Should Errors Be Disclosed Fully?

A doctor treats a longtime patient with a skin infection by prescribing dicloxacillin, a form of penicillin. The patient is allergic to penicillin and the allergy is recorded in the medical record, but the doctor misses the notation and the patient doesn't know that the drug is related to penicillin. Shortly after taking the first dose, the patient develops hives, calls the doctor's office and is told to stop taking the new prescription and to take diphenhydramine for the hives.

The doctor now faces the question of whether and how much to tell his patient about the error.

Research consistently shows that patients want to be informed of errors, experts say. Yet full disclosure—in which doctors inform patients that an error has occurred, describe how and why it happened, the medical consequence and what's being done to prevent a future recurrence—often doesn't take place.

Four variations of this vignette were part of a study, published in the March 16, 2004, issue of Annals of Internal Medicine, to determine how patients respond to medical errors and their disclosure, or lack of it, by doctors. The study, led by Kathleen Mazor, Ed.D., assistant professor at the Meyers Primary Care Institute at the University of Massachusetts Medical School, found that "people respond more positively to full disclosure than nondisclosure," Dr. Mazor says.

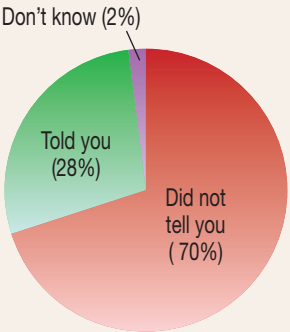
"If they feel [their doctor] is covering up, not taking their concerns seriously or treating them respectfully," patients are "less happy and angrier" than when physicians explain what happened and apologize, she adds.

Research consistently shows that patients want to be informed of errors, experts say. Yet full disclosure—in which doctors in-

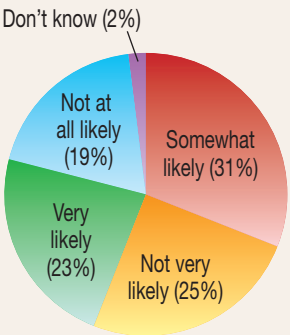
Public Perceptions on Error Reporting

After being read a common definition of a medical error, about one in three people (34%) said they or a family member had experienced a medical error at some point in their lives.

Among the 34% who've experienced medical errors: Did the doctor or the health professionals involved tell you that a medical error had been made?



Among total public: If a preventable medical error that resulted in serious harm were made in your care, how likely do you think the doctor would be to tell you?



Source: Kaiser Family Foundation / Agency for Healthcare Research and Quality/Harvard School of Public Health National Survey on Consumers' Experiences with Patient Safety and Quality Information, November 2004 (Conducted July 7 - September 5, 2004).

form patients that an error has occurred, describe how and why it happened, the medical consequence and what's being done to prevent a future recurrence—often doesn't take place.

A 2002 survey of 831 practicing doctors and 1,207 consumers, conducted by a research team led by Robert Blendon at the Harvard School of Public Health, found that only one-third of respondents in each group who said they had experienced an error in their own care or that of a family member were told about it and offered an apology by the health professionals involved. Furthermore, the survey, published in the Dec. 12, 2002, New England Journal of Medicine, found that only 23 percent of doctors, compared with 71 percent of the public, considered error reporting to state agencies an effective strategy for preventing errors.

Doctors' biggest fear is that admission of an error could trigger a lawsuit, experts say. A review of 17 disclosure studies found that in addition to litigation, doctors were concerned about the distress that disclosure might cause patients, damage to their reputation, loss of patients and consequences such as license revocation.

Doctors' biggest fear is that admission of an error could trigger a lawsuit, experts say. A literature review of 17 disclosure studies, also led by Dr. Mazor and published in the August 2004 issue of Archives of Internal Medicine, found that in addition to litigation, doctors were concerned about the distress that disclosure might cause patients, damage to their reputation, loss of patients and consequences such as license revocation.

In fact, little is known about the impact of disclosure on litigation or other potential sanctions, according to Dr. Mazor.

"Empirical research on disclosure of medical errors to patients and families has been limited, and studies have focused primarily on the decision stage of disclosure," the review concluded. "Fewer [studies] have considered the disclosure process, the consequences of disclosure or the relationship between the two."

Understanding the Consequences

Dr. Mazor's study on patients' response to disclosure begins to close that gap in understanding the potential impact of disclosure. Based on 958 surveys from enrollees in a New England-

based health maintenance organization, researchers at the HMO Research Network Centers for Education and Research on Therapeutics (CERT) found that full disclosure reduced the likelihood that patients would change doctors, increased their trust and satisfaction, and produced a positive emotional response compared with nondisclosure.

Disclosure was no guarantee, however, that patients would not seek legal advice, and the lack of empirical research on its impact in this and other areas "may be a barrier to disclosure," the study said.

While patients respond more positively to disclosure, their decision to seek legal recourse is also influenced by the severity of the clinical consequence of the error and the circumstances under which it occurred, Dr. Mazor and her research team found.

The study measured patients' responses to a survey in which they were given one of two hypothetical medication errors, one of two clinical outcomes, and one of two possible dialogues between the doctor and patient explaining what happened.

One vignette involved the administration of the penicillin-related drug to a patient allergic to penicillin; the second involved an order to increase the dosage of seizure medication for an elderly nursing home resident and failure to monitor its effect.

In one version of the penicillin reaction, the patient developed hives, and in another experienced life-threatening respiratory distress resulting in hospitalization. The patient who received an overdose of seizure medication without appropriate monitoring became unsteady, fell and experienced bruising and a broken nose in one scenario. In a second scenario, the patient fell and broke a hip.

Each of the scenarios was accompanied by one of two hypothetical dialogues between the doctor and patient or family member. In one version, the doctor acknowledged that an error had occurred, explained why and accepted responsibility, assured the patient of steps being taken to avoid similar errors in the future and apologized. In a second version, the doctor described the outcome as unfortunate but did not disclose the error or its source. (*See box on next page.*)

Researchers found that almost all respondents (98.8 percent)

wanted to be told of errors, most (83 percent) favored financial compensation if harm occurred and few (12.7 percent) wanted compensation if no harm occurred.

While disclosure didn't guarantee that patients would forgo legal recourse, a smaller segment in the group that received the full-disclosure scenarios said that they would opt to pursue litigation than those whose doctor did not disclose. Among those

Description of Sample Vignette and Dialogue Excerpts

A. Lack of monitoring of seizure medication: serious outcome/full disclosure

Your father is in a nursing home with a history of seizures, and takes medication to control them. The doctor decides to increase the medication; and while his seizures remain under control, your father starts having balance problems that become more serious over the next two weeks. One morning he falls due to the medication that has made him unsteady. He is sent to the emergency room, where the level of medication in his blood is found to be in the toxic range.

The doctor should have monitored your father for side effects from the increased dosage with a blood test, but did not. Your father suffers a broken nose and black eyes from the fall. The next day you call the doctor to find out what happened.

The doctor admits that high level of medication likely contributed to the fall, and that he failed to follow up as he should have. "I felt terrible that he fell and that I did not pick up the mistake earlier. I am sorry that it happened," he says.

Furthermore, he tells you that the next meeting of the patient safety committee will make it their "first order of business" to work out a system that prevents the error from happening again.

B. Lack of monitoring of seizure medication: serious outcome/nondisclosure

The scenario is the same as above, but when the doctor gets the call, he deflects an admission of the error by saying that the cause of the fall is unclear, as the patient is elderly, suffers from seizures, and takes several medications. Despite the finding in the emergency room that the medication level was too high, the doctor says it's unclear whether the medication was a factor or "if he fell for some other reason."

Source: Kathleen M. Mazor et al, Health Plan Members' Views About Disclosure of Medical Errors, Annals of Internal Medicine, March 16, 2004.

who received the less-serious missed allergy scenario, 19 percent said they would seek legal advice when the doctor failed to disclose the error, compared with less than 1 percent of those who were given full disclosure. The gap closed significantly in the life-threatening scenario involving respiratory distress, with 30 percent in the non-disclosure group saying that they would seek legal advice, compared with 24 percent who received full disclosure.

While it's unclear whether doctors are more or less likely to face a lawsuit in the wake of disclosure of a medical error, some experts say that nondisclosure and secrecy fuel litigation, as patients see it as the only way to find out what happened when something goes wrong and vent their anger.

Among the group that was surveyed with the less-severe seizure medication scenarios, 24 percent in the non-disclosure group said that they would pursue legal action, compared with 21 percent whose doctor gave full disclosure. For the more severe outcome, a broken hip, higher percentages in both groups—47 percent of those with non-disclosure dialogues and 39 percent with full disclosure—said they would seek legal advice.

In other areas, however, the differentials were wider. Patient satisfaction, measured on a scale of one (most negative) to five (most positive), ranged from a mean of 3.3 to 3.4 for disclosure scenarios, compared with a mean 1.8 to 2.3 for nondisclosure. Trust in the physician rated 2.9 to 3.4 among the disclosure groups and only 2.1 to 2.7 with nondisclosure. Patients' emotional response measured 2.3 to 3.1 in the disclosure groups, compared with 1.8 to 2.5 among those who did not get full disclosure.

One of the best defenses against the undesirable consequences of medical errors and the thorny questions surrounding disclosure may be to hone communication skills, says Dr. Mazor. In general, doctors who have good communication skills and good relationships with their patients are less likely to be sued and less likely to find themselves in situations where they have to make disclosures, she adds.

"If you start out as a good communicator, you may be less likely to have errors, and are starting out ahead," she says. When er-

rors do occur, however, "what people want is to be respected, treated like people, and they want an apology if they have been harmed."

Litigation Fears

While it's unclear whether doctors are more or less likely to face a lawsuit in the wake of disclosure of a medical error, some experts say that nondisclosure and secrecy fuel litigation, as patients see it as the only way to find out what happened when something goes wrong and vent their anger.

"Patients want honesty, even patients who have been mistreated," says Dr. Lee Hilborne, director of University of California Los Angeles' Center for Patient Safety and Quality. "Patients frequently know more than you think they do. When a mistake occurs, there are lawsuits, and that's a big concern, but patients often want someone to admit the mistake, promise to fix the problem and apologize for it. When you talk to patients about errors, that's what they want."

Dr. Albert Wu of Johns Hopkins University found that at a Department of Veterans Affairs medical center in Lexington, Ky., which adopted a policy of error disclosure in 1987, the number of settlements has risen, but payments have been moderate. "Overall, the institution has realized a cost savings, in part because of reduced legal expenses," he reported.

Dr. Hilborne gives the example of a family that settled a malpractice lawsuit and later told him that no one had ever talked to them about what happened. He quotes one family member as saying, "Everyone got so defensive that we got angry" and ended up suing.

Dr. Mazor agrees, noting that some studies have shown that people consider legal action when they hit a wall of silence about the error and feel that litigation "is their only recourse."

The first step that doctors should take in moving towards full disclosure is to better understand that talking to patients about errors and apologizing for them does not definitively heighten the risk of successful litigation, says Dr. Thomas Gallagher, an internist and assistant professor of medicine at the University of Washington in Seattle.

"On the one hand, the vast majority of patients who are injured by negligent care never file a lawsuit," he says. Only a small por-

tion, "probably 3 percent to 5 percent," do so.

While doctors may fear that disclosure will increase that rate, it's likely that concealing errors from patients will make them angrier and more determined to sue, and that juries will respond negatively by awarding higher punitive damages, he adds. Furthermore, at institutions that have moved to open disclosure, "the sky doesn't appear to be falling in," Dr. Gallagher says. "In fact, some report that the number of claims and legal defense [costs] are going down."

Dr. Albert Wu, a patient safety researcher at The Johns Hopkins University School of Medicine in Baltimore, reported the experiences of several malpractice defense attorneys in the Dec. 21, 1999, Annals of Internal Medicine. A review of closed claims by one Florida attorney found that nearly half of perinatal injury lawsuits "were motivated by suspicion of a cover-up or by the desire for revenge," Dr. Wu reported.

An estimated three-fourths of all malpractice lawsuits involved inpatient or emergency-room care, settings in which doctors and patients do not typically have a relationship, the report said. Nearly all malpractice cases were linked to "a breakdown in the physician-patient relationship," one defense attorney said. Primary-care doctors would reduce their exposure to malpractice claims "if they told patients what to expect, encouraged them to talk, used humor and spent more time with them," said one study cited in the report.

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"Overall, the institution has realized a cost savings, in part because of reduced legal expenses," Dr. Wu reported.

While there are no guarantees, "the overall impact of disclosure is likely to be a positive one," he adds.

The Attitude Gap

Dr. Gallagher's research on medical-error disclosure has focused on patients' and physicians' attitudes about disclosure and closing the gap between what patients want to know and what doctors tell them.

"Greater insight into patients' and physicians' attitudes toward error disclosure could improve the way institutions and practitioners handle these events," said a study led by Dr. Gallagher, the results of which were published in the Feb. 26, 2003 issue of Journal of the American Medical Association.

A research team from the University of Washington School of Medicine in Seattle, Washington University School of Medicine in St. Louis, and University of Toronto, convened 13 focus groups. Six of the groups were comprised of adult patients, four were made up of doctors from academic and community settings, and three groups combined doctors and patients. A total of 52 patients and 46 doctors participated. The groups were asked to imagine that they were a patient with diabetes who had been hospitalized with breathing problems and given a ten-fold overdose of insulin, partly due to misinterpretation of a doctor's poor handwriting. The patient lost consciousness and was transferred to the intensive care unit, where he recovered without permanent harm.

"The medical profession at large needs to develop standards and guidelines for disclosure," says Dr. Thomas Gallagher of the University of Washington. "We don't even have agreement on basic ideas like whether you should say the word 'error.' As a profession, we need to come up with basic guidelines about what it is you should tell patients, regardless of what they ask."

In discussions about errors in general, and the hypothetical vignette in particular, patients said that they wanted to be informed about what had happened, the health implications of the error, why it happened, how the problem would be corrected and how future errors would be prevented—and they wanted to be told all of this without having to ask a lot of questions.

Furthermore, patients wanted to be assured that they would not suffer financially due to the error and to know that "the practitioner and institution regretted what happened, that they have learned from the error and that they have plans for preventing similar errors in the future."

Doctors, however, "were more circumspect regarding exactly what they would tell patients about errors," researchers reported. While they would be truthful, focus group participants talked of the need to "put the most positive 'spin' on the event as possi-

ble," the study said. Doctors talked about "choosing their words carefully," meaning they would discuss the adverse event without "explicitly stating that an error took place," researchers reported. Doctors also assumed that patients who wanted more information than they were given would ask questions.

One participant, for example, said he "would be very straightforward, and say, 'You were given too much insulin. Your blood sugar was lowered, and that's how you arrived in the intensive care unit.'" The doctor said he would apologize, and if the patient asked how the error happened, he would explain, but added that he "wouldn't walk in saying, 'I have sloppy handwriting and they didn't know what they were reading.' You just tell the facts: 'You got a big bunch of insulin and your blood sugar went down, and we got that fixed up, and we're glad you're great.'"

While medical errors take an emotional toll on the patients and families who are directly affected, doctors also suffer, Dr. Gallagher found. Practitioners participating in the focus groups reported feelings of guilt, failure, fear of a lawsuit and loss of their reputation. Some said they experienced sleeplessness, difficulty concentrating and anxiety.

Overall, the study suggests "that the current response to medical errors may meet neither patients' desire for information about errors nor the needs of patients and physicians for emotional support following an error," researchers concluded. "While patients and physicians largely agreed on whether to tell patients about errors that cause harm, they disagreed about what to disclose regarding such errors."

Dr. Gallagher and his research team recommended that doctors at least give patients "an explicit statement that an error occurred, a basic description of what the error was, why the error happened, how recurrences will be prevented and an apology."

Basic Guidelines Seen Needed

Beyond a broad medical ethical and professional standard that urges disclosure, however, there is scant guidance available to doctors on how to proceed with such discussions, experts say.

"The medical profession at large needs to develop standards and guidelines for disclosure," Dr. Gallagher says. "We don't even have agreement on basic ideas like whether you should say

the word 'error.' As a profession, we need to come up with basic guidelines about what it is you should tell patients, regardless of what they ask."

Dr. Mazor's literature found discrepancies and disconnects even in the definition of medical error. Some patients, for example, considered "rudeness or poor service quality as medical errors, events that most physicians would not include," the study said.

"Ethical and professional guidelines, credentialing organizations, patient-safety organizations, and experts on medical errors advocate disclosure of medical errors to patients and families, but there is little empirical evidence to guide practitioners," the report said. In the face of inadequate disclosure and an overwhelming desire by patients and the public for information when errors occur, there is yet no available research "to guide practitioners with respect to the practical questions of who, what, when, and how to disclose."

Experts indicated that while there is broad agreement on the need for disclosure in cases of clear-cut, egregious errors, several gray areas cry out for consensus and clarification, such as disclosure of so-called near misses, in which a potentially harmful error almost occurred, and cases in which there was minimal or no harm to the patient. The timing of disclosure may also be problematic.

"Premature disclosure may cause unnecessary distress, but waiting for an investigation to be completed may increase patient anger and frustration, especially when causality is obscure to the patient and family," said Dr. Mazor's literature review.

Twenty-one states have enacted mandatory reporting statutes for serious medical errors and adverse events, according to the National Academy for State Health Policy (NASHP) in Portland, Me. But in most states there is little, if any, intersection between direct patient disclosure about a specific incident and error reports that flow from hospitals to state databases. Most state mandates focus on institutional reporting as opposed to independent practices, and they make it difficult for the public to request information about medical errors and adverse events, according to a 2003 NASHP report critical of state reporting systems.

Even medical societies and organizations that provide exten-

Opinions About Error Disclosure

Select findings from literature review of 17 studies

Frequency of Disclosure

- Only 21 percent of doctors and 24 percent of physician trainees had discussed "their last significant medical mistake in the last year" with the patient or family.
- Among hospital risk managers, 65 percent said that the facility's practice was to always disclose errors that led to death or serious injury, and 37 percent indicated that they always disclosed errors that caused short-term harm.
- A study that used a vignette of a medication error resulting in death found that about half of doctors would admit the error.
- More than half, 53 percent, of risk managers said that they would be less likely to disclose preventable harm than nonpreventable harm.
- A survey of doctors and consumers found that 34 percent of doctors and 33 percent of the public who had experienced an error in their care or that of a family member reported receiving an apology from the health care professional involved.

Attitudes Toward Disclosure

According to a national survey, 89 percent of the public and 77 percent of doctors believe that physicians should be required to tell patients when errors occur. In response to a hypothetical medication error that led to a patient's death, 90 percent of doctors and 95 percent of consumers surveyed for the study believed that the error should be disclosed by the prescribing doctor.

Disclosure Process

- Hospital risk managers report that the most common elements of disclosure were explanations (92 percent), investigation (87 percent), apology (68 percent) and acknowledgment of harm (66 percent). Less common were offers to reveal investigation findings (41 percent) or take responsibility for harm (33 percent). The vast majority, 82 percent, said that hospitals offered payment for error-related care.
- A study from the United Kingdom found that explanations of errors didn't always satisfy patients who subsequently sought legal advice: 82 percent were dissatisfied with the amount of information they received, while more than 63 percent were dissatisfied with the accuracy and 67 percent with the clarity of information. Sixty-three percent said that the explanation was given "unsympathetically."

Source: Kathleen M. Mazor, Ed.D.; Steven R. Simon, M.D.; Jerry H. Gurwitz, M.D., Communicating With Patients About Medical Errors: A Review of the Literature. Archives of Internal Medicine, August 9/23, 2004.

sive patient-safety tools and voluntary reporting systems to facilitate research and prevention of errors offer little in the way of detailed standards and guidance on the patient disclosure process.

Furthermore, state disclosure mandates and those imposed on hospitals by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) often focus on adverse events without explicitly tying the outcome to an error, says Dr. Gallagher. Health professionals "can meet the standard by telling [patients] about the adverse event, but not whether it was preventable."

"Disclosure is especially stressful for physicians in private practice," he adds. Independent doctors are on their own in the professional liability insurance market, and fear that triggering a claim could mean the loss of coverage or a premium increase, he adds. Some liability insurance contracts include language that impedes disclosure by implying that an admission of error or apology may "constitute noncooperation in their defense," an act that voids coverage, Dr. Gallagher says.

While this clause is rarely, if ever, enforced, "it is a pretty big stick for physicians," he adds, leading doctors to worry that saying the wrong thing could strip them of coverage.

"You often hear from physicians in private practice that recommendations for disclosure sound nice in theory, but sound unacceptably risky," Dr. Gallagher says.

Private practitioners also lack the support that an academic in-

Liability Fears Chill Error Discussion: Poll

In a nationwide poll, 300 practicing physicians, 100 hospital administrators and 100 nurses were asked: Generally speaking, how much do you think that each of the following discourages medical professionals from openly discussing and thinking about ways to reduce medical errors?

Those who say "a lot"	Physicians	Nurses	Hospital Administrators
Fear of liability	59%	22%	25%
Not wanting to upset or criticize a colleague	34%	24%	23%
The environment in your hospital	16%	14%	3%

Source: Harris Interactive, Feb. 7, 2003.

stitution, hospital or large group offers in analyzing errors and helping with the disclosure process, he adds.

"A lot of times it's not clear that an error has happened, or it's clear that it happened, but it's not clear that it harmed the patient," says Dr. Gallagher. Errors are often the result of a "system breakdown," and in these cases doctors may wonder how to explain it to a patient "in a way that doesn't sound as if no one is responsible," he adds. For doctors struggling with whether and how much to disclose, the line is also blurry in cases where the harm to patients is trivial or when the "error is horrendous," but the impact on the ultimate outcome is unclear because the patient's prognosis was so poor from the outset.

Large institutions often have teams of experts in place to conduct error analysis and help communicate to patients what happened. Kaiser Permanente, for example, has a "nationwide program of full disclosure to patients," says Suzanne Graham, patient safety practice leader for Kaiser in California. When a doctor or team makes an error, and is uncertain how to break the news to patients, a "situation management team" can be called upon to walk them through the process, Ms. Graham says.

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Doctors in private practice, however, lack the advantage of built-in support systems. As a result, doctors should seek help and guidance from risk managers or others skilled in the disclosure process before discussing errors with patients, Dr. Gallagher advises.

One insurer, COPIC Insurance Company in Denver, encourages doctors to communicate openly with patients about errors and offers financial assistance to patients through a program called the "3Rs," which stand for "recognize, respond, resolve." The program, launched in 2000, pays for medical expenses and other costs, such as lost work time, associated with medical errors. An October 2004 newsletter reported that patients had re-

ceived a total of $1.2 million as of June 30, 2004, through the 3Rs program, with payments ranging from $95 to $30,000. So far, none of the cases have proceeded to litigation, COPIC reported.

The program has "significant cost-saving potential," in addition to "enhanced physician/patient communication, sustained physician/patient relationship and improved satisfaction on the part of all concerned parties," the newsletter said.

The Value of an Apology

A new coalition representing patients, physicians, hospitals and attorneys is promoting the widespread adoption of the practice of full disclosure after medical errors, followed by an apology and a quick financial settlement. The group, called the Sorry Works! Coalition, says that its approach removes the anger from the situation when a patient is injured due to a mistake. "By offering an apology and providing a fair settlement upfront, patients and families are treated in a compassionate manner," the group says on its Website (*www.sorryworks.net*). "Instead of being treated like the enemy, patients are elevated to a special status where the hospital tries to make amends for the error or bad outcome. When patients and families are treated with good will, the feelings are usually reciprocated."

"**By offering an apology** and providing a fair settlement upfront, patients and families are treated in a compassionate manner," says the Sorry Works! Coalition. "Instead of being treated like the enemy, patients are elevated to a special status where the hospital tries to make amends for the error or bad outcome."

Sorry Works! says that when medical mistakes or unanticipated outcomes occur, doctors and hospitals should thoroughly review the facts of the case and quickly notify the patient and/or family with the findings. If an error is found, the provider should apologize, offer answers and provide a fair settlement up front. The family should retain legal counsel to ensure that their rights are protected and preserved throughout the process. Finally, patients and families should be allowed to participate to the extent possible in the effort to make sure that the medical error does not happen again.

Will Patients Forgive Physicians for Medical Errors?

Patients are most likely to forgive a physician for a medical error if the patient failed to provide complete information to the doctor and least likely to forgive if the error was a result of cost-containment efforts. These are the findings of a survey led by Kathleen Mazor, Ed.D., assistant professor at the Meyers Primary Care Institute at the University of Massachusetts Medical School, and published in the American Journal of Managed Care (January 2005).

The researchers mailed a questionnaire to 1,500 randomly selected health plan members to assess the likelihood of forgiveness following a medical error under 12 different circumstances. A summary of their results follows:

Circumstance	Would Forgive	Might Forgive	Would Not Forgive
Patient did not tell the physician everything	56%	37%	7%
Patient's condition was unusual and the physician was not familiar with it	25%	59%	16%
An emergency situation	20%	58%	22%
Physician got bad advice from another physician	15%	51%	34%
Physician was too aggressive in the treatment	10%	65%	25%
Physician wasn't the patient's regular physician	10%	57%	33%
Physician was not aggressive enough in the treatment	6%	55%	39%
Physician was tired or distracted	6%	27%	68%
Physician wasn't thorough in the examination or in talking with the patient	3%	22%	76%
Physician did not have, or forgot, important medical knowledge that most physicians have	3%	19%	78%
Physician made a poor decision because he or she was trying to keep costs down	3%	8%	89%
Physician did not follow up or did not monitor test results or treatment	2%	12%	85%

Source: "Health Plan Members' Views on Forgiving Medical Errors," The American Journal of Managed Care, January 2005.

The Sorry Works! board consists of a cross section of patient-safety experts, consumer advocates and malpractice attorneys. The board includes the following members:

- Dr. Albert Wu, Johns Hopkins University, whose research into error disclosure at the VA medical center in Lexington, Ky., was discussed earlier in this chapter.
- Dr. Michael Woods, founding partner of Doctors in Touch, a consulting firm that provides tools to help physicians improve communication skills.
- John Banja, Ph.D, bioethics professor at Emory University in Atlanta and author of Medical Errors and Medical Narcissism (Jones & Bartlett, 2005). Dr. Banja is working on developing a model policy for disclosing medical errors.
- Ilene Corina, co-president of PULSE, a national patient-safety network and support group for patients who've experienced medical errors. Ms. Corina is also on the board of directors for the National Patient Safety Foundation.
- Charles Inlander, president of the People's Medical Society, a consumer health advocacy organization.
- Dr. Lester Jones, assistant chief of staff for quality assurance at the Veterans Affairs Greater Los Angeles Healthcare System.
- Dr. Steve Kraman, former chief of staff, Veterans Administration Hospital in Lexington, Ky.
- David Patton, medical malpractice attorney representing plaintiffs, based in Paradise Valley, Ariz.
- James Cunningham, president of The Cunningham Group, an independent insurance agent and broker specializing in medical malpractice insurance, headquartered in Oak Park, Ill.

In 2003, Colorado enacted a law providing that any apology made by a medical provider to a patient who experienced a medical error would be inadmissible as evidence in a medical malpractice lawsuit. Lawmakers in Arizona are reportedly working on similar legislation.

In addition to promoting its program to hospitals, physicians and attorneys, Sorry Works! is seeking to advance legislation at the state and federal level that would provide funding to establish pilot programs. The coalition sees its approach as a possible solution to the medical malpractice crisis in many states and an alternative to tort reform, particularly the damages caps that are

supported by medical organizations. "The goals of tort reform are immediately within reach with Sorry Works! without the protracted political and legal battles frequently experienced with caps," the coalition says on its Website, in a message targeted to physicians and malpractice insurers. "Fewer lawsuits, lower settlement costs, lower liability costs and more certainty over liability exposure are yours with Sorry Works! without waiting for a legislative vote or a state supreme court to decide on issues of constitutionality."

A bill to establish a Sorry Works! Pilot program in Illinois was passed by the Illinois State Senate in late 2004 and was awaiting action in the House. Dr. Kenneth J. Printen, president of the Illinois State Medical Society, expressed some reservations about this approach in a November 2004 letter to the Madison County Record:

"Doctors are by nature compassionate people, but the litigious environment in which we work often forces us to speak with our heads over our hearts. Sadly, it is possible for an expression of grief or sympathy to be twisted into an admission of guilt and used against us by opportunistic lawyers with visions of dollar signs dancing in their heads," Dr. Printen wrote. "Without legal protection, those who speak from their hearts often get slapped with unwarranted litigation. Proposals that ignore this legal reality merely open the door to greater abuses in the system and a bigger healthcare access crisis."

Other states have addressed the issue of apologies in different ways. In 2003, Colorado enacted a law providing that any apology made by a medical provider to a patient who experienced a medical error would be inadmissible as evidence in a medical malpractice lawsuit. Lawmakers in Arizona are reportedly working on similar legislation.

Such an approach may have benefits beyond the obvious ones for healthcare providers. Jonathan R. Cohen, J.D., Ph.D., associate professor of law at the University of Florida Levin College of Law, believes that laws of this type may have a long-term impact on error prevention. "A key component of preventing future medical errors is gathering information about errors that have occurred. No doubt one of the greatest barriers to gathering information on medical error is the fear that it will be 'used against

one,' that it will come back to haunt the medical practitioner in court," Dr. Cohen wrote in an article published in the Harvard Health Policy Review in Spring 2004. "By stating in effect that it is 'safe' for a physician to apologize to a patient for medical error, the Colorado law may help break the silence that so often shrouds medical mistakes. As that silence breaks, preventing future medical errors becomes more hopeful."

In general, Dr. Gallagher compares the state of error disclosure today to that of end-of-life care 20 years ago, when doctors "wanted to withdraw care but worried they would be thrown in jail for it. They wanted to tell the truth about [a patient's] diagnosis, but worried about harm to the patient and cultural norms."

Dr. Mazor and researchers at CERT stressed the need for more research in this arena, noting that in the absence of "empirical data to provide guidance on how to disclose well and without a better understanding of the relationship between the disclosure process and the consequences of disclosure, clinicians can only guess at what is most effective in this difficult situation." Specifically, investigators should examine barriers to the decision to disclose and how to reduce them, and develop answers to questions "such as who should disclose, what information should be provided, and when disclosure should occur."