Beyond Apology to Early Non-Judicial Resolution: The MedicOm Program as a Patient Safety-Focused Alternative to Malpractice Litigation

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Scenario #1: An unanticipated adverse outcome occurs leading to a patient death. The medical staff remains silent, and refuses to discuss what happened with the family. The grieving, angry, and mistrustful family sues. Regardless of who wins the lawsuit, the family remains spiteful and heartbroken; the hospital, with a sense of inevitability, awaits the next catastrophe.

Scenario #2: An unanticipated adverse outcome occurs leading to a patient death. A Medical Ombuds/Mediator is called in by the provider to meet with the family to express her and her organization's concern and condolences, coach the provider in preparation for a disclosure conversation, and continue to be the compassionate face of the organization to provide answers to the inevitable questions that will arise. Next, an autopsy is performed and the Medical Ombuds/Mediator facilitates the meeting between the providers and the families to understand what happened to their loved one and why. Co-morbidities and extenuating factors are explained. A systems failure is identified, a full apology with responsibility is offered, and the hospital pledges to make immediate changes to prevent further recurrences, keeping the family notified as the changes are institutionalized. No lawsuit results.

Which scenario do you think is more typically played out in the majority of hospitals across the United States? Which would you prefer if you or your family member were involved? Which would be better for the hospital in the long run? Which would lead to an improvement in patient safety, and which would result in similar errors being repeated? Evidence is mounting that the historical status quo of "deny and defend" must give way to alternative methods of responding to unanticipated adverse outcomes, including medical errors. The Institute of Medicine (IOM) estimated in 1999 that more than one million preventable adverse events occur each year in the United States, of which 44,000 to 98,000 are fatal.[2] This death toll, equivalent to two jumbo jets crashing to the earth every three days, goes relatively unnoticed because these deaths occur one at a time in places where death is not unexpected. In addition to enormous monetary costs ranging from $17 billion to $29 billion annually (for lost income, disability, and related healthcare expenses), medical errors result in immeasurable non-monetary costs such as "loss of trust in the [medical] system by patients and diminished satisfaction by both

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[2] LINDA T. KOHN ET AL., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 2 (National Academy Press 2000).

patients and healthcare professionals."[3] Patients may experience physical and psychological pain after errors, and become less likely to trust their caregivers in the future.[4] Nor are providers immune from the harmful effects. They may experience psychological distress, frustration, loss of morale, and fears about the impact that their mistake will have on the way colleagues judge their ability.[5]

The costs of disputing unanticipated adverse outcomes–of pursuing and defending medical malpractice actions–are phenomenal. While total yearly malpractice premiums paid by physicians, hospitals, and other healthcare providers are a presumably significant unknown, reported medical malpractice tort costs (losses, defense costs, and administrative expenses) totaled $30.3 billion in 2006, up from $29.4 billion in 2005.[6] One recent study which examined nearly 1,500 closed claims found that the overhead costs associated with medical malpractice were exorbitant, averaging fifty-four percent of the compensation paid to plaintiffs.[7] Moreover, even though sixty-three percent of the examined claims were found to have involved real injuries associated with error, patients and their families waited an average of five years from claim to resolution while defendants had to endure the uncertainty of litigation for the duration.[8] The authors, a consortium of well known physicians and researchers from the Harvard School of Public Health tasked to examine the state of "frivolous litigation" in the malpractice field; they discovered that the number of meritorious claims that did not get paid was actually larger than the group of meritless claims that were paid.[9] They further found that the popularly asserted claim that frivolous litigation was driving up the costs of healthcare was overblown, and concluded by stating:

> Our findings suggest that moves to curb frivolous litigation, if successful, will have a relatively limited effect on the caseload and costs of litigation. The vast majority of resources go toward resolving and paying claims that involve errors. A higher-value target for reform than discouraging claims that do not belong in the system would be streamlining the processing of claims that do belong.[10]

Given these tangible and intangible costs, managing unanticipated adverse outcomes in health care is of critical importance. In institutions that offer no alternative to litigation for redress after a medical error, litigation is a likely result for those who wish to pursue some sort of remedy, although relatively few victims of medical errors actually sue and only a very small subset of those are victorious in the win-lose arena of

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[3] *Id*.
[4] *Id*.
[5] Thomas A. Gallagher et al., *Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors*, 289 JAMA 1001, 1005 (2003).
[6] Tillinghast-Towers Perrin, *2007 Update on U.S. Tort Cost Trends*, App. 5 at 19 (2007), http://www.towersperrin.com/tp/getwebcachedoc?webc=TILL/USA/2007/200712/tort_2007_1242007.pdf.
[7] David M. Studdert *et al., Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 N. ENGL. J. MED. 2024, 2031 (2006). Note: the 54 % includes attorney's contingent fees of 35 % and without this information the number is inaccurate.
[8] *Id*.
[9] *Id*. at 2024.
[10] *Id.* at 2032.

the judicial system.[11] What if litigation were not the only way for patients and families to feel treated fairly after a bad outcome in a healthcare setting? What if people could achieve fair, honest, and equitable ends without going to court? In the litigious society to which Americans have grown accustomed, a feeling of being wronged by a healthcare provider often makes both providers and families suspicious, mistrusting, [12] and fearful of the other. Emotions run high, communication is stilted, and distrust leads to further distancing between caregivers and patients.[13] This breakdown of civility, of indeed the entire system that is currently in place to respond when people are harmed in the course of receiving healthcare, contributes to patients and families who have grievances with a hospital or physician to seek recourse through the legal system, feeding a perpetual cycle of litigation and distrust.[14] This status quo is not acceptable. Vast system redesigns are necessary in order to change the healthcare culture from one caught in this cycle of error, fear, blame and shame, into one based on mutual respect, communication, trust, and patient safety.[15]

A Medical Ombuds/Mediator (MedicOm) program offers one such system redesign for changing the way that adverse outcomes are managed within health care institutions. First implemented at the National Naval Medical Center in Bethesda, Maryland in 2001, the MedicOm program is premised on the notion that both providers and patients are capable, willing, and, in many cases, would prefer to resolve conflicts arising during patient-provider interactions in a non-adversarial way, if given the opportunity.[16]

Several studies indicate that ineffective communication with patients and families, rather than quality of care, is the underlying cause of patients' and families' decisions to file suit against their caregivers.[17] Gallagher found that most patients would be less angry and less likely to sue if the physician honestly and compassionately disclosed the medical error that occurred, admitted responsibility, took steps to reduce the chances of a repeat error in the future, and offered a sincere apology for the suffering that may have resulted because of the bad outcome.[18] Research on apology-making suggests that individuals receiving a full apology expressing sympathy by the person that wronged them are more likely to accept settlement offers and negotiate towards a resolution rather than going to trial.[19] Further, research indicates that physicians about whom patients

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[11] Thomas Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients. Results of the Harvard Medical Practice Study I"*, 324 N. ENGL. J. MED. 370 (1991); *see also* A. Russell Localio et al., *Relation between Malpractice Claims and Adverse Events due to Negligence: Results of the Harvard Medical Practice Study III*, 325 N. ENGL. J. MED. 245 (1991).

[12] Jonathan R. Cohen, *Toward Candor after Medical Error: The First Apology Law*, 5 HARV. HEALTH POL. REV. 21, 22 (2004).

[13] *Id. at 22-23.*

[14] *Id*.

[15] Kohn et al., *supra* note 2, at 5-7.

[16] Carole Schneider Houk & Barbara I. Moidel, *Integrated Conflict Management Systems in Health Care: A Practical Innovation Whose Time Has Come*, 2 ACRESOLUTION 30 (2003).

[17] Charles Vincent et al., *Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 LANCET 1609, 1612 (1994); s*ee also* Gerald Hickson *et al*., *Factors that Prompted Families to file Malpractice Claims Following Perinatal Injuries*, 67 JAMA 1359 (1992).

[18] Gallagher, *supra* note 5, at 1004.

[19] Jennifer K. Robbennolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 MICH. L. REV. 460 (2003).

complain of rudeness, lack of respect, failure to listen, and non-responsiveness to patient concerns are the same physicians facing the highest rates of malpractice lawsuits.[20] This data suggests that a system to foster and support physicians' ability to communicate honestly and apologize sincerely may have a deep impact on the way patients and families respond when a medical error takes place.[21]

If patients and families desire open, honest communication, why have physicians been shying away from it? On one hand, there are fears of legal repercussions. In federal courts and in all but a handful of states, apologies are admissible against the declarant; physicians are therefore instructed by their lawyers not to apologize.[22] While these concerns can be alleviated by changes in laws, such as state laws barring admission of apologies, some fears do not have their genesis within the legal system. For example, physicians may have a fear "of looking bad in front of colleagues, of facing one's own imperfections, of reprisals from hospitals, of rising malpractice insurance costs, and of having to communicate this emotionally charged subject to angry patients and their families," which have added up to decisions to avoid honest, sincere truth-telling and apologies.[23]

The concerns and fears that undermine healthcare providers' abilities to communicate openly and honestly have contributed to this cycle of repeated medical errors and malpractice litigation. Consequently, institutions can benefit greatly from a system that encourages physicians and staff to engage in open and honest communication with patients and families. This is the underlying theory behind the MedicOm program, that improved communication premised on honesty, transparency, and compassion as well as an integrated conflict management system supported internally by the institution, can improve the way that organizations respond to the adverse outcomes that will inevitably occur. It is that response – compassionate, humane, and just – that the organization has responsibility for and control over. It is also just the response that is not currently meeting people's underlying needs.

A MedicOm program provides neutral, independent, and confidential conflict management experts who assist both patients *and* providers in addressing concerns about unanticipated adverse outcomes, medical errors, provider-patient communication breakdowns, and dissatisfaction with treatment outcome or quality of care.[24] It offers an approach to conflict resolution that is quicker and more respectful than litigation, utilizing organizational ombuds and mediation techniques to rapidly intervene after an unintended outcome occurs.[25] An institution with a MedicOm program in place can

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[20] Gerald B. Hickson et al., *Factors that Prompted Families to File Medical Malpractice Claims Following Prenatal Injuries*, 267 JAMA 1359, 1361 (1992).
[21] Wendy Levinson, et al. *Physician-Patient Communication: the Relationship with Malpractice Claims among Primary Care Physicians and Surgeons*, 277 JAMA 553 (1997).
[22] *See* Robbennolt, *supra* note 19.
[23] Joint Commission on the Accreditation of Healthcare Organizations, *Disclosing Medical Errors: A Guide to an Effective Explanation and Apology*, Joint Commission Resources 2 (2007) (citing S. Fein, et al., *A Conceptual Model for Disclosure of Medical Error*, Agency for Healthcare Research and Quality (2005)); A. Kachalia, et al., *Does Full Disclosure of Medical Errors Affect Malpractice Liability? The Jury is Still Out*, 29 JOINT COMMISSION J. ON QUALITY & SAFETY 503 (2003); Rae Lamb, et al., *Hospital Disclosure Practices: Results of a National Survey*, 22 HEALTH AFF. 73-83 (2003).
[24] Bonacum et al., *Communicating About Episodes of Harm to Patients, in* Michael Leonard et al., *Achieving Safe and Reliable Healthcare: Strategies and Solutions* 104 (2004).
[25] *Id*.

coach or assist providers in conversations with patients and families where emotions run high, and where an apology may be in order.[26] In every instance of an unintended adverse outcome, personal acknowledgement of the pain and suffering that individuals are going through is the starting point as both informal and formal investigations begin to ascertain a causality.[27] Information is shared as it is obtained, and conjecture and uncertainty are kept to a minimum.[28] Understanding what happened close in time to the event can prevent litigation from being used as a way to acquire information and may further reduce the filing of meritless claims.[29]

The systemic changes that a MedicOm helps to create impact institutional culture by encouraging greater transparency and promoting open communication.[30] A hospital cannot fix something it does not know about. A MedicOm permits individuals to acknowledge error in a way that maximizes confidentiality and security, helps to pinpoint system vulnerabilities and encourages collaboration among medical care professionals to prevent further error by promoting a culture of safety in healthcare practice.[31] A MedicOm does not displace or replace any function, but is a facet of a larger organizational conflict management system that may involve Hospital Administration, Medical Staff, the Ethics Committee, Risk Management, Patient Safety, Quality Improvement, Peer Review, and Legal Claims.[32]

Programs such as MedicOm serve an important purpose in reaching the goals outlined in the Institute of Medicine report, *To Err is Human*, which are intended to fix the broken medical error management structures in the United States.[33] The program can contribute to a much needed "safety system" with the flexibility and informality to modify its procedures and practices in order to address the specific needs of a given case.[34] Further, the MedicOm program provides services which are in line with the guidelines for change outlined in a white paper by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to help guide institutions in making the changes recommended by the IOM report.[35] Traditional approaches to dealing with unanticipated adverse outcomes invoke organizational bodies which manage quality, peer review, risk management, patient safety, and legal systems, all of which may take considerable time and do not necessarily assist the patient or physician through the difficulties of the situation. The MedicOm model, by contrast, offers the emotional, personal, and institutional support to physicians, staff and the healthcare institution to see that amends are made, conflicts are resolved, errors are reported and lessons learned and applied. MedicOm provides alternative mechanisms for compensating injured patients, resolves disputes, and helps to take some of the burden off of individuals and onto institutions for

[26] *Id.* at 105.
[27] Joint Commission on Accreditation of Healthcare Organizations, *supra* note 23, at 25.
[28] *Id.*
[29] *See* Studdert, *supra* note 7, at 2030-31.
[30] Bonacum *supra* note 24, at 107.
[31] *Id*.
[32] Bonacum *supra* note 24, at 104-05.
[33] Kohn, *supra* note 2.
[34] Kohn, *supra* note 2, at 6.
[35] Joint Commission on Accreditation of Healthcare Organizations, *Health Care at the Crossroads: Strategies for Improving the Medical Liability System and Preventing Patient Injury* 31 (2005).

a systemic analysis once an error has taken place.[36] System-wide changes such as those embodied in the MedicOm program are reflective of the recommendations by prominent authorities such as the IOM and JCAHO, indicating that healthcare institutions ought to further explore such opportunities in order to reform their medical error management systems.

Evidence is beginning to emerge to support the utility of the MedicOm program. At the National Naval Medical Center, the Ombuds/Mediator is completing her seventh year as an internal, designated neutral that handles patient-provider conflicts and is supporting an expansion of the program into other large Naval medical centers. Numerous lessons learned from hundreds of cases have been analyzed and translated into recommendations to facilitate improvement in patient care delivery and to reduce future medical errors.[37]

A program based on the MedicOm model was adopted by Kaiser Permanente, the nation's largest not for profit Health Maintenance Organization, in order to offer more equitable and integrative solutions to injured patients and their families after an unanticipated outcome has occurred.[38] In building this program at Kaiser Permanente, more than 11,000 physicians and other health professionals were trained in communication skills that encouraged honesty, empathy and sympathy, including how to acknowledge the effects that the adverse outcome might have on patients and families as well as to apologize personally when appropriate.[39] Beginning in 2003, a Healthcare Ombuds/Mediator program was created in nearly every one of Kaiser Permanente's medical centers to act as coaches for physicians, and to aid them in strategizing what and how they will communicate to families in difficult situations.[40] These Ombuds/Mediators then act as shuttle diplomats or "go-betweens" to check in with patients and families to see that their needs and questions are being taken care of appropriately. It should be noted that in both the Navy's and Kaiser Permanente's program, the MedicOm gets involved in cases of unanticipated adverse outcomes whether there is negligent involvement or not, responding compassionately and helping patients, families and providers get answers to the critical questions of what happened and why. It is estimated that by investing in this program Kaiser is saving significant legal fees associated with litigation which would have resulted in the absence of the Ombuds/Mediator program.[41]

Saving litigation costs was a side effect rather than a motivating cause for Kaiser Permanente's leadership because there were fears that open disclosure and apologies might increase rather than decrease claims.[42] The Healthcare Ombuds/Mediator program was put in place at Kaiser Permanente "to help ensure that their members' quality-of-care concerns are addressed in a timely, empathetic and honest manner."[43] The motto for their program, "do the right thing," allows people's needs to be surfaced and met in real time,

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[36] *Id*.
[37] Houk & Moidel, *supra* note 16, at 31.
[38] Joint Commission on Accreditation of Healthcare Organizations, *supra* note 23, at 23.
[39] *Id*.
[40] *Id.*
[41] Patrick J. Kiger, *The Art of the Apology*, 83 WORKFORCE MGMT. 57, 58 (2004).
[42] Joint Commission on Accreditation of Healthcare Organizations, *supra* note 23, at 26.
[43] Tracey Walker, *Advocacy with Compassion: Dorothy Tarrant's Role as Healthcare Ombudsman/Mediator Places Her at the Nexus of Patient-Provider Interaction*, 16 MANAGED HEALTHCARE EXEC. 34, 36 (2006).

and trends of concern to be responsibly raised and addressed. Equally as important, it provides a neutral, independent and confidential resource to Kaiser Permanente providers to ensure that issues are fairly resolved and to help address their needs and interests as well–a true advocate for a fair process which is the foundation of all organizational ombuds.[44] After many years of handling literally thousands of cases, the evidence now clearly supports that patients and families who are harmed by unanticipated outcomes have the same basic trio of needs: honesty and information in real time, close to the event rather than after a lengthy investigation; an acknowledgement of their pain and suffering and an apology if warranted; and an assurance that what happened to them won't happen to someone else–the patient safety connection.

What about compensation? While compensation is not always expected, or even desired in medical injury cases, seeking it can be a form of revenge or punishment against an individual or institution that has hurt someone and does not appear to care.[45] There are cases, however, where compensation is clearly warranted and expected. Early resolution programs have been created at numerous hospitals and insurers to work in conjunction with, or separately from, an Ombuds/Mediator program.[46] These programs do not require the initiation of a lawsuit to justify a payment to an injured party and can target payments to meet immediate needs such as lost income, childcare, rehabilitation services, additional healthcare, etc., as well as long term needs.[47]

By removing the secrecy and fear that surround a potential malpractice case, healthcare providers, families, and patients alike may be able to re-instill trust in the medical system and stave off costly litigation expenses. Instead of allowing patients' and families' anger, dissatisfaction, feelings of disappointment, and frustration to ignite and lead to malpractice lawsuits, this difficult experience can be channeled into an integrated conflict management system where patient and family needs can be addressed and fulfilled, open communication and transparency can be promoted, and a culture of identifying system vulnerabilities and collaborating in improving the healthcare system can be supported – truly, a better way.

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[44] *Id*.
[45] Bonacum, *supra* note 24, at 111; *see also* KENNETH CLOKE, MEDIATING DANGEROUSLY: THE FRONTIERS OF CONFLICT RESOLUTION 74 (2001).
[46] MICHAEL S. WOODS, HEALING WORDS: THE POWER OF APOLOGY IN MEDICINE, 81-91 (2d ed. 2007).
[47] *Id*.