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Since 1989, **Med League Support Services, Inc.** has aided attorneys in 37 states. We perform these services:

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- Develop case chronologies
- Screen malpractice cases for merit
- Prepare PowerPoint presentations for settlement negotiations or trial
- Provide literature searches
- Prepare pain and suffering reports
- Transcribe handwriting
- Prepare life care plans
- Locate nursing & physician experts
- Assist with demonstrative evidence
- Prepare medical illustrations
- Assist with preparation of demand letters and settlement brochures

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Will apologies to patients drive med mal attorneys out of business?

Studies have shown that the primary factor in a patient's decision to pursue a medical malpractice case is lack of communication from the provider after an unexpected outcome or undesirable result has occurred. Often a patient's decision to sue was influenced not only by the original injury, but also by insensitive handling and poor communication afterwards.

Some individuals file suit and persist through the years of legal proceedings because they do not want someone else to get injured by the same mistake. Often the question asked of healthcare providers is, "What is the organization doing to find out how the event occurred and prevent it from happening again?"

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) published a standard in 2001 that requires healthcare providers to inform patients and their families about unanticipated outcomes. An immediate outcry was heard from risk managers, doctors, and others who were fearful of the implications of telling patients the truth about errors. Compliance with this standard is not universal; there is still considerable resistance and fear rooted in the perception that admitting mistakes is not safe in a culture that still subscribes to blame and punishment as methods for ensuring accountability. According to a 2005 survey of physicians and risk managers, the risk managers were more



willing to participate in discussions with patients that used the word "error" than were the physicians. The surgeons were the least likely to admit to error. [1] A 2002 survey found risk managers who expressed the most concern about malpractice litigation were the ones who were the least likely to disclose mistakes. [2]

The 2007 JCAHO National Patient Safety Goals, which affect all accredited healthcare facilities, were released in June 2006. The focus on patient safety continues with Goal 13: "Encourage patients' active involvement in their own care as a patient safety strategy" 13A: "Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so." [3] The subject of patient safety has come out of the closet.

A June 2006 announcement verified the success of the 100,000 Lives campaign sponsored by the Institute for Healthcare Improvement. It is estimated that 6 initiatives implemented to varying degrees in 75% of US hospitals saved 122,000 lives in the last 18 months [4]

Patient safety and the disclosure of errors continue to be troublesome aspects of healthcare. Many healthcare providers believe a number of myths, including that there is no real ethical or legal duty to disclose medical errors to patients or that

patients do not really want to know about errors in their care. However, patients expect acknowledgement of even minor errors. In one study, only 60 percent of doctors believed that a patient should always be told when a complication occurred. [5] Doctors are less likely to disclose mistakes that result in serious injury or death. In some studies, physicians said that they do not disclose errors for fear of further harming patients or of losing the patient's trust. In one study, thirty-three percent of physicians said they would offer incomplete or misleading information to a patient's family if a mistake led to a patient's death. The reasons for dishonesty to patients were associated with the emotional devastation felt by a physician associated with being involved in an error, pressure to be perfect, anxiety about losing professional reputation, and fear of litigation.[6]

A study of 1,747 open and closed Michigan claims reported an analysis of the interval between the report date (when the doctor learned of the first lawsuit) for a first claim and the loss date (the date of the alleged negligent incident occurrence) of a second claim. During any given quarter, an insured physician's average risk of being named in a lawsuit was 5 percent. But during the three months following the report date for the first claim, a physician's risk for having a patient encounter that led to a second legal action almost tripled to 14.4 percent. The risk of a second lawsuit remained elevated for a two-year period after the initial notice. The study suggested a circular relationship: being named in a lawsuit increases stress, which in turn impairs clinical performance and increases exposure to subsequent liability.[7]

Some doctors do not disclose errors because of the belief that if they tell the truth, they increase their chances of being sued. Only one to two percent of negligent adverse events led to actual claims, but physicians estimated their risk of being sued is about three times the actual rate.[8]

Healthcare systems are achieving results with disclosure models. Catholic Healthcare West supports "The Mistakes Project", which recognizes that patients are far more likely to seek legal representation if they believe that information has been concealed from them. Timely disclosure of mistakes is cost effective from the standpoint of the institution. Fair compensation is discussed with the family as part of the disclosure of the mistake. At University of Michigan Health Systems, encouraging doctors to apologize for mistakes is part of a broader effort to help doctors feel comfortable in being honest with their patients. Annual attorneys' fees have since dropped from \$3 million to \$1 million and malpractice lawsuits dropped from 262 in 2001 to 130 per year. [9]

COPIC, a Denver-based malpractice insurer who provides malpractice insurance to 6,000 physicians and

also insures hospitals and health plans, developed the "3Rs" program: "Recognize, Respond to, and Resolve Patient Injury." The objective of the program is to respond to patient injuries before they escalate into disputes, claims or lawsuits by better preparing physicians to disclose unanticipated outcomes to patients. COPIC's own risk managers swiftly evaluate incidents and make settlement offers in cases in which a patient's need for fair compensation can be satisfied without a formal malpractice claim. Savings have been considerable. As of December 31, 2003, payments to patients under the 3Rs Program averaged \$1,820, as opposed to an average cost of more than \$250,000 for traditional paid claims handled by the same insurer, and an average cost of more than \$78,000 for handling claims in which there was no payment to patients. In summary, organizations that have practiced open disclosure approaches with patients have found that it actually decreases their litigation by removing incentives to sue. [10]

The advice to disclose errors challenges the traditional legal view to remain silent when a mistake has reached a patient. That advice serves to block the ability of fellow doctors and nurses even in the same facility to get the clinical details of what went wrong in time to change their system to prevent a repeat tragedy. [11] The process of apologizing and taking responsibility for errors is spreading. As of December 2005, nineteen states had enacted legislation that prohibits apologies from being used against a doctor in court. Refer to www.sorryworks.net for more information about efforts to foster disclosure and provide apologies to patients. The value of offering apologies and the risks of these statements being seen as admission and used against the healthcare provider in court will be resolved as more healthcare providers begin to understand the benefits of being open and truthful with patients about medical errors. However, the fear of being open and the impulse to conceal will continue to influence disclosure, and keep patients heading to attorneys.

1. Presentation at ASHRM October 2005 conference
2. Berlinger, N. "Fair compensation without litigation: Addressing patients' financial needs in disclosure", ASHRM Journal, pgs. 7-11, 24 (1) 2004
3. www.jcaho.org
4. www.ihl.org
5. Berlinger, N. "Fair compensation without litigation: Addressing patients' financial needs in disclosure", ASHRM Journal, pgs. 7-11, 24 (1) 2004
6. Porto, G. "Disclosure of medical error: Facts and fallacies", Journal of Healthcare Risk Management, pgs. 67-76, Fall 2001.
7. Bartlett, E. "Physician stress management: a new approach to reducing medical errors and liability risk", ASHRM Journal, pgs. 3-7, Spring 2002.
8. See note 6.
9. Tanner, L. "Doctors eye apologies for medical mistakes", www.yahoo.com, accessed 11/8/04
10. See note 5.
11. Nance, J. A tragic error, and a laudible response, http://seattlepi.nwsource.com/opinion/202730_sorry12.html, accessed 12/14/04.

Med League locates nursing and physician experts, retrieves articles supporting the standard of care, prepares timelines, chronologies, & other exhibits.