"Sorry" seems to be the hardest word…

How do apologies impact lawsuits?

By J. Thaddeus Eckenrode, Eckenrode-Maupin, Attorneys at Law

With apologies to Elton John, who sang the above title phrase in his hit song of the same name, shortly after lamenting "what have I got to do to make you love me?", physicians may feel the same way. Despite their best intentions, they often have a rather fluid relationship with their patients, some of whom love them, some of whom dislike them, and some of whom have thoughts that tend to change with the wind. While many recognize that they owe their lives or their good health to the capable care of their physicians, others have less complimentary thoughts about their physicians for a variety of reasons, whether because of personality clashes, difficulty obtaining office visit times that meet their particular needs, health insurance issues (for which they mistakenly blame their doctors), etc. Given this potential love/hate situation, a physician who makes some type of technical treatment mistake or diagnostic error faces a wide spectrum of possible reactions from his patients. Not surprisingly, one common response, often devastating to the physician, is the filing of a lawsuit.

While we firmly believe and have long espoused the notion that physicians who communicate openly and thoroughly with their patients are more likely to avoid some suits, we admittedly have no empirical data to support that. After all, trying to prove a negative seems counterintuitive. It is similar to trying to prove that the United States has avoided one or more terrorist attacks on our soil because of aggressive questioning of suspected terrorist cell members. After all, short of an actual admission that they were just about to detonate a device somewhere, we usually have no direct evidence that the information gleaned from such interrogations truly prevented an attack … yet our government fundamentally believes that to be the case.

Likewise, we tend to believe that open dialogue with patients after a surgical or treatment misadventure tends to mitigate harsh patient reactions and likely deflects some away from the filing of suit. For example, in a vast majority of medical malpractice cases that we have defended over the past several decades, litigating plaintiffs frequently claim in their depositions that they had little or no helpful communication with their physicians about their care, diagnosis or treatment, and often will say they "just wanted answers" and couldn't get any. Rare is the plaintiff who files suit yet states that they loved their doctor because he/she fully explained everything that was going on.

Growing Trend to Apologize for Errors

Over the past several years, the medical profession has seen a growing trend to suggest apologizing to patients for medical errors. Various studies suggest that suits can often be avoided by saying "I'm sorry" to patients. Likewise, "apology laws" are being enacted to encourage physician-patient discussion under the general theory that physicians would be more likely to apologize to patients for adverse outcomes but for the prospect of inviting suit. Not surprisingly, however, some argue that encouraging physicians to apologize to patients will actually convince some patients, who may be otherwise unaware, that a mistake actually occurred and may therefore lead to suits being filed.

With the increasing discussions in the medical community about the potential benefit of apologizing to patients, we have talked to some physicians who mistakenly believe that the "Sorry Works! Coalition" simply supports the concept of offering apologies and suggests that doing so leads to suit avoidance. What must be understood, however, is that the "Sorry Works! Coalition" (an organization of doctors, lawyers, insurers and patient advocates, launched in 2005) "believes that apologies for medical errors, along with up-front compensation, reduce anger of patients and families, which leads to a reduction in medical malpractice lawsuits …" (See "The Sorry Works! Coalition: Making the Case for Full Disclosure," *Joint Commission Journal on Quality and Patient Safety*, June 2006). Therein lies the rub … payment of upfront compensation. It effectively advocates settlement when medical mistakes occur, to minimize suit.

But what if your "mistake" is not truly a deviation from the standard of care? How many physicians want to settle over known risks and complications of surgery, or misdiagnoses based upon confusing presentations, or adverse responses to one of multiple treatment alternatives? While no doctor wants to face a suit if it can be avoided, very few really want to settle cases where they feel they did not actually violate the standard of care. In these cases, can an apology be effective in preventing law suits?

Caution Advised

Missouri, like the majority of states, has now enacted legislation

to prevent statements of apology or other benevolent gestures expressing sympathy from being admissible in court (section 538.229 RSMo). This statute was enacted along with some of the other sweeping "tort reform" provisions of 2005. It remains in place today, despite a slow evisceration of other parts of that law, most notably, non-economic caps.

However, in spite of this statute, before engaging in any type of apology to a patient, we recommend great caution. While both medical and legal journal articles exploring apology statutes on a national scope have trumpeted the benefit of apologizing to patients, keep in mind that apology statutes vary from state to state. Some are considered "full" apology statutes, which protect against the admission of essentially all statements made by way of apology to patients, including explanation about the mistakes, fault and even liability.

The wording of our Missouri statute notes that benevolent gestures expressing sympathy "shall be inadmissible as evidence of an admission of liability in a civil action," but goes on to state, "However, nothing in this section shall prohibit admission of a statement of fault." This constitutes a "partial" apology statute. To that end, in Missouri, while you may very well be protected from the admission at a subsequent trial of your statement to a patient that you are sorry about their particular problem, untoward outcome or surgical complication, one must be aware that going further, i.e., explaining what happened, who did what, why things turned out as they did, etc., are all potentially admissible in evidence.

No reported case in Missouri to date has taken up the issue or otherwise attempted to define the parameters of what may be a protected "benevolent gesture" statement or what may be admissible as an "admission of fault." The savvy plaintiff's attorney will undoubtedly claim that anything a health-care provider may say beyond "I'm sorry" constitutes the latter, or at the very least, constitutes a non-benevolent discussion of the patient's medical condition and is therefore not protected. Without any judicial guidance on these issues to date, you should approach any potential benevolent conversations with patients with great caution, and watch your words carefully.

Another potential quagmire in which a physician may find himself with regard to his/her patients is when hospitals or other health-care providers make plans to approach the patient with an apology for an untoward outcome or problem. Should they offer any information or an explanation about what happened and why he suffered this complication or injury, that may prove problematic for others. Their account of what happened and where fault may lie could be rather different from your own perspective.

Would attending such a meeting and offering your own apology but a different explanation be "protected"? Would a "debate" about those details defeat the goal of trying to avoid a suit by suggesting the health-care providers are at odds? Would your absence from such a meeting be viewed by the family as a lack of

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April

20 Congenital Heart Disease in the Adult: Evaluation and Management, Eric P. Newman Education Center. CME credits. For more information, http://cme.wustl.edu.

20-21 Geriatrics Board Review and Update, Holiday Inn Oak Brook Terrace, Chicago Suburb. CME credits. For more information, http://medschool.slu.edu/cme.

26 The ABC's of Hematology (Anemia, Bleeding, Clotting), Eric P. Newman Education Center. CME credits. For more information, http://cme.wustl.edu.

26-27 16th Annual Saint Louis University Obstetrics and Gynecology Spring Conference and Residents' Research Symposium, Kohler Auditorium, SSM St. Mary's Health Center, St. Louis. CME credits. For more information, http://medschool.slu.edu/cme.

27 Care for the Hospitalized Patient 2013, Eric P. Newman Education Center. CME credits. For more information, http://cme.wustl.edu.

26-27 1st Annual Acute Pain Medicine and Regional Anesthesia Course, University of Maryland School of Medicine, Baltimore. CME credits. For more information, http://medschool.slu.edu/cme.

May

3 Transitioning from Active Oncology Treatment to Primary Care: Important Medical and Psychosocial Issues Related to Cancer Survivorship, West Campus Conference Center. CME credits. For more information, http://cme.wustl.edu.

4 Update on Osteoporosis and Fracture Prevention, Eric P. Newman Education Center. CME credits. For more information, http://cme.wustl.edu.

14 SLMMS Council, 7 p.m.

27 Memorial Day, SLMMS office closed.

June

8 Inflammatory Bowel Disease: A Combined Medical and Surgical Symposium, Eric P. Newman Education Center. CME credits. For more information, http://cme.wustl.edu.

11 SLMMS Executive Committee, 6 p.m.

15 Liver Cancer Update, Eric P. Newman Education Center. CME credits. For more information, http://cme.wustl.edu.

15-19 AMA Annual Meeting, Chicago.

List your events: Please send listings of continuing education programs, organizational meetings and other events related to the practice of medicine, to *St. Louis Metropolitan Medicine* by e-mail editor@slmms.org, by fax to (314) 989-0560, or by mail to Editor, *St. Louis Metropolitan Medicine*, 680 Craig Rd., Suite 308, St. Louis, MO 63141.

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care or concern on your part? And in an effort to avoid any conflict, should the administration and health-care providers meet in advance to discuss their planned apology and any potential explanation?

We suggest not—such a meeting, and anything discussed therein, are clearly NOT benevolent statements that would be protected, and would be unquestionably discoverable and admissible in subsequent litigation. Evidence that the providers are "getting their stories straight" before approaching a patient can look even more suspicious.

Honesty and Openness Are Best Approach

We surmise that when expressing sympathy of any sort to a patient, he or she (or the family) is very likely to ask WHY this outcome occurred, and for more of an explanation. In other words, simply saying "I'm sorry" is very rarely going to be enough. If a physician does apologize for the complication or problem but then sidesteps offering any explanation, especially if directly asked for one, that may lead to even more skepticism about the sincerity of the apology itself.

As noted above, we think a constant open and honest dialogue with patients is ultimately the best approach, and is the type of "bedside manner" that patients strongly seek from their physicians. Therefore, should a complication or problem arise, we suggest that it be discussed proactively and promptly by the physician, and that all questions be answered honestly and without reservation, but care should be taken to avoid suggesting that the problem is anyone's particular "fault."

In short, while we continue to believe that most patients appreciate communication with their physicians, and in the long run, that may prevent some suits, physicians should not presume that "fessing up" will not be used against them; but honesty and openness rarely hurt as much as avoidance and evasiveness. Moreover, while "sorry" may very well work, we simply recommend that physicians be aware that Missouri's "Apology" statute is not carte blanche protection for all that you might choose to say.

J. Thaddeus Eckenrode practices with the Clayton-based firm of Eckenrode-Maupin, Attorneys at Law. He can be reached at 314-726-6670 and www.eckenrode-law.com.