

# Full Disclosure and Apology—An Idea Whose Time has Come

By Lucian L. Leape, MD

**One of the groundbreaking trends set in motion by the famous Institute of Medicine reports of 2000 and 2001<sup>1,2</sup> and promoted by a growing number of patient advocacy groups is increasing transparency in all aspects of health care.**

Perhaps the most important manifestation is the call for full disclosure following an adverse event. While both the Joint Commission on Accreditation of Healthcare Organizations and the American Medical Association call for informing the patient when complications occur, what takes place in practice is often less than “full” disclosure. Why is this, and what do hospitals need to do?

What hospitals need to do is develop and implement policies that ensure that all patients who are harmed by their treatment receive timely, open, complete information on the causes and circumstances that led to their injury, delivered in a compassionate manner by the responsible caregiver. When the injury results from an error or system breakdown, the response should include an apology and restitution.

The arguments for such an approach are both theoretical and practical. The theoretical argument has two pillars: ethical and therapeutic.

The ethical case is straightforward and rarely challenged: the patient has a right to know what happened. Conversely, hospitals and physicians or nurses have no right, morally or legally, to withhold information from patients.

Just as patients are entitled to know all the results of laboratory tests, opinions from consultants, risks of treatment and alternative therapeutic options, they are entitled to know what the causes of the breakdown are when things go wrong. It is also what each of us would want for ourselves. We want to know what went wrong, why, and what will be done to prevent it from happening again.

Full disclosure is the right thing to do. It is not an option; it is an ethical imperative.

The therapeutic argument is also simple and straightforward: full disclosure is essential for healing.

## IN THIS ARTICLE...

Examine some persuasive arguments that support full disclosure and apologies for medical errors and learn the key steps hospitals need to take.

Curiously, for the healing professions, this aspect of disclosure is frequently overlooked in the obsession with liability. But the evidence is clear that a serious preventable injury causes severe emotional trauma. The patient was wounded by those he or she trusted for care.

Unfortunately, on the surface, in the absence of other information, for the patient the accident may appear to have resulted from lack of caring, from not being careful.

The incident damages the patient’s trust—in the physician and in the institution. If it is not openly and honestly dealt with, trust is irrevocably destroyed and the patient will be psychologically scarred for life.

The doctor-patient relationship also suffers, for it is based on trust. Trust is based on truth. If there is silence, or dissembling, or incomplete information (partial “truths”), trust crumbles, both in the physician and in the institution.

The only treatment, the only way trust can be restored and the patient begin to heal, is for the caregiver to acknowledge the error, take responsibility—and apologize.

## Apology vs disclosure

The case for apology is very different from that for disclosure. Apology is not an ethical right, but a therapeutic necessity. Apology makes it possible for the patient to recognize our humanity, our fallibility, our remorse at having caused harm. It “levels the playing field.” It makes it possible for the patient to forgive us.

Apology is necessary for healing, for “getting over it.” It doesn’t always work. Sometimes the patient’s anger is too great for forgiveness. But healing cannot occur without it. To be effective, it must be a true apology, in which the caregiver takes responsibility for the event and shows remorse and a desire to make amends.

"I'm sorry this happened to you," is no substitute, for it lacks responsibility and remorse. Making amends should include reimbursement for expenses as well compensation for long-term disability.

Apologizing is also necessary for healing of the doctor or nurse who made the error. They, too, are emotionally traumatized. They are the "second victims," devastated by having been the unwitting instrument that seriously harmed another. They feel shame and guilt that sometimes can be overwhelming.

Apologizing, expressing their remorse and desire to make amends, can lead to forgiveness and healing for them as well. So apology is a balm for both the patient and the caregiver. It heals their psychological wounds.

### **Can we afford it?**

The practical arguments for open and complete communication, with apology and restitution, are that it is effective treatment for patient and doctor and that it is less costly for all parties.

For decades, lawyers and risk managers have claimed that admitting responsibility and apologizing will increase the likelihood of the patient filing a malpractice suit and be used against the doctor in court if they do sue.

However, this assertion, which on the surface seems reasonable, has no basis in fact. There is to my knowledge not a shred of evidence to support it. It is a myth.

The reality, in fact, appears to be just the reverse. Patients are much more likely to sue when they feel you have not been honest with them. There now are several experiments under way—the Veterans Administration, University of Michigan, COPIC in Colorado—where full disclosure and small early settlements have resulted in dramatic reductions in suits and in



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payouts. These need to be expanded and replicated in other locations.

Again, the ethical argument is clear: patients should not have to bear expenses caused by our mistakes. From a practical standpoint, the figures are encouraging.

In the 1990 Harvard Medical Practice Study in New York state, it was found that compensating all patients with disabling injuries for their out-of-pocket expenses would cost less than liability insurance premiums paid by doctors and hospitals.<sup>3</sup>

A no-fault compensation system was recommended. While this has yet to happen, the experience at the VA, Michigan, and COPIC provides further evidence of its feasibility.

### **Barriers to disclosure**

Why does full disclosure so often not occur? Why do so many patients fail to receive a full and truthful explanation of what went wrong and hear their caregiver accept responsibility and apologize? The reasons are many and complex, but several stand out.

First, apologizing is hard to do—for anyone. As we all know, it is difficult in non-medical situations, even when the “injury” is merely a slight or an insult. But a medical apology is much more difficult.

The harm we have caused is physical and may even be disabling or fatal. The more serious the injury, the more difficult it is to apologize. Showing sympathy (“I’m sorry you were hurt.”) is much easier, but lacks the essence of true apology, which is to take responsibility for the harm and express true remorse.

In fact, because it seems to specifically communicate no responsibility or remorse, some believe it can be, paradoxically, more harmful than no expression of concern.

Second, the injury was not intentional. The doctor or nurse didn’t harm the patient on purpose. It was an accident, due to an error, not a deliberate act. Even though the caregiver may feel bad for the patient, and chagrined, it was an “honest mistake.”

Third, many physicians lack the skills, which are considerable, to present bad news well. We haven’t been trained to control our own emotions while we try to handle patients’ anger, frustration and disappointment.

But probably the most important reason caregivers don’t readily admit errors and apologize is shame and fear. Shame at failing to live up to our own and the patient’s expectations of perfection. Fear of the consequences: loss of the patient’s trust, loss of respect of colleagues, the risk of being sued.

These rational fears have been fed and amplified by bad legal advice that ignores the emotional consequences of injury for both patient and caregiver. Indeed, hospital lawyers and insurance companies sometimes demand that doctors and nurses not admit responsibility or apologize following a pre-

ventable adverse event. Fortunately, that is changing.

## Moving ahead

What should hospitals do? It is time to take our focus off self-protection and put it on our mission, which is patient care.

Leaders have an obligation to their patients and to their staff to help heal the emotional trauma that follows a serious adverse event. The core is to establish effective methods for disclosure, apology and support. To do this, leaders have to set expectations, provide training, and provide support systems for patients and personnel.

First, set expectations. Hospital policy should be clear and unequivocal (and in writing): patients are entitled to a full and compassionate explanation when things go wrong. Usually, this will be the responsibility of the patient’s physician, although nurses, pharmacists and others should be involved when appropriate. The policy also should include providing apology when indicated.

Second, doctors and nurses, as well as risk managers and other support personnel, need training in communicating with patients after adverse events. They also need training on how to support colleagues when they are “second victims.”

Third, support systems need to be developed for all parties. Patients need help after an event, including after discharge from the hospital. We also need to provide support and “just-in-time training” to help the physician communicate with the patient following the event. And we need to help these second victims deal with their emotional trauma. Professional and peer support systems must be developed.

Finally—and this is the tough part—after enlisting full support of the boards of trustees, hospital leaders need to insist that liability carriers provide early settlements for

injured patients.

Making amends, financial or otherwise, is intrinsic to a meaningful apology. No patient should have to sue to receive a just settlement. The amounts required are often surprisingly small. But they should be sufficient to meet the actual expenses, and should be given freely, not grudgingly, as true reparations.

The new world of transparency can be daunting, requiring substantial changes in many of our practices and ways of thinking. The benefits for our patients, and for ourselves, can be tremendous.



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