effect on medical malpractice claims and payouts. A study that appeared last November in JAMA showed claims against doctors fell from 18.6 to 9.9 paid claims per 1,000 physicians between 2002 and 2013. And for the past seven years, the amount paid per claim has declined in inflation-adjusted dollars by 1.1% a year on average.

The declining financial impact of medical malpractice claims may be retarding more widespread adoption of communication-and-resolution programs. They are also coming under fire from some consultants who worry it may become another way of manipulating patients or their families.
It can appear to be “a staged affair” intended to manipulate grieving patients from pursuing their legal rights, said Dr. Victor Cotton, president of the Hershey, Pa.-based healthcare consultancy Law and Medicine. Upon recognizing an error, the physician or facility consults first with their lawyer or insurer before going to a patient or caregiver, “who may be totally unsuspecting and is not represented by an attorney,” said Cotton, who is also a lawyer. “That's a form of manipulation that I think crosses a line.”

However, most agree that the current system needs to change. Losing a loved one or seeing a person injured by a medical error is an emotional experience, and patients surveyed in the recent BMJ survey said they often don't want to sue. They just want someone to hear them out.

Shaw says she received an apology letter from the Dallas Regional Medical Center five months after filing her complaint. The letter said the hospital deeply regretted that the care did not meet her family’s expectations, but that the quality team determined that the care given was appropriate. Still, their delayed response made Shaw suspicious. She is continuing her search for an attorney.

“I would have felt better if they had called and apologized. Anybody would have felt better with that,” she said.

Sabriya Rice

Sabriya Rice reports on quality of care and patient-safety issues. Rice previously wrote and produced for the medical unit of CNN, where she contributed to the Empowered Patient column and the weekly medical program formerly called “Housecall with Dr. Sanjay Gupta.” She earned a bachelor's degree in film and television from the University of Notre Dame and a master's in communication studies from the University of Miami in Coral Gables, Fla. She joined Modern Healthcare in 2014.