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Commentary: Physician Apologies for Adverse Outcomes—Beware the Minefields of Mea Culpa

By Patricia Legant, MD, PhD

Lucien Leape, the eminent proponent of patient safety, has called for transparency in sharing information with patients about their care, even—and especially—about poor outcomes.¹ For the past 10 years, evidence has mounted that patients themselves want to hear an explanation of and apology for adverse events and that physicians want to give one.² The American Medical Association has included disclosure of bad outcomes in its list of ethical guidelines,³ and the Joint Commission on Accreditation of Healthcare Organizations has designated such disclosure as a patient safety standard.⁴ Several articles in *JOP* have advised physicians to apologize to their patients for unfortunate outcomes.⁵⁻⁷ Yet physicians still hesitate to give such explanations.² As discussed below, there are a number of reasons why this may be true.

Chung et al⁸ describe a pioneering program begun at the University of Michigan, which encourages physicians to apologize to their patients for episodes of negligent care. The chief goal of the program is to improve quality of care by trying to eliminate future similar errors. Though not a universal finding in other programs, a welcome additional benefit in their experience was a decrease in malpractice expense. There are a few comparable programs around the country, including one of the first established at the Lexington Veterans Administration Medical Center, one at Stanford, and another organized by COPIC, the physician-run nonprofit medical malpractice insurance company of Colorado.⁹ Although these may represent ideal situations, it is noteworthy that they have not proliferated, raising the question of what barriers exist to more widespread adoption. What caveats, then, should physicians consider before they offer an apology to an injured patient?

Risk of Legal Liability

One reason for physician hesitation is that an ill-considered apology may prove personally costly in terms of malpractice

liability. Although some dismiss this concern as exaggerated, it may actually be well-founded.^{10,11} Even in states with laws ostensibly protecting physician apology, there are significant pitfalls.

An apology actually consists of two elements, namely, disclosure of the event itself and assignment of responsibility.¹² As of 2010, 36 states had laws intended to promote physician apology by protecting those comments from being revealed in later litigation. A thorough review in 2008¹⁰ found that the content of these laws varies considerably from state to state. In 28 states, “expressions of sympathy, regret, and condolence” were protected from use in subsequent litigation. In only eight states, however, did the law protect both such expressions of sympathy and specific or implied admission of fault. Other important differences included protection of oral, but not written, statements; mandatory requirements to disclose; obligations of hospitals, but not physicians, to disclose; and time limits on the period in which such a disclosure may be protected. Physicians would be well advised to discuss these details with their malpractice insurer before they talk with patients.

Moreover, the evidence suggests that patients expect not only an expression of sympathy but also some explanation of and apology for the mishap.¹² In states in which disclosure is protected but admission of fault is not, expressions of sympathy alone may be poorly received by patients, and even raise suspicion of wrongdoing.

Unclear Causation

The exact cause of a bad outcome may initially be ambiguous. The tort system tends to assign individual blame; in contrast, the 1999 Institute of Medicine report¹³ on medical error emphasized a more systemic approach, recognizing that the cause of bad outcomes is often multifactorial, arising not just from individual error but rather from a series of mistakes. All

the factors involved may not be apparent immediately after the event, hence prompting a “root cause” analysis. Physicians may overestimate their role in this process and, in the heat of the moment, assume blame prematurely when they speak with the patient. Alternately, they may deny their own part in the error and mistakenly assign disproportionate blame to some other party. In the program offered by COPIC, physicians are required to contact a specially trained nurse to discuss their response before they visit the patient.

Crucial Program Support

A timely and successful apology, which offers both patient satisfaction and physician protection, does not happen in an institutional vacuum. It must be backed by a dedicated program whose elements may include physician preparation, filtering of cases, more detailed preprocedural consent, early settlement offer and/or other patient financial benefits, assurance of root cause analysis for the adverse outcome, and so on. For example, at the University of Michigan, “careful claims evaluation, . . . patient safety initiatives and staff education” are an integral part of the program. Chung et al themselves emphasize the unique characteristics of the Michigan program, including self-insurance and hospital-employed physicians. Several similar programs, such as the Lexington VA and Stanford, share these features, although COPIC does not. Constructing such a program in a nonclosed system may be more difficult. It is not clear, for example, how a program of apology would play out in a situation in which physicians and hospitals have conflicting interests. For example, who should be the one to apologize if several parties may be at fault?

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If the constraints of legal liability were lifted, would physicians feel able to apologize? In a thoughtful article,¹⁴ one author speculates that there may well be physician concerns besides liability, such as loss of reputation, self-esteem, and income. In addition, the norms of medicine may also contribute to doctors’ reluctance to apologize for mistakes. Both the patient and physician may feel a mutual need for the physician to seem invulnerable, an illusion potentially jeopardized by admission of error. One could perhaps argue that this is particularly the case for patients with cancer.

Whatever the truth of this theory, relieving physician anxiety about legal risk would certainly improve the current dysfunctional situation. Moreover, there are ample moral, legal, and patient safety grounds to support disclosure and apology to patients for poor outcomes. For patient and physician alike, these considerations clearly justify continued efforts to promote physician apology together with adequate legal protection.

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