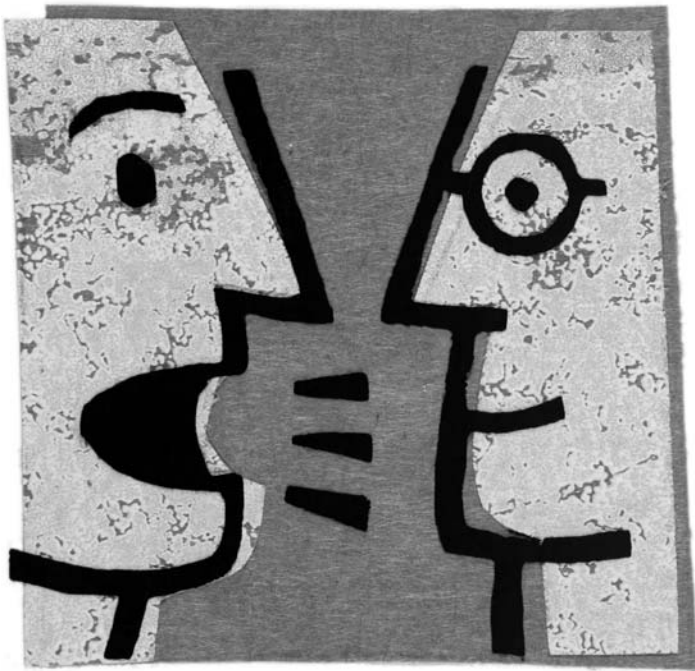


the Reporter



Impertinent remarks

when critical comments lead to litigation

by Laura Brockway

Case study*

A 42-year-old patient was referred by her gynecologist to a mammography center for a screening mammogram. The patient did not complain of any problems with her breasts. She provided the screening center with her medical history, including a family history of breast cancer. Her mother, two aunts and grandmother all had breast cancer. At the time of this mammogram, the patient's two previous mammogram films were available. The radiologist, the defendant in this case, interpreted the mammogram as negative for evidence of malignancy.

Approximately seven months later, the patient returned to her gynecologist complaining of a knot in her left breast. She detected this lump a week before the visit. The gynecologist attempted to aspirate the lump, but no fluid was obtained. He referred the patient back to the mammography center for a diagnostic mammogram and sonogram.

The defendant radiologist reviewed the diagnostic mammogram and sonogram. He believed the mass, visible on the mammogram, was suspicious for malignancy. He measured it at approximately 1.5 cm in diameter and recommended a surgical consultation. During this visit to the mammogram center, the patient reported that a staff member "in a white coat" informed her that the radiologist would have found the lump in her breast on the earlier mammogram if he had looked for it. This statement was made as the staff member reviewed her films. The patient was unaware of the staff person's name.

The patient next presented to a general surgeon, who performed a needle biopsy. The biopsy showed malignant cells consistent with mammary duct cell carcinoma. The surgeon told the patient that he did not want to offer an opinion as to why the radiologist did not detect the lump on the earlier mammogram. The patient was quite curious and concerned that the condition had gone undetected.

The patient was admitted to the hospital where the surgeon performed a left excisional breast biopsy, a left breast lumpectomy and axillary lymph node dissection. Clean margins were established around the tumor during surgery. The pathologist staged the patient's cancer at stage II A. Over the next two years, the patient completed chemotherapy, radiation therapy and was started on

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hormonal therapy. She has remained free of cancer and reported a return to her active lifestyle.

In her suit against the radiologist, the patient alleged that he negligently interpreted the screening mammogram films. As a result of this alleged seven-month delay, the plaintiffs claim the cancer progressed to a more advanced stage, required more extensive treatment than would otherwise have been necessary, and that the patient's prognosis worsened. The plaintiffs were able to obtain experts supportive of their allegations, mainly that the mass was visible on the patient's earlier mammogram and was missed by the radiologist. However, defense experts felt the radiologist did not perform below the standard of care in his interpretation of the mammogram. The expert reviewers, including one for the plaintiff, also stated the patient would have received the same treatment — surgery, chemotherapy, radiation, hormone therapy — if the cancer had been detected in the earlier mammogram. The experts also hotly debated whether or not the cancer progressed to a more advanced stage during the seven-month period between mammograms. In order to avoid the uncertainty of a jury trial, the radiologist opted to settle this case.

Impertinent remarks

The sequence of events from this case are played out in doctors' offices, hospitals, day surgery centers, clinics, every day in this country. As this case illustrates, health care professionals can and do incite patients to file lawsuits. A simple remark such as "your child's seizures are the result of birth trauma," may be all it takes for a patient to seek legal counsel, thus opening the liability floodgates.

Patients report that they sue physicians because they want answers.¹ When faced with an unanticipated or catastrophic outcome, some may immediately suspect a cover up or want more information. They "see the threat of litigation as the only tool to rectify the imbalance of power and knowledge."² Others may have lingering doubts about their treatment, especially when the outcome is unexpected. When another physician, nurse or "someone in a white coat" is critical of the treatment they received, the patient may mistakenly believe this person is an "expert" or has inside information. This confirms their suspicions and their next step is to hire an attorney, whom they believe will find the answers they are seeking.

Before discussing this issue further, it should be made clear that "impertinent remarks" neither includes expert witness testimony, nor does it include statements made during professional peer review. Physicians serving as potential expert witnesses in malpractice cases have had the opportunity to review the relevant medical records, the pertinent medical literature and depositions of those involved before rendering an opinion. Likewise, those serving on peer review committees also have the benefit of knowing the facts of the situation before expressing their views. (Both topics have been covered in previous issues of this publication.^{3,4}) For the purposes of this article, "impertinent remarks" are either inadvertent comments or deliberate critical statements made about the care a patient received from a physician by someone who probably does not have all the facts.

The research

Experienced defense attorneys estimate that 25 percent of all claims may be prompted by an inadvertent or delib-

erate critical comment by a health care professional.⁵ In a study conducted by a California-based professional liability carrier, more than 20 percent of lawsuits eventually won by the physicians had been triggered by another health care provider's remarks.⁶

While there is no shortage of articles about malpractice in the medical literature, little effort has been focused on answering the question "what prompts patients to sue?"⁷ Two studies have examined motivations for suing by asking the plaintiffs themselves what was wrong with the care they received and what induced them to sue.

In a study published in *JAMA*, researchers surveyed families of infants who experienced perinatal injuries and had closed malpractice claims in Florida. The most frequently reported reason families filed suit was that they had been advised to do so by a knowledgeable acquaintance (33 percent of the sample). Most often, the knowledgeable acquaintance was a member of the medical profession.

"Some families appear to have been told by medical personnel that poor care had been provided and that they ought to sue. On the other hand, some families may have interpreted a physician's comments as a criticism of medical services even when that may not have been intended."

Further, those families advised to sue indicated they had not suspected any problem with medical care until someone outside the immediate family brought it to their attention.

For a study reported in the *Archives of Internal Medicine*, researchers reviewed a sample of plaintiffs' depositions available from settled malpractice suits filed against a large metropolitan hospital. They found that 54.8 percent of those asked what prompted them to sue responded that a health care professional suggested "maloccurrence."

This study also looked at who questioned the quality of care delivered. In 70.6 percent of the cases, the specialist consulted after the outcome was perceived by the plaintiffs as being critical of the care received. In 35 percent of the cases, more than one health care professional suggested maloccurrence. In each case where a non-physician implied maloccurrence, a physician had implied it as well.

"These data suggest that the consulting physician has an important role in shaping the patient and/or family understanding of what creates a bad outcome and potentially influences the enthusiasm with which a patient or family member considers initiating a suit."⁸

Risk management considerations

These studies raise some important questions about how physicians should approach situations in which they disagree with another physician's opinion or when negligence may well have contributed to a patient's condition.

"The focus must remain on the patient, even if you disagree with the previous physician. You must keep in mind what is best for the patient. Making critical remarks about a previous treater simply provides plaintiffs' attorneys with ammunition for a lawsuit," says Jane Holeman, vice president of risk management at TMLT. "Blaming other physicians or finding fault with their treatment without having all the facts is rarely appropriate or helpful to the patient."

The *American College of Physicians Ethics Manual* also offers some guidance. It states: "It is unethical for a physician to disparage the professional competence, knowledge, qualifications, or services of another physician to a patient or third party or to state or imply that a patient has been poorly managed or mistreated by a colleague, without sub-

stantial evidence, especially when such behavior is used to recruit patients. Avoiding such inducement is especially necessary for the physician who has been called in as a consultant. Of equal importance, it is unethical for a physician not to report fraud, professional misconduct, incompetence or abandonment of a patient by another physician. Professional peer review is critical in assuring fair assessment of physician performance for the benefit of the patient.”⁹

The following risk management recommendations may help minimize the risk of triggering lawsuits against other physicians.

- Stick to the facts without blame. If the patient asks you directly whether a previous physician was negligent, you might say “I can tell you what I’ve found and what I recommend. But I did not see for myself what happened, and it’s not my role to determine fault.”

- If the patient is coming to you for a second opinion and you disagree with the first physician’s opinion, be honest with the patient and state your opinion factually. Do not state the other physician is wrong. Simply acknowledge that your course of treatment is different.

- When an error has occurred, you must be open about the situation. Do not lie or cover up for a colleague. Be factual and honest, but do not disparage the previous physician. If the patient asks you why the error occurred, you might say “There are a number of factors that could have caused this to happen. But, I was not there and I cannot answer that for you.”

- Avoid coming to a conclusion without having all the facts. Collect all relevant information before assuming that a patient or family account of the care delivered is accurate.

- Express empathy for the patient’s situation. Showing sincere interest and commitment to solving the problem is important.

- Be aware that seemingly innocent remarks, tone of voice, facial expressions and body language may lead the patient to believe there was something wrong with their previous treatment. Comments such as “I would hardly expect that kind of complication from such a simple procedure,” or “This surgery will be much more complicated now because someone else has been here before,” may signal a problem to the patient.

- Make sure your employees understand this applies equally to them. A casual comment made by a staff member preparing a patient for examination may be all it takes to provoke a lawsuit. Instruct staff to tell patients to refer questions about previous treatment to you.

- Beware if a patient presents with less than optimal results from a procedure, expresses anger at the previous physician, and solicits your opinion about the treatment. Encourage the patient to speak directly to the physician about the problem. State that since you were not present at the initial treatment, you do not know how or why the result occurred.

- Just as you would not want to openly criticize a colleague in front of the patient, do not do so in the medical record. When describing the situation, it is appropriate to quote the patient. You might document as follows: “Patient states that Dr. Jones felt a biopsy was unnecessary.”

- If you suspect there may be a problem with the physician, go through the appropriate channels to address it. Appropriate channels include a hospital peer review committee, the state medical board, a specialty society disciplinary committee, etc.

- The medical record is not the place to air grievances or discuss differing opinions with other physicians, nurses,

therapists, etc. This, too, should be handled through the appropriate channels.

- Extreme caution is warranted if you are contacted by a plaintiff’s attorney asking about a patient’s previous physician. A number of times, the TMLT claim department has learned that a plaintiff’s attorney has told the doctor if you’ll help me, I won’t sue you. Often, those “helping” doctors are later sued by that same attorney.

- As always, whether you have talked to the patient or communicated with the previous physician yourself, document your conversations and recommendations in the medical record.

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* This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician’s defensibility. The ultimate goal in presenting this case is to help physicians practice safe medicine. An attempt has been made to make the material less easy to identify. If you recognize your own case, please be assured it is presented solely for the purpose of emphasizing the issues of the case.

Delivering bad news

a communication challenge



Objectives

At the conclusion of this activity, the physician will be able to:

1. identify the elements of medical error and unanticipated outcome disclosure;
2. identify the essential elements of a medical error disclosure policy; and
3. describe communication strategies for breaking bad news.

Course author

Louise Walling is a risk management representative at TMLT.

Disclosure

Louise Walling has no commercial affiliations/interests to disclose related to this activity.

Target audience

This one-hour activity is intended for physicians of all specialties who are interested in practical ways to reduce the potential for malpractice liability.

CME credit statement

TMLT is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

TMLT designates this educational activity for a maximum of 1 category 1 credit toward the AMA Physician's Recognition Award. Each physician should claim only those credits that he/she actually spent in the activity.

Ethics statement

This course has been designated by TMLT for one hour of education in medical ethics and/or professional responsibility.

Directions

Please read the entire article and answer the CME test questions. In order to receive credit, submit the completed test and evaluation form to TMLT. All test questions must be completed. Please print your name and address clearly. Allow four to six weeks from receipt of test and evaluation forms for delivery of certificate.

Estimated time to complete activity

It should take approximately one hour to read this article and complete the questions.

Release/review date

This activity is released on December 10, 2003, and expires on December 10, 2005. Please note that this CME activity does **not** meet TMLT's discount criteria. Physicians completing this CME activity will not receive a premium discount.

There are few occasions when a physician feels as poorly equipped as when the duty of breaking bad news looms in the not-too-distant future. Medical schools cannot offer adequate preparation for these critical, life and death discussions. While experience and

repetition may be of some value, each occasion brings its own set of challenges and dynamics. Once again, we are reminded that medicine is as much an art as it is a science.

This article will focus on breaking bad news in the following context: disclosure when a medical error has occurred and disclosure of a bad outcome or poor prognosis. To help illustrate the complexities of these situations, we will begin each discussion with a case study.

Medical errors: case studies

This scenario was taken from *Ethics Forum*, November 4, 2003. A physician mistakenly ordered a higher dose of a chemotherapy drug than was indicated. The overdose caused temporary acute renal failure in the patient. Now recovered, the patient was reluctant to continue chemotherapy, and asked the oncologist why he became so ill. How did the oncologist respond?

Putting the needs of the patient before one's own needs is a deeply held ethic of the patient/physician relationship. Acting on this ethic is the great challenge of disclosure. Assuming that the oncologist wrote the incorrect dose, the doctor is now confronted with the duty of disclosure. He approached the patient, offered his hand, looked the patient straight in the eye, sat in an equal position and began:

"Mr. Cancer Patient, I have some serious information I would like to share with you. Is this a good time?" The patient replied that it was, so the physician continued.

"Well, sir, I believe there has been a mistake in the dosage of your medication. From my initial review it appears I inadvertently wrote a higher dose than was required."

What followed was a painful, though ultimately powerful dialogue. The patient asked questions, the oncologist listened and answered. The moment of disclosure encompassed the indispensable elements of listening, empathy and apology. Because the patient placed his trust in the physician, the conversation of disclosure was genuine and straightforward.

There is no question that if done properly, disclosure of even harmless errors increases the level of trust in the patient/doctor relationship and probably reduces the risk of malpractice suits.¹

The following case study illustrates disclosure of a medical error that may have gone undetected by the parent. An 18-month-old presented to a pediatric clinic with a runny nose. Since she was otherwise well, the immunizations due at 18 months were administered. After she and her mother left the clinic, the physician realized that the

patient was in the clinic the week before and had received the same immunizations at the earlier visit. Should the physician tell the parents about the mistake?

The error was a minor one. Aside from the discomfort of the unnecessary immunizations, no harm resulted. Nonetheless, an open and honest approach is most appropriate. While the parents may be angry initially they will appreciate the physician's candor. On the other hand, should they discover the error and believe the physician has been dishonest, their loss of trust may be significant.²

Never is a physician's heart as heavy as when it becomes clear that an error has produced serious, irrevocable harm, as the following case describes. A 3-month-old was admitted to the hospital with a newly diagnosed ventricular septal defect. She was in early congestive heart failure and digoxin was indicated. After discussing the proper dose with the attending physician, the physician wrote the order for the drug. Thirty minutes later the baby vomited, had a cardiac arrest and died. The physician later discovered that in writing the digoxin order he misplaced the decimal point and the child received 10 times the appropriate dose of digoxin. What is the physician's duty here? Will he be sued if he tells the truth?

This unfortunate event represents a serious error with profound implications for the patient and family. The physician owes this family an honest explanation. They need to hear him say he is sorry. Any attempt to hide the details of the event would be dishonest, disrespectful and wrong. Though a lawsuit may follow, these parents may be less likely to litigate if dealt with honestly and if the physician takes responsibility for the error.³

Medical errors and disclosure

The 1999 Institute of Medicine (IOM) report, *To Err is Human*, concluded that as many as 98,000 American hospital patients die each year from preventable errors. This resulted in a flood of public discussion and initiatives addressing the need for a patient safety policy. It also raised the issue of mandatory versus voluntary reporting of medical errors.

The IOM recommended that hospitals be required to report sentinel events. These errors should first be reported to the state government, with states reporting to a national data collection center. In an effort to find out what went wrong, unexpected deaths and serious injuries that at least on the surface should not have happened would be the focus of the reports. These adverse events would be analyzed, and an effort to devise improved

processes would be identified and shared. Unfortunately, mandatory reporting is underfunded and has not contributed significantly to patient safety.

Voluntary reporting systems have proven more beneficial to patient safety efforts. The IOM recommended that legal protection be afforded for data used for internal reasons or shared with others for the purpose of improving patient safety and quality of care.⁴

The IOM report received a reaction from the executive branch of government in February 2000, when President Clinton said reducing medical errors was a "worthy endeavor." The Department of Health and Human Services allocated \$10 million for improving safety through the increased use of known safety practices, development of new approaches, and support of a more expedient reporting system for medical errors and adverse outcomes. The FDA was given \$5 million to improve reporting involving FDA-regulated products.

In March 2000, Congress responded to the IOM report with the introduction of the Medical Error Reduction Act that would give states financial grants to establish error-reporting systems. The data would be passed on to the federal government and the information held non-discoverable in nature. Reporting would be voluntary and non-punitive. Other bills were subsequently introduced culminating in the introduction of legislation in the summer of 2002 aimed at reducing the number of medical errors in hospitals, and offering protection to nurses and doctors from lawsuits.

State governments have not been far behind. Legislation addressing medical errors has been introduced in 26 states. Reporting for adverse events in hospitals is mandatory in 15 states, including Texas. Voluntary reporting legislation has been introduced in six states.

Texas offers comprehensive legislation, including mandatory reporting of an unexpected patient death. This applies to hospitals, ambulatory care centers, psychiatric hospitals and renal dialysis facilities. The reports should be made in a timely manner and are maintained by the applicable licensing agency. Identifying information is removed from the reports and access to the reports is limited by the statute of limitations. Report content is protected from discovery except under court order.

JCAHO standards for disclosure

The Joint Commission of Accreditation of Healthcare Organizations Patient Right Standard RI.1.2.2. states "patients, and when

appropriate, their families, are informed about the outcomes of care, including unanticipated outcomes.” The intent of RL.1.2.2. states “the responsible licensed independent practitioner or his or her designee clearly explains the outcomes of any treatments or procedures to the patient, and when appropriate, the family, whenever those outcomes differ significantly from the anticipated outcomes.”

Further clarification offers, “at a minimum, the patient and, when appropriate the patient’s family are informed about outcomes of care that the patient (or family) must be knowledgeable about in order to participate in current and future decisions affecting the patient’s care and unanticipated outcomes of care that relate to sentinel events considered reviewable by the Joint Commission.”

JCAHO further defines a sentinel event as “an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function.” The use of the word “risk” expands the responsibility to report to include a deviation for which a recurrence would carry a significant chance of a serious adverse outcome.

A reviewable sentinel event is defined when “the event has resulted in an unanticipated death or a major permanent loss of function, not related to the natural course of the patient’s illness or underlying condition.” It includes one of the following:

- suicide of a patient under constant supervision
- infant abduction or discharge to the wrong family
- rape
- transfusion reaction involving major blood group incompatibilities
- surgery on wrong patient/body part ⁵

The JCAHO standards encourage clear, objective communication within the team of caregivers, as well as with the patient and family. This includes verbal notification of an unanticipated outcome, discussion of plan of care issues and changes, and documentation of the key point of those conversations. In the language of JCAHO, “error” means an unintended outcome, either of omission or commission, or an act that does not achieve its intended outcome. ⁶

AMA standards for disclosure

The AMA has not remained silent on the matter of disclosure and reporting. “It is a fundamental ethical requirement that a physician should at all times deal honestly and openly with patients. Situations occa-

sionally occur in which a patient suffers significant medical complications that may have resulted from the physician’s mistake or judgment. The physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred. Only through full disclosure can a patient make informed decisions regarding future medical care. Concerns about legal liability which might result from truthful disclosure should not affect the physician’s honesty with a patient.” ⁷ Disclosure should include an objective discussion of the incident and should not take the form of an admission or accusation of liability or fault.

In addition, AMA policies encourage a non-punitive approach be taken in the tracking and reduction of errors, with the ultimate goal of educating physicians on how to avoid accidents that harm patients. Taking a leadership role, the AMA founded the National Patient Safety Foundation to study and provide solutions to the systemic problems that plague contemporary health care and cause most patient injuries. ⁸

The dilemma

Our modern day tort system has created an adversarial, contentious environment. Many physicians wrestle with discussing a medical error openly and honestly for fear of severe, punitive legal ramifications. This creates a hindrance to disclosure and prevents important findings from becoming new knowledge that can ultimately benefit all of society. Quality improvement escapes both fronts. ⁹

Disclosure may be accomplished in a series of discussions. Initially the first concern is the patient’s safety and well-being. Only after the immediate concerns are resolved should the caregiver proceed to answer any questions about the error. As head of the treatment team, the physician would do well to communicate a sense of responsibility and a desire to address any errors, but the assignment of blame to an individual, process or facility benefits no one.

If you believe litigation may ensue, consider discussing the anticipated, necessary disclosure with a TMLT risk management or claims representative. When appropriately handled, disclosure may aid in your defense because it demonstrates your patient’s best interest was your first concern. ¹⁰

Can full disclosure work?

Many hospitals and physicians are learning that acknowledging and apologizing for errors and adverse outcomes have both ethical and practical advantages. Often, disclosing

the error can begin the process of correcting the problem. Disclosure may raise awareness and prevent such events from recurring.

An article published in *JAMA* reported on reasons patients sue. In 24 percent of the cases, the plaintiff believed there was a cover-up. In 20 percent of the cases, the plaintiff wanted more information. ¹¹

Marcus and Dorn have published their findings on the needs of patients when an error has occurred. “Our research indicates patients are eager for three key outcomes: to know what happened; to receive an apology or an acknowledgement from the caregiver; and to see that corrective actions are taken so that what happened to them will not recur. These objectives are in keeping with those of the caregiver, who is eager to reduce anxiety related to the unresolved claim or complaint, wanting to communicate on a human level with the patient and encouraged and assured by the prospect that corrective actions can be taken to reduce the likelihood of repetition.”

Often the best medicine to quiet threats of litigation is “ongoing clear, engaging and respectful talk with patients.” ¹²

Is full disclosure necessary when a medical error has been made, but no apparent harm has resulted? The Lexington Veterans Administration Center, affiliated with the University of Kentucky College of Medicine, has operated under a policy of full disclosure since 1987. A study published in the *Annals of Internal Medicine*, reported that between 1990 and 1996, a total of 88 medical malpractice claims were filed against the facility. The average payment was \$15,622. The quality manager for this facility has reported that the figures have remained the same into 2003.

The process of disclosure at the VA facility has more components to it than the doctor-to-patient apology. The facility maintains and executes a policy that includes identifying the adverse event or error and a full review of the incident by a nurse executive, risk management officer, chief medical officer and hospital attorney. If an error has occurred, a meeting with the patient or patient representative is called. The meeting entails an explanation of what happened and a plan of corrective action to prevent the error from repeating itself. Because this process may take some time, maintaining contact with the family is important and cultivates trust.

While the full disclosure policy has proven financially beneficial to the Lexington facility, this strategy comes with no guarantees. A conscious choice was made in the beginning that full disclosure was the right thing to do. The event that triggered the policy involved a medication error leading to a

patient's death. Although the family was not aware and would not have known, a decision was made that ethical duty brought an obligation to disclose the truth.¹³

Risk management considerations

Disclosure of a medical error to the patient should never contradict good risk management practices. The first step includes the internal analysis. The second step is the actual discussion with the patient. It is crucial that this order be followed. The intent of the first step is not to create a way to deceive or produce denial; however, the root cause must be determined before the dialogue with the patient can begin. Without a doubt, the discussion is the more critical element.

Each discussion is essential to maintaining the trust of the patient-doctor relationship. This is accomplished when the patient is provided with an honest explanation, compassion and the questions are addressed in a professional, respectful manner. The patient may also need time to process the information. Statistics show that a physician is less likely to suffer ethical, legal and professional backlash if the patient is addressed honestly and proactively.¹⁴

Mark A. Levine, MD, a member of the AMA's Council on Ethical and Judicial Affairs, endorses a four prong approach: recognize, respond and resolve because it is the right thing to do.¹⁵

Jonathan R. Cohen, PhD, an expert on negotiation, dispute resolution and evidence at the University of Florida's law school has concluded that apologies in medical settings are more powerful than in any other accident scene because of the existing physician-patient relationship. Silence from a physician after a mistake has occurred may be interpreted as apathy and could turn the caregiver into the enemy.¹⁶

The importance of documentation when the doctor has made an error or when there is an unexpected outcome cannot be overstated. The documentation should be factual and clear without emotion, the assignment of blame or finger pointing. Of utmost importance is the doctor's detailed clinical rationale for selecting the course of treatment. If the adverse outcome occurred within boundaries of the well formulated plan of care, the issue may go no further.

If a suit is filed, it will begin with the plaintiff's attorney examination of the medical record. It is at this juncture that the medical record may be either the physician's strongest defense or weakest link.

Altering the medical record in the event of a medical error may be a great temptation

but will come back to haunt the doctor. In our era of unprecedented technology, there are multiple methods that may determine if the record has been altered. The doctor has more to lose than the lawsuit. His integrity and conscience are a greater loss.¹⁷

Amendments or late entries in the medical record, when clearly labeled with the date and initials of the person preparing it, are acceptable. This is perceived as a clarification with no attempt to conceal.

Should the medical error or adverse event have occurred in a hospital, ambulatory care center, psychiatric hospital or dialysis facility, policies will be in place for incident reporting and documentation. Becoming knowledgeable or at the least, cooperating with the internal risk identification process will serve the physician well.

A physician's office staff should be educated in the matters of reporting and documenting medical errors and adverse outcomes. They should be aware which type of incident is reportable, and that an incident occurrence should always be channeled through the clinical manager. Written policies and applicable forms for medical error disclosure are suitable for any practice. The policy should reflect the philosophy that the patient and physician have an open and honest relationship, including a constant dialogue on the patient's care, treatment, general health and well being.¹⁸

Case study — poor prognosis

A case study published in *Ethics In Medicine* illustrates the difficulties encountered when communicating bad news to a patient and the patient's family. It involves a 62-year-old man who has just undergone a needle biopsy of the pancreas revealing adenocarcinoma. The physician in charge of his care is approached by the patient's brother who begs the physician not to tell the patient about the test results because the knowledge would kill him even faster. A family conference to discuss the prognosis is scheduled for later that afternoon. How should the physician handle this?

It is common for family members to want to protect their loved ones from bad news, but this is not always what the patient would want. It would be reasonable to tell the patient's brother that withholding information is unwise because it creates a climate of dishonesty between the patient, the family and the health care team. The patient also needs to understand the diagnosis so he has a voice in the decision making. Ask the patient how he wants to handle the situation in front of the rest of the family, and allow

time for family discussion of this matter.¹⁹

Communication strategies

Many physicians maintain that communicating bad news is an inherent ability. However, studies of physician education hold that communication skills can be learned and improve over time. Robert Buckman has authored a six-step protocol for breaking bad news:

1. Getting started

The physical setting ought to be private, with both physician and patient comfortably seated. The physician should ask the patient who else ought to be present, and let the patient decide. Studies show that different patients have widely varying views on what they would want. It is helpful to start with a question like, "How are you feeling right now?" This indicates to the patient that this conversation will be a two-way affair.

2. Finding out how much the patient knows

By asking a question such as, "What have you already been told about your illness?" the physician can begin to understand what the patient has already been told ("I have lung cancer, and I need surgery"); how much the patient understood about what has been said ("the doctor said something about a spot on my chest x-ray"); the patient's level of technical sophistication ("I've got a T2NO adenocarcinoma"); and the patient's emotional state ("I've been so worried I might have cancer that I haven't slept for a week").

3. Finding out how much the patient wants to know

It is useful to ask patients what level of detail should be covered. For instance, the physician can say, "Some patients want me to cover every medical detail, but other patients want only the big picture — what would you prefer now?" This establishes that there is no right answer, and that different patients have different styles. This question also establishes that a patient may ask for something different during the next conversation.

4. Sharing the information

Decide on the agenda before sitting down with the patient, so the relevant information is at hand. The topics to consider in planning an agenda are: diagnosis, treatment, prognosis, and support or coping. However, an appropriate agenda will usually focus on one or two topics. For a patient on a medicine service whose biopsy just showed lung cancer, the agenda might be: a) disclose diagnosis of lung cancer; b) discuss the process of

workup and formulation of treatment options (“We will have the cancer doctors see you this afternoon to see whether other tests would be helpful to outline your treatment options”). Give the information in small pieces, and be sure to stop between each piece to ask the patient if he or she understands (“I’m going to stop for a minute to see if you have questions”). Long lectures are overwhelming and confusing. Remember to translate medical terms into plain English, and do not try to teach pathophysiology.

5. Responding to the patient’s feelings

Physicians who do not understand the patient’s reaction will leave a lot of unfinished business and will miss an opportunity to be a caring physician. Learning to identify and acknowledge a patient’s reaction is something that definitely improves with experience. Consider asking (“Could you tell me a bit about what you are feeling?”).

6. Planning and follow-through

At this point, synthesize the patient’s concerns and the medical issues into a concrete plan that can be carried out in the patient’s system of health care. Outline a step-by-step plan, explain it to the patient, and discuss the next step. Be explicit when explaining the next contact with the patient (“I’ll see you in clinic in two weeks”) or about the fact that you won’t see the patient (“I’m going to be rotating off service, so you will see another doctor at the clinic”). Give the patient a phone number or a way to contact the relevant medical personnel if something arises before the next planned contact.²⁰

The *Family Practice Notebook* offers a simple mnemonic approach to discussions with patients when the news is bad: ABCDEF.

Advanced preparation will involve a review of the patient’s case and treatment options. Rehearsing a plan to deliver the message will be well worth the physician’s time.

Build a therapeutic environment to enable the messenger to deliver the news in a setting that communicates privacy and respect.

Communicate well and avoid using medical jargon or language that is too technical, thus overwhelming the participants. Speak slowly and clearly, expressing compassion. Encourage questions.

Deal with the reactions of the patient and the family. They may demonstrate some anger. Depersonalizing and avoiding argu-

ments or defensiveness will benefit both you and the patient.

Encourage and validate the emotions of the response. Emphasize what can be done in terms of treatment options or comfort measures. Offer a prognosis in general time frames (weeks, months).

Follow up plans should involve the next appointment or contact. An explanation of support services or names of relevant resources can be beneficial.²¹

Conclusion

Studies show that most patients want to hear important medical information from their physician. If frustrated, patients or family members may consult an attorney because they believe information has been withheld. As such, it seems prudent to communicate information in a timely and open manner. Disclosure of a medical error or unanticipated outcome includes a process of risk management and learned communication skills. It is important to remember that these conversations may set the stage for future interactions with the patient. “Many patients with cancer, for example, can recall in detail how their diagnosis was disclosed, even if they remember little of the conversation that followed, and they report that physician competence in these situations is critical to establishing trust.”²²

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P.O. Box 160140
Austin, TX 78716-0140
800-580-8658 or 512-425-5800
Fax: 512-425-5998
E-mail: laura-brockway@tmlt.org
Web address: www.tmlt.org

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In case you missed it . . .

Bill to study alternative malpractice programs

After the U.S. Senate failed to pass a \$250,000 cap for noneconomic damages, other legislation was introduced intending to address the medical liability crisis without enacting caps.

Senator Mike Enzi (R-Wyoming) has introduced legislation that would explore alternative dispute resolution programs for medical malpractice.

The bill, currently known as the Reliable Medical Justice Act (S 1518), is intended to “restore reliability to the medical justice system by fostering alternatives to current medical tort litigation that promote early disclosure of health care errors and provide prompt, fair, and reasonable compensation to patients who are injured by health care errors.”

Under the bill, the Department of Health and Human Services would fund three

model programs in up to seven states.

One proposal would allow states to study early disclosure and compensation. States would give physicians lawsuit immunity if they offered compensation to injured patients for the net economic losses they suffered and a scheduled payment for pain and suffering.

States could also study administrative determination of compensation, in which the state would determine what injuries are avoidable and break them into classes. The classes would be established based on the severity of the injury. The state would then create an administrative board to resolve patients' claims. The board consist of representatives from state licensing boards, patient advocacy groups, physicians and attorneys. The system could be fault-based or no-fault and the board would develop a schedule of compensation for both economic and non-

economic damages.

The third approach would test the creation of special health care courts. Judges in these courts would have expertise in health care and would make binding rulings on causation, compensation, standards of care and related issues.

The American Medical Association says it is supportive of alternative dispute resolution programs, but says the priority is \$250,000 cap on noneconomic damages.

“The models in Senator Enzi's bill are interesting and the AMA has discussed models in the past, but we don't have time to wait for the demonstration models to happen,” said AMA President Donald J. Palmisano, MD, in an issue of *American Medical News*.

The bill has been referred to the Senate Committee on Health, Education, Labor and Pensions.