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APOLOGY NOT ACCEPTED: DISCLOSURE OF MEDICAL ERRORS AND LEGAL LIABILITY

*By: David C. Szostak**

I. INTRODUCTION

In the long-gone era of the generalized family physician that made house calls, people built a relationship with their doctors; trust and honesty between patient and physician were common. In more modern times, however, the health care industry has dramatically specialized and diversified, leaving patients often feeling alienated and distanced from any particular medical professional. Such a climate has taken a toll on trust and honesty as both patients and medical staff feel less connected to each other: patients, for example, are more likely to sue a faceless hospital than an individual, friendly physician, and the physicians, in turn, are more likely to hide information and conceal the truth because they fear lawsuits. Nevertheless, recent trends in policies regarding disclosure of medical errors have begun to swing the pendulum in the opposite direction once again: an ever-growing number of hospitals and doctors support full disclosure of medical mistakes to patients, and though it is still a controversial topic within the medical community, the profession is increasingly receptive to the idea. The public, by contrast, has long supported disclosure with near unanimity.

The U.S. health care system makes an alarmingly large number of medical errors: the infamous study that the Institute of Medicine of the National Academies published in 1999 found that medical errors kill between 44,000 and 98,000 Americans each year. The effect of medical errors on the staff, sometimes known as the second victim problem, is almost equally disturbing. When physicians or nurses commit errors, it often results in negative emotions, such as remorse, guilt, feelings of inadequacy or frustration.¹ As a result of committing errors, eighty-one percent of physicians say that they increase attention to detail, but only

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1. Cheri Hobgood et al., *The Influence of the Causes and Contexts of Medical Errors on Emergency Medicine Residents' Responses to Their Errors: An Exploration*, 80(8) *Academic Medicine* 758, 760 (2005).

five percent increase their use of evidence-based medicine.² Self-perceived medical errors are common among residents and are associated with substantial personal distress. This distress is associated with increased odds of future self-perceived errors, suggesting a cyclical pattern of negative feelings and errors, each fueling the other.³ Another contributor to errors is sleep deprivation, which can impair medical and surgical performance. Nursing fatigue and workload have documented effects on increasing intensive care unit error, infections, and cost.⁴ Sleep loss results in higher levels of stress and depression, more complaints about bodily pain, and especially more motor vehicle crashes.⁵ Nurses also make more medical errors when they work in a hospital with a higher patient-to-nurse ratio; their workload is overwhelming. In such hospitals, surgical patients experience higher thirty-day mortality and failure-to-rescue rates, and nurses are more likely to experience burnout and job dissatisfaction.⁶ All of these statistics are disastrous for patients.

II. DISCLOSURE OF MEDICAL ERRORS TO PATIENTS

The situation is dire, and much medical and ethical literature has focused on the controversial topic of disclosing medical errors to patients and their families. Studies have generally found that patients want to learn about all errors, regardless of their severity: they want to learn how and why the mistake happened, and they are concerned about preventive measures that the hospital will take in the future to ensure that such a mistake does not happen to anybody else.⁷ Patients also want emotional support after being injured.⁸ So what do hospitals, nurses, and doctors actually do? Health care providers do not always reveal errors, mostly because of their fear of litigation and damage to their reputations.⁹ The vast majority of hospitals disclose harm at least sometimes, but only one-

2. *Id.*

3. Colin West et al., *Association of Perceived Medical Errors With Resident Distress and Empathy*, 296(9) *J. Am. Med. Ass'n* 1071, 1074 (2006).

4. Vicki Montgomery, *Effect of fatigue, workload, and environment on patient safety in the pediatric intensive care unit*, 8(2) *Pediatric Crit. Care Med.* S11, S13-S14 (2007).

5. Sigrid Veasey et al., *Sleep Loss and Fatigue in Residency Training: A Reappraisal*, 288(9) *J. Am. Med. Ass'n* 1116, 1117 (2002).

6. Linda Aiken et al., *Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction*, 288(16) *J. Am. Med. Ass'n* 1987, 1990 (2002).

7. Juliana Wilson & Ruth McCaffrey, *Disclosure of Medical Errors to Patients*, 14(5) *Medsurg Nursing* 319, 321 (2005).

8. *Id.*

9. *Id.*

third of hospitals have board-approved policies in place.¹⁰ More than half of hospitals would always disclose a death or serious injury.¹¹ This of course begs the question: what are the rest of the hospitals doing in these situations?

Furthermore, when given clinical scenarios, medical professionals are much less likely to disclose preventable harm than non-preventable harm of the same severity.¹² Other research has focused on what hospital staff actually knows about disclosure and how well it has been trained in this respect. For example, in a study on incident-reporting systems, most staff knew that their hospital had such a system, but thirty percent of respondents did not know how to find a list of reportable incidents.¹³ Moreover, views on the necessity of reporting different incidents vary considerably.¹⁴ Ironically, even though medical personnel are reluctant to disclose errors for fear of getting sued, full disclosure might actually reduce litigation while creating trust and satisfaction in patients.¹⁵

Interestingly, house staff uses a variety of psychological mechanisms to deny or defend its errors. First, it denies that so-called “errors” even take place by pointing out that doctors are not perfect, and the medical field has a lot of “grey areas.”¹⁶ How can patients expect a physician to be flawless when neither current medical knowledge nor technology is ideal? Other doctors repress the errors, admitting they have probably made mistakes in the past, but claim to be unable to recall any specific situation. Another denial technique is to redefine the word “mistake,” so that when asked whether they have ever made a mistake that has harmed a patient in any way, doctors may reply that they have never killed anybody or done anything catastrophic.¹⁷ Physicians also discount errors, externalizing the blame and placing it on someone or something else – the fault lies with the bureaucracy at the hospital, the incompetent subordinates, the superiors, or even the patient herself. A physician’s common response to an undeniable error is that the treatment or procedure would have normally worked on most patients, but this particular patient is unusual and something

10. Rae Lamb et al., *Hospital Disclosure Practices: Results of a National Survey*, 22(2) Health Aff. 73, 75 (2003).

11. *Id.*

12. *Id.* at 77.

13. Charles Vincent et al., *Reasons for not reporting adverse incidents: an empirical study*, 5(1) J. of Eval. in Clinical Prac. 13, 16 (1998).

14. *Id.*

15. Wilson, *supra* note 7.

16. Terry Mizrahi, *Managing Medical Mistakes: Ideology, Insularity and Accountability among Internists-in-Training*, 19(2) Soc. Sci. Med. 135, 137 (1984).

17. *Id.* at 138.

unexpected happened.¹⁸

When a doctor can neither deny nor discount that she has made an error, she may use distancing techniques such as asserting that it could not be helped and everyone makes mistakes, confusing the uncertainty of the collective medical profession with her own uncertainty.¹⁹ Doctors may not even realize that they are doing this, but they rarely take direct, full responsibility for injuring a patient even within their own minds, making it far less likely they would disclose medical errors to patients.

The situation is thus complex, and a number of studies have been conducted to ascertain opinion both in the general public and in the medical community. Regardless of severity, patients want to be informed of any errors, and patients are less likely to sue if the doctor discloses the error than they would be if the error is discovered by other means.²⁰ A widespread concern about medical errors exists in public opinion polls as well as among doctors, but only a fraction of doctors believe that the problem is really as serious as the public thinks.²¹ Whether the situation in American hospitals is a mere troublesome predicament or an urgent crisis, patients will respond more favorably to physicians who fully disclose medical errors. In some cases, of course, patients will sue despite full disclosure; in most cases, however, disclosing either has no effect or has a net positive effect.²² In the end, as common sense would dictate, patients simply do not want to be deceived.

For physicians, it is not so easy. Terminally ill patients, for example, often request that their doctors prognosticate and give them survival estimates, in months or years. In one study, doctors only gave an honest estimate thirty-seven percent of the time – the other times they consciously underestimate or overestimate.²³ Physicians frequently have to make such predictions, and they feel poorly prepared to do so. They find it stressful and think that patients expect too much certainty.²⁴ So what factors help or impede physicians' willingness to disclose their harmful mistakes? A

18. *Id.* at 139.

19. *Id.* at 140.

20. Cherri Hobgood et al., *Parental Preferences for Error Disclosure, Reporting, and Legal Action After Medical Error in the Care of Their Children*, 116(6) *Pediatrics* 1276, 1282 (2005).

21. Andrew Robinson et al., *Physician and Public Opinions on Quality of Health Care and the Problem of Medical Errors*, 162 *Arch. Intern. Med.*, 2186, 2188 (2002).

22. Kathleen Mazor et al., *Health Plan Members' Views about Disclosure of Medical Errors*, 140(6) *Ann. Intern. Med.* 409, 414 (2004).

23. Elizabeth Lamont & Nicholas A. Christakis, *Prognostic Disclosure to Patients with Cancer near the End of Life*, 134 *Ann. Intern. Med.* 1096, 1099-1100 (2001).

24. Nicholas A. Christakis, *Attitude and Self-reported Practice Regarding Prognostication in a National Sample of Internists*, 158 *Arch. Intern. Med.* 2389, 2391-92 (1998).

feeling of responsibility is what primarily facilitates disclosure: responsibility to the patient, to themselves, to the profession, and to the community.²⁵ On the other hand, various factors impede disclosure: attitudinal barriers, uncertainties, a feeling of helplessness, and fears or anxieties.²⁶

III. LEGAL LIABILITY

These fears include the fear of getting sued, which is probably the largest reason that hospitals and doctors will not disclose errors and take full responsibility for them. Patients, however, are not solely – or even primarily – seeking money when they are injured by a doctor’s negligence. Investigating people’s reasons for suing doctors, one study found that patients file a claim not only because of the original injury, but also because of subsequent insensitive handling of the incident and poor communication after it occurs. Less than fifteen percent of patients who received an explanation found it to be satisfactory.²⁷ Overall, four themes emerged as to why people sue: first, patients are concerned with the standard of care in the future – will other people be injured? What steps are being taken by the hospital to prevent such a mistake from occurring again? Second, patients genuinely want an adequate explanation of what happened and why. Third, they do want compensation, but typically only for their injuries and medical bills, lost wages, and other similar expenses – not necessarily anything excessive or punitive. And lastly, patients desire accountability – they want a nurse, physician, or some other individual to step up and admit responsibility for what happened.²⁸ Here, patients also want an apology, and the importance of the words “I’m sorry” to an injured patient cannot be emphasized enough.

Whether an apology is an admission of guilt and acceptance of financial responsibility for all consequences is a question that divides lawyers as well as doctors. Some lawyers say that apologizing for a medical error is an admission of guilt, while others disagree.²⁹ In one situation, a surgeon apologized after a serious infection emerged near the patient’s surgery site, prematurely confessing, “We must have done

25. Lauris Kaldjian et al., *An Empirically Derived Taxonomy of Factors Affecting Physicians’ Willingness to Disclose Medical Errors*, 21(9) *J. Gen. Intern. Med.* 942, 945 (2006).

26. *Id.* at 946.

27. Charles Vincent et al., *Why do people sue doctors? A study of patients and relatives taking legal action*, 343 *The Lancet* 1609, 1611 (1994).

28. *Id.*

29. Lola Butcher, *Lawyers Say ‘Sorry’ May Sink You in Court*, 32(2) *Physician Executive* 20, 20-21 (2006).

something wrong. I'm sorry." Later, an infectious disease specialist determined that the infection had been present before the surgery even took place, but the jury sided with the patient because of the surgeon's early apology. The jurors were actually polled after the trial, and they admitted that they were sympathetic to the surgeon's situation but found his remark more convincing than anything the expert witness said.³⁰ An apology evidently can, for legal purposes, be tantamount to an admission of guilt that has far-reaching repercussions. This makes full and honest disclosure difficult, if not impossible.

Disclosure of medical mistakes presents a conundrum. If doctors refuse to disclose, then the relationship between physician and patient suffers from a lack of trust and openness. If doctors do decide to disclose, then they open themselves up to legal liability. The number of medical malpractice lawsuits over the past half century has dramatically increased: in the 1950s, one claim was filed per hundred doctors in a year, whereas ten claims were filed per hundred doctors in the 1990s.³¹ At the same time, however, the number of medical mistakes documented has skyrocketed: when disabling injuries occur during hospitalizations, one in four of these injuries is due to provider negligence.³² Injuries due to hospital staff's negligence are outstripping the number of medical malpractice claims filed at a rate of at least three to one, if not higher.³³ Mistakes are commonplace, and health care providers face many obstacles against disclosing: not only must they deal with malpractice insurance, but a professional physician or nurse may damage her reputation or even lose her job.

IV. PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)

The health care reform legislation that Congress passed last year attempts to remedy the problem of widespread medical errors. On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA).³⁴ This legislation is incredibly complex and contains a plethora of changes to existing law, such as prohibiting health insurers from denying coverage based on pre-existing

30. *Id.* at 22.

31. Paul C. Weiler, *The Case for No-Fault Medical Liability*, 52 Md. L. Rev. 908, 912 (1993).

32. *Id.*

33. *Id.* at 912-13.

34. Patient Protection and Affordable Care Act ("PPACA"), 124 Stat. 119-1025 (2010), available at <http://docs.house.gov/energycommerce/ppacacon.pdf>.

conditions, and prohibiting them from imposing annual or lifetime dollar maximums on coverage. Some changes to the law took effect immediately, while many others will not actually occur for several years. Particularly relevant here, however, are the provisions through which the federal government will use the Medicare and Medicaid programs to decrease funding to hospitals where too many patients acquire infections or other deleterious conditions because of avoidable medical errors.

Medicaid provides assistance to certain low-income individuals, as well as disabled people, pregnant women, and children, among other groups. Medicaid, of course, is a joint federal and state program; that is, the federal government funds part of Medicaid costs, while states administer the program and are required to pick up part of the tab, as well.³⁵ As of July 1, 2011, PPACA will prohibit federal payments to states for Medicaid services related to certain hospital-acquired infections.³⁶ Thus, with this legislation, the federal government is using its spending power through Medicaid to give hospitals an incentive to implement safer policies and procedures, with the admirable goal of reducing unnecessary infections.

After several years, the health care bill will go further by doing something similar with Medicare spending. Medicare is a completely federally funded and administered program, assisting people age 65 and older, as well as some disabled people under 65.³⁷ In 2014 (to be implemented in FY 2015), PPACA will reduce Medicare payments to certain hospitals by 1 percent because of patients receiving certain hospital-acquired conditions.³⁸ These conditions include errors like foreign objects being left in a patient after surgery, air embolisms, blood incompatibility, and surgical site infections.³⁹ Once again, the federal government here is simply attempting to reduce medical errors in hospitals through its spending power.

One final provision addresses the problem from a slightly different direction. Just over a year from now, on Oct. 1, 2012, PPACA will reduce Medicare payments that would otherwise be made to hospitals to account

35. Centers for Medicare & Medicaid Services, Medicaid Program – General Information, *available at* <http://www.cms.gov/MedicaidGenInfo/>.

36. PPACA, *supra* note 34, at 229.

37. Medicare.gov, Medicare Eligibility, *available at* <http://www.medicare.gov/MedicareEligibility/home.asp>.

38. PPACA, *supra* note 34, at 291.

39. Centers for Medicare & Medicaid Services, Medicare – Hospital-Acquired Conditions, *available at* https://www.cms.gov/HospitalAcqCond/06_Hospital-Acquired_Conditions.asp.

for excess (preventable) hospital readmissions.⁴⁰ Here, in a similar manner as before, the legislation penalizes hospitals for making too many medical errors. Hospitals will be forced – or at least given a strong incentive – to develop new and better policies to prevent unnecessary readmissions. Patient safety will thus be increased.

In light of these provisions, several things are clear. The Affordable Care Act does not directly address the issue of disclosure of medical errors in hospitals. It neither mandates nor even tries to regulate disclosure. What the Act does do is recognize that a widespread problem exists, and it tries to decrease these errors through spending incentives. Open and honest disclosure of mistakes, as a policy matter, is ultimately left in the hands of individual hospitals, but the hope is evidently that hospitals will choose to implement disclosure as one way to help reduce medical errors.

V. WHAT IS TO BE DONE?

The consensus seems to be in favor of disclosure, but actually implementing such a policy is riddled with problems and obstacles that will not disappear until something drastic happens. Perhaps legislatures and courts should require that physicians disclose errors: patients can already sue for negligence, but the penalties may need to be increased for physicians who are found guilty of negligence and did not disclose their mistake to the patient – i.e., punitive damages may be necessary. A different and preferable way to view such a system is that it rewards physicians who disclose all mistakes at an early point in time. Such a scheme would be comparable to how criminals can get a lesser punishment by pleading guilty at the outset and avoiding trial, which is both costly and time-consuming for the judicial system.

Alternatively, perhaps physicians who disclose medical mistakes to their patients should be granted total immunity from any lawsuits for negligence. There is substantial support for a “no-fault” compensation system, which would replace the current individually-oriented “shame and blame” tort system for medical malpractice with no-fault institutional liability. This would seem to have the adverse effect of removing incentives for health care providers to be careful, yet physicians do not perceive the fault-based malpractice system to improve quality of care. Several other countries have implemented no-fault liability systems, particularly Scandinavian countries, with substantial success.⁴¹ Avoiding

40. PPACA, *supra* note 34, at 328.

41. David M. Studdert & Troyen A Brennan, *No-Fault Compensation for Medical Injuries: The Prospect*

medical mistakes in the first place is the most important aspect of these systems: when the hospital or health plan is responsible for the actions of all its affiliated employees and staff, it tends to take steps to prevent any harm from occurring.⁴² In effect, this is a system of *respondeat superior*: the hospital, vicariously liable for its staff, will take steps to more carefully screen and hire excellent physicians and nurses, and it will continuously train them well to ensure that errors are minimized and that quality of patient care remains high. Furthermore, patients could choose a participating hospital or physician, allowing for market forces to drive the no-fault liability system.⁴³

The objections to the current system of tort law for compensating patients for medical mistakes are not only coming from the medical profession: the legal community, too, does not necessarily believe that tort law actually deters hospital staff from making mistakes. Many leading tort law scholars have challenged economists' claims about the ability of tort law to deter.⁴⁴ Other forces, such as morality or self-interest, may act upon staff to deter certain harmful conduct. Physicians may feel bound by their morals and their professional oath to "do no harm" to patients. Similarly, even assuming the more cynical view that health care providers are only interested in their own well-being, damage to their reputations may be a sufficient incentive for them to avoid making mistakes and causing injuries.⁴⁵

Furthermore, even if other forces were *not* sufficient, it does not logically follow that tort law *is* sufficient to deter harmful conduct. Physicians may not be aware of the legal significance of a certain decision, or they may discount the chance of future liability.⁴⁶ It is by no means certain that tort law is the optimal way to address the widespread problem of medical mistakes in America, for purposes of compensation or even for deterrence. What factors actually do influence physicians' standards of care? A Harvard survey found that physicians consider continuing medical education to be the single most influential factor on their behavior, scoring 3.73 on a scale from 1 to 5; financial liability was rated 2.54.⁴⁷ This demonstrates that, at least according to physicians'

for Error Prevention, 286(2) *J. Am. Med. Ass'n* 217, 219 (2001).

42. *Id.* at 219-20.

43. *Id.* at 222.

44. Gary T. Schwartz, *Reality in the Economic Analysis of Tort Law: Does Tort Law Really Deter?* 42 *UCLA L. Rev.* 377, 381-82 (1994).

45. *Id.* at 382.

46. *Id.* at 382-83.

47. *Id.* at 401.

perceptions, liability does play a role, but other factors are more influential. Perhaps one effective alternative to tort law would be to require more continuing medical education on the subject of medical errors and how to prevent them.

Preventing mistakes from occurring in the first place should be a top priority at every American hospital. Residents are working far too many hours and are often performing at a suboptimal level; nurses are understaffed and overwhelmed by huge workloads. No solution will be perfect, no matter how draconian or creative, and the optimal answer may be a combination of many different measures. Nevertheless, some sweeping reforms need to be enacted as soon as possible because lives are hanging in the balance – and reforms of this magnitude do not typically come about absent an active citizenry. A single preventable death is thoroughly unacceptable; hundreds of thousands of preventable deaths betray the sad state of the supposedly finest health care system in the world. The only thing more dismal would be a population too indifferent to demand immediate and drastic changes.