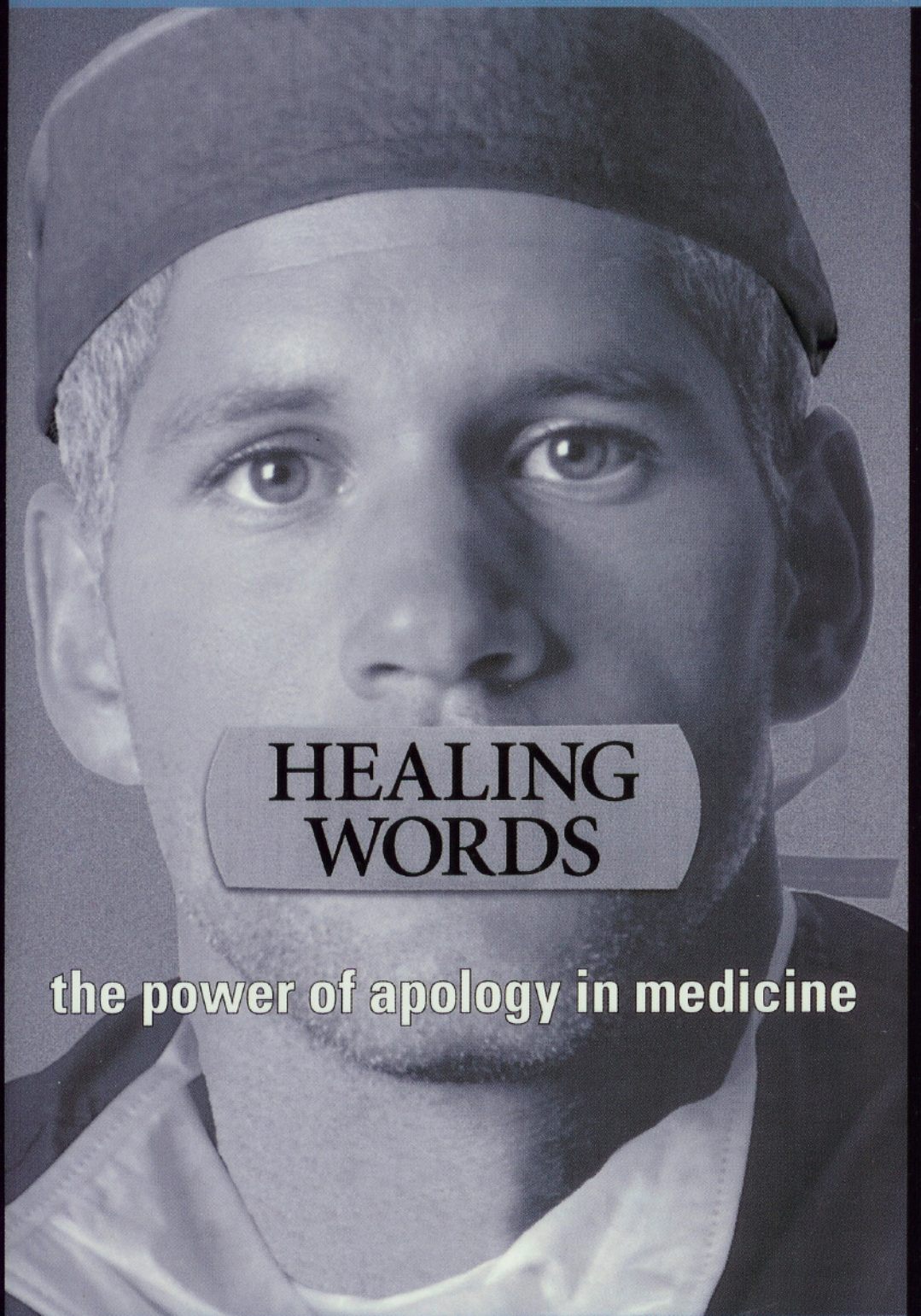

HEALING WORDS

the power of apology in medicine

MICHAEL S. WOODS, M.D.

HEALING WORDS

THE POWER OF APOLOGY IN MEDICINE

MICHAEL S. WOODS, M.D.

HILDA J. BRUCKER
CONTRIBUTING AUTHOR AND RESEARCHER

introduction

For every medical intervention there is an expected outcome. But there is also the possibility for unintended consequences. While it's comforting to believe modern medical science can perform miracles, the reality is that human bodies often react in unpredictable ways—even when the treatment is standardized and evidence-based.

In this book, I propose that when complications occur, physicians should apologize, offer ongoing care and support, and fully disclose all details to the patient. They should never breach the patient's trust and engage in the kind of cover-ups that have become all too common in healthcare today. This sort of unethical behavior demeans the practice of medicine and fosters a mindset that interferes with our ability to act effectively as healers.

I believe—and statistics support this—that, when dealt with honestly, respectfully, and compassionately, patients will accept an apology and choose not to litigate. Instead, they will accept a fair financial remedy that covers the costs of additional care made necessary by the complication.

What I'm proposing in this book is simple, but profoundly important. I'm encouraging my fellow physicians to practice a common courtesy played out on the street every day.

Just as a stranger automatically apologizes for unintentionally bumping into someone on a sidewalk, an apology should be the norm if a doctor is running late, interrupts a patient to take a phone call, misplaces a file—or initiates care that results in an unexpected or life-threatening outcome.

I believe most physicians long to do the right thing. When one of our patients is in pain, suffers an unanticipated outcome, or fails to respond to treatment, our hearts tell us to empathize, to reach out. Unfortunately, our profession has become increasingly deaf to the calls of the heart. Only we can change this situation.

A word of caution is in order. I believe that saying *I'm sorry* is the right thing to do, and this book contains accurate information on the value of apology in doctor-patient relationships as well as its ability to reduce malpractice claims. Despite this, some malpractice policies are written in such a way that physicians risk loss of coverage by offering an apology or information to a patient without getting prior clearance from the insurer. You must understand what your policy states concerning this issue before following my advice.

Finally, if this book fails to meet the expectations of the reader, I would like to say *I'm sorry* in advance.

Chapter One

reclaiming good medicine

I'm sorry is one of the most commonly used phrases in any language. Few others are applicable to such a wide range of situations. The simple apology is, in fact, something of a rhetorical catchall. It's spoken as a simple act of courtesy when reaching across another person for salt at the dinner table. It's presented as a plea to judges before sentencing is pronounced. It's offered as an expression of sympathy to the bereaved.

For most people, *I'm sorry* is spoken almost reflexively throughout the day to express respect, regret, compassion. Depending on the situation and the way it's said, an apology can be everything from a throwaway social nicety to a profound utterance from the heart.

Yet for us physicians, the words *I'm sorry* are among the hardest to pronounce. In our professional situation, they are fraught with serous ramifications and nuances that other people never have to consider. In many ways, they are words that separate us from the rest of the human race.

During our training, we are taught that we must be infallible—that we cannot make mistakes. Our educations drill into us that data are absolute, that facts allow us to explain outcomes in a linear fashion and figure odds with some

measure of precision. But no matter how much comfort we take in the scientific method, the simple truth remains that life is DUN: dynamic, unpredictable, and non-linear. Chaos theory demonstrates that the possibility always exists for unintended consequences. Thus, our schooling sets us up to deny the failure that is embedded in our discipline.

The simple truth remains that life is DUN: dynamic, unpredictable, and non-linear. Thus, our schooling sets us up to deny the failure that is embedded in our discipline.

As practitioners, insurers tell us that an apology might be interpreted as an admission of fault or negligence that could expose us to litigation. Some insurers will even void the policy of a doctor who apologizes to a patient in the wake of a complication or error.

So it's not surprising that the culture of medicine has evolved to be apology-avoidant. I propose that the health-care profession should take a fresh look at apology—why it is important, how to recognize when it is needed, and how it should be delivered. All of this must be examined within the context of "authentic apology"—that is, apology that is heart-felt and offered because it is the right thing to do—and not apology as a technique to manipulate and placate an angry patient to avoid a lawsuit.

As healers we must also recognize that apology is good medicine that has restorative powers. We must reclaim our right to say *I'm sorry*, because we owe it to our patients. They have a fundamental human need to hear an apology when something goes awry, whether it was directly caused by us or not. In the wake of a bad outcome, saying *I'm sorry* could be as helpful for the patient's—and the physician's—psychic healing process as antibiotics are for curing an infection. This simple but eloquent phrase of compassion is as essential to a doctor's medicine bag as the stethoscope and tongue depressor.

Ironically, despite the warnings of some insurers, data indicate that the likelihood of a lawsuit falls by 50 percent when an apology is offered and the details of a medical error are disclosed immediately. Considering our profession's urgent need to protect itself from medical malpractice liability and considering the near-anarchy over tort reform to limit jury awards, you'd think doctors would be eager to adopt a risk management strategy that offers a 50-percent reduction in litigation.

But unfortunately medicine's difficulty with apology is symptomatic of a much larger communication crisis in healthcare. The environment in which doctors operate today—both literally and figuratively—makes it difficult for us to maintain our focus on the very reason we entered the field in the first place: to serve humanity. We begin learning detachment from the moment we begin medical school, and that attitude is reinforced by a system that demands practicing physicians to see more patients in less time and to be wary of engaging with them in honest, open dialogue.

That's unfortunate, because the quality of our communication with patients affects every aspect of the care we provide. And it has a direct bearing on our job satisfaction as well.

Why Patients Really Sue Their Doctors

In 1993, Wendy Levinson, M.D., and her colleagues designed a research study they hoped would show a link between physician-patient communication and the risk of malpractice. They analyzed audiotapes of routine office visits with two groups of physicians: those who had never been sued and those with two or more malpractice suits filed against them.

Levinson found that the physicians with the best communication skills were also those who had not been sued. The former tended to ask more questions, encourage patients to talk about their feelings, use humor when appropriate, and educate patients about what to expect during treatment. These physicians also spent more time per visit with patients than those who had been sued. In fact, the length of office visits alone was strongly correlated with a physician's history of malpractice claims. How much extra time, on average, did the doctors who had never been sued spend with their patients? Three minutes.

Another group of physician researchers studied transcripts of legal depositions given by patients who had filed lawsuits. All of the transcripts included the question *Why are you suing the doctor*? The study concluded that 71 percent of the patient-plaintiffs had had problematic relationships with their physicians before the

incidents prompting the lawsuits. The researchers also identified four distinct factors underlying the suits:

- The patients felt their doctors had deserted them.
- The patients felt their doctors had discounted their concerns.
- The patients felt their doctors had not provided adequate information.
- The patients felt their doctors did not understand their (or their families') perspectives.

Some of the most dramatic evidence revealing the effect of the patient-doctor relationship on malpractice claims comes from Gerald Hickson, M.D., and his research group at Vanderbilt University Medical Center. They set out to examine the association between unsolicited complaints about a physician, as recorded by Vanderbilt's patient affairs office, and that same physician's malpractice experiences. The authors concluded that a relatively small number of physicians generated a disproportionate share of complaints. They also found that a history of numerous complaints was an indicator that a physician runs a higher risk of being sued. In their words:

> *Results are consistent with previously published research on the relationship between patients' dissatisfaction with care and malpractice claims. Patients who saw physicians with the highest number of lawsuits were more likely to complain that their physicians would not listen or return telephone calls, were rude, and did not show respect.*

Risk [of being sued for malpractice] seems not to be predicted by patient characteristics, illness complexity, or even physicians' technical skills. Instead, risk appears related to patients' dissatisfaction with their physicians' ability to establish rapport, provide access, administer care and treatment consistent with expectations, and communicate effectively.

Chapter Two

a case of failing to say *i'm sorry*

She was an extremely fit, slender, 24-year-old female who presented with classic symptoms of appendicitis: pain in the lower right abdomen, nausea, fever, and an elevated white blood count. After obtaining informed consent, I took her to the O.R. to do an exploratory laparoscopy, expecting it to result in laparoscopic appendectomy. Because I was operating in a teaching hospital, I allowed a third-year surgical resident to make the umbilical incision—not an unusual degree of responsibility for his position. His technique was not perfect and, after inserting the laparoscope, what we saw would make the heart of any surgeon skip a beat: an abdomen filling with blood from an injured artery.

We quickly converted to an open surgical procedure by making a full incision. A vascular surgeon soon arrived and controlled the accidental puncture wound with two stitches. We explored the patient's abdomen to ensure no other injuries had occurred, then performed the appendectomy and closed. Afterward, I spoke candidly with the family about what had happened, telling them this was obviously not a planned outcome or result. The patient

had a rough couple of days, and I had to admit her into the intensive care unit. Her hospital stay lasted nine days.

During follow-up visits, the patient was very concerned about the scar, despite the fact that it was healing fine—from my point of view. I offered to refer her to a plastic surgeon. On the third and final follow-up visit she complained that her "insides felt all jumbled up." Since this was a non-specific complaint from a scientific standpoint, I dismissed it with the simple reassurance that it would get better with time. I said she could call me with questions any time and discharged her from my care.

The next time I heard from her, it was in the form of a malpractice suit. I was incredulous! How could she do this when I had saved her life? After much discussion with my attorney and malpractice insurer, we decided to fight the case. I was delighted that we were going to defend and deny this claim. If I'd had any idea what was to come, I would not have been so gleeful.

The legal depositions began months after the actual events. As I grew increasingly anxious about the suit, I began to see my patients in a much different light than before. I perceived each one as a possible adversary. I began habitually working out strategies for defensive recordkeeping in my head, so I would be in an advantageous position in the event of another suit. My job was no longer about care; it was about defense. It was no longer about trust and open discussion with patients; it was about cautious commentary and limiting my exposure to risk.

On the first day of the trial, my retired parents, brother, several friends, and partner attended to provide moral support. I needed it. My introduction to trial law began with 45 minutes of opening arguments in which the plaintiff's counsel derided me for incompetence as well as disregard for truth and patient welfare. He told jurors that I had committed fraud and breached my duty as a physician. He didn't merely question my character. He annihilated it. By the end of the opening arguments, my head was reeling.

The plaintiff—my patient—testified to all sorts of things regarding her care, but it was her response to the question of why she had sued that absolutely floored me: *I sued because he acted like what happened to me was no big deal. One time when I saw him in the office after this happened, he actually put his feet up on the desk while we talked. He just didn't care.*

That comment hit me like the heat from a blast furnace. It wasn't the injury and outcome that had led to that miserable day in court—it was her perception that I didn't care. My actions had communicated apathy, and that was what had landed me in court, not the medical complication.

After two weeks of intense legal debate, we won the case. But although we prevailed in battle, I still felt as if I'd lost the war. The emotional trauma of the ordeal lingered long after the case was closed. My most difficult memory surrounding the event was the reaction of my father, a physician who had practiced for over 40 years without a single malpractice claim and the man I admire more than anyone else on earth. While my attorneys were congratulating each other, he approached me

and said: *I love you with all my heart, Mike, but if you ever have to go through this again, I will not be here. I will never again willingly listen to people talk about one of my children as they have talked about you these past two weeks. It is the hardest thing I have ever done, so please don't ever ask me to do this again.*

What did I learn from all this? I think the entire experience made me begin to ponder exactly how and when the entire medical profession had lost a very basic form of human kindness: the ability to offer a heart-felt, authentic *I'm sorry.*