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**All I Can Say Is “I’m Sorry!”**



**VIPC&S**  
***Partnering for Quality Conference***  
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## Road Map

- I. Background
- II. Hospital Disclosure Policies
- III. House Joint Resolution 101 (2008)
- IV. Joint Commission on Health Care Work Group
- V. House Bill 2057 (2009)
- VI. Next Steps



## **I. BACKGROUND**



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## Historical Perspective

- **Discussions of failed interventions historically were an important educational tool for the development of medicine**
- **Over time physicians became fearful of discussing unsuccessful outcomes due to:**
  - **Threat of being sued**
  - **Misuse of peer review as a disciplinary mechanism**

Report on the Council of Ethical and Judicial Affairs, American Medical Association (2003)



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## Incentives for Disclosure

- **Rebuilds trust and solidifies the provider-patient relationship**
  - **Result: Decreased malpractice litigation and overall costs**
- **Allows the hospital to correct mistakes and prevent future harm**
  - **Result: Patients' increased confidence in the integrity of the health care system**



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## Incentives for Disclosure

- **Creates a culture of transparency and accountability where medical errors can be identified and corrected**
  - **Result: Further support for the patient safety movement**
- **Staves off health care from becoming the next Enron or AIG of public opinion and journalistic convictions**



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## State Disclosure Laws

- **Approximately five states now mandate disclosure of serious adverse events to patients**
  - PA, NE, NJ, FL, VT
- **Pennsylvania, Florida and Nevada require written notification to the patient**

Liebman CB, Hyman CS. A mediation skills model to manage disclosure of errors and adverse events to patients. *Health Affairs*. 2004;23:22-32.



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## Adverse Event Reporting Laws

- **As of January 2008, 26 states had hospital adverse reporting systems and another state had taken action to develop one**
  - **23 states reported using data to hold individual hospitals accountable**
  - **18 states reported using data to promote learning and prevent adverse events**

*Adverse Events in Hospitals: State Reporting Systems, United States Office of Inspector General (2008)*



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## **AMA Position on Disclosure**

***“Physicians must offer professional and compassionate concern toward patients who have been harmed, regardless of whether the harm was caused by a health care error. An expression of concern need not be an admission of responsibility. When patient harm has been caused by an error, physicians should offer a general explanation regarding the nature of the error and the measures being taken to prevent similar occurrences in the future.”***

***Opinion 8.121, AMA Code of Medical Ethics***



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## JCAHO Requirements

Requires a patient and when appropriate, his or her family, be informed about *“unanticipated outcomes of care, treatment, and services that relate to sentinel events considered reviewable by the Joint Commission”*

*RI.2.90, Comprehensive Accreditation Manual*



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## Virginia BOM Regulations

***“[...] a practitioner shall accurately inform a patient or his legally authorized representative of his medical diagnoses, prognosis and prescribed treatment or plan of care.”***

***18VAC85-20-28, BOM Regulations***



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## Patient's Perspective

- Don't lie
  - “Honesty and sincerity are always the best policies”
- Refrain from blocking patients' access to their records
  - “Any challenge to the release of a record will probably raise a red flag for the patient and is, at a minimum, a psychological indicator that the physician cannot be trusted”



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## Patient's Perspective

- Remember that patients bring their past personal experiences to their health care
  - “Don’t assume that patients are ignorant to their health or are ill-educated about the condition from which they suffer”
  - “Remember that patients know their bodies best”
- When treating a patient, imagine the face of a loved one on the shoulders of that patient



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## **II. HOSPITAL DISCLOSURE POLICIES**



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## Hospital Disclosure Policies

- Many of the hospitals and health systems pioneering the implementation of disclosure policies were systems where the hospital, their employees, and their physicians were insured by the same professional liability insurer or self-insured plan



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## Hospital Disclosure Policies

- **More recently, hospitals staffed by independent physicians have begun to consider disclosure policies**
  - **Involvement of private practice physicians, employed physicians, and senior administrators has become essential**
- **Changes in hospital staffing have made it prudent for hospitals and health systems to follow certain steps in implementing their disclosure policies**



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## **Recommended Steps**

- **Seek input from the professional liability carriers who insure private practice physicians on the medical staff**
- **Have the medical executive committee thoroughly vet the disclosure policy**
  - **Avoid perception that “this is something administration is forcing upon the medical staff”**
- **Schedule a process to annually review the disclosure policy and assess disclosures made in the previous year**



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## Drafting an Effective Policy

- **State the policy in positive, proactive terms**
  - “It is the policy of Prince William Hospital that patients be treated with openness and honesty at all times, and that their right to know their medical status is respected.”
- **Include clear definitions for any terms used within the policy that may be ambiguous**
  - Ex. adverse event, unanticipated outcome, medical error



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## Drafting an Effective Policy

- Include procedural steps for disclosure conversations and conflict resolution
- Include circumstances where disclosure may not be appropriate
  - “The rare exception to this policy would be if the [...] Physician in conjunction with family members determines it would be injurious to the patient’s emotional well being to receive disclosure information.”



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### **III. HOUSE JOINT RESOLUTION 101** **(2008 – Delegate John O’Bannon)**



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## HJR 101

- **Legislation introduced in 2008 by Delegate John O'Bannon (R-Henrico) at the request of the VBA**
- **Directed the JCHC to *“study the use of disclosure, apologies, alternative dispute resolution, and other measures in the case of medical errors and adverse medical outcomes and the impact of such measures on the cost and quality of care, patient confidence, and the medical malpractice system”***



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## **HJR 101**

- **Legislation did not pass, but agreement among the VBA and Joint Commission on Health Care to study the issues raised in HJR 101 led to the formation of a work group**



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## **IV. JOINT COMMISSION ON HEALTH CARE WORK GROUP**

**<http://jchc.state.va.us>**

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## JCHC Work Group

- **Group of stakeholders included:**
  - **Medical Society of Virginia**
  - **Virginia Hospital and Healthcare Association**
  - **Virginia Trial Lawyers Association**
  - **Virginia Association of Defense Attorneys**
  - **Office of the Attorney General**
  - **Medical Liability Insurers**
- **Began meeting in the summer of 2008 to outline the work group's goals and objectives**



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## Study Focus

- Advise the JCHC on the prudence of fostering disclosure and dispute resolution discussions with patients and their families in instances when an adverse event has occurred; consider:
  - An improvement in quality of care
  - An increase in patient and provider satisfaction
  - Achievement of fair and timely economic resolutions
  - An improvement in patient trust and confidence in the health care system



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## JCHC Work Group

- **Component issues**
  - Define terms related to disclosure
  - Clarify the nature and scope of disclosure and privilege
  - Determine the most effective processes in medical error situations
  - Determine how to foster disclosure/resolution and what protections are appropriate to serve the patient and provider



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## JCHC Work Group

- Identified terms related to disclosure and developed/identified potential definitions
  - Unanticipated outcome
  - Adverse event
  - Adverse medical event
  - Sentinel event
  - Medical error
  - Medical accident
  - Undesirable event
  - Serious event



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## JCHC Work Group

- **Discussed the pros and cons of disclosure**
  - Ethical considerations
  - Patient safety
  - Legal considerations
- **Reviewed numerous definitions of “disclosure” and the related term “apology”**
- **Reviewed potential disclosure processes that would meet patient, provider, and system needs**



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## JCHC Work Group

- **Identified basic elements of disclosure process**
  - Pre-disclosure
    - Investigate to determine what happened and report to appropriate staff
  - Disclosure
    - Explain what happened, describe probable effects, issue an apology, assure analysis and follow-up are done
  - Post-disclosure
    - Document steps and debrief practitioners/staff



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## JCHC Work Group

- Discussed how each step in the disclosure process would be protected
- Determined two points in the disclosure process where privilege is an issue:
  - Initial internal report done to determine what occurred
  - Actual disclosure to the patient/family
- Discussed expanding apology statute or creating a new statute to include privilege for disclosure to a patient



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## JCHC Work Group

- Agreed that adoption of a state law to protect privilege is the threshold issue for motivating providers to develop disclosure programs
  - Assessed increased concern among providers given the Johnson v. Riverside decision
- Agreed that early mediation was the most promising process to address patient and provider needs in medical error situations and warrants further study



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## **JCHC Work Group**

- **Determined that empirical evidence is insufficient to support a mandatory disclosure requirement in state statute**
- **Decided that disclosure programs must be voluntary in order to accommodate:**
  - Individual nature of provider-patient communications
  - Varying levels of expertise in having disclosure discussions



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## **JCHC Work Group**

- **JCHC staff prepared an initial 21-page report outlining the work group's findings and discussions**
  - **Work group was unable to conclude that Virginia should take action to mandate or foster disclosure programs at this time**
  - **Recommended that a task force of stakeholders be convened after the 2009 Virginia General Assembly Session to study the issue further**



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## Recommendations for Task Force

- Charged the task force with:
  - Developing definitions for key terms such as *adverse outcome*, *medical error*, and *disclosure* in order to facilitate discussions
  - Tracking results and developments in disclosure and resolution programs in Virginia and other states, as well as at the federal level



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## **Recommendations for Task Force**

- **Crafting a model or models for disclosure and early resolution programs that could be used by health care providers, insurers, and attorneys**
- **Considering ways to incentivize health care providers to use such models and report outcomes of their use with regard to cost, claims experience, impact on quality/patient safety efforts, and reported patient/provider satisfaction**



**V. HOUSE BILL 2057**  
**(2009 - Delegate Phil Hamilton)**



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## **House Bill 2057**

- **Medical Society of Virginia engaged an expert to review Virginia’s malpractice laws given the looming medical malpractice cap debate**
- **The expert suggested broadening Virginia’s “I’m Sorry” statute to make it consistent with similar statutes in other states**
  - **Could favorably impact claims frequency and liability insurance premiums**



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## House Bill 2057

- **36 states have adopted apology laws**
  - **28 states protect only expressions of sympathy, regret, or condolence (includes Virginia)**
    - Ex. “I’m sorry about your mother’s situation.”
  - **8 states protect expressions of sympathy and admissions of fault**
    - Ex. “I’m sorry, I screwed up.” OR “Things might have turned out better had I been more up to date on current treatment options.”

McDonnell WM. Guenther E. Narrative Review: Do state laws make it easier to say "I'm sorry?" *Ann Intern Med.* 2008;149:811-815.



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## **House Bill 2057**

- **Legislation introduced in 2009 by Delegate Phil Hamilton (R-Newport News) at the request of the MSV**
- **Originally expanded the list of expressions of sympathy that are inadmissible in medical malpractice actions and permitted providers to give explanations of untoward events without legal repercussions**



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## House Bill 2057

- Legislation was amended at the request of the VTLA to exclude the language permitting explanations
- List of expressions of sympathy that are inadmissible was expanded to include:

*“commiseration, condolence, compassion, or a general sense of benevolence, together with apologies that are made by a health care provider”*

*Va. Code §§ 8.01-52.1 and 8.01-581.20:1*



## **VI. NEXT STEPS**



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## Next Steps

- **Still need to address the ability of physicians to provide their patients or their patients' representatives with an “explanation” following an adverse outcome**
  - **An increasing number of physicians are expressing interest and support for measures which enhance communication with their patients or their patients' representatives**



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## *Questions?*





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