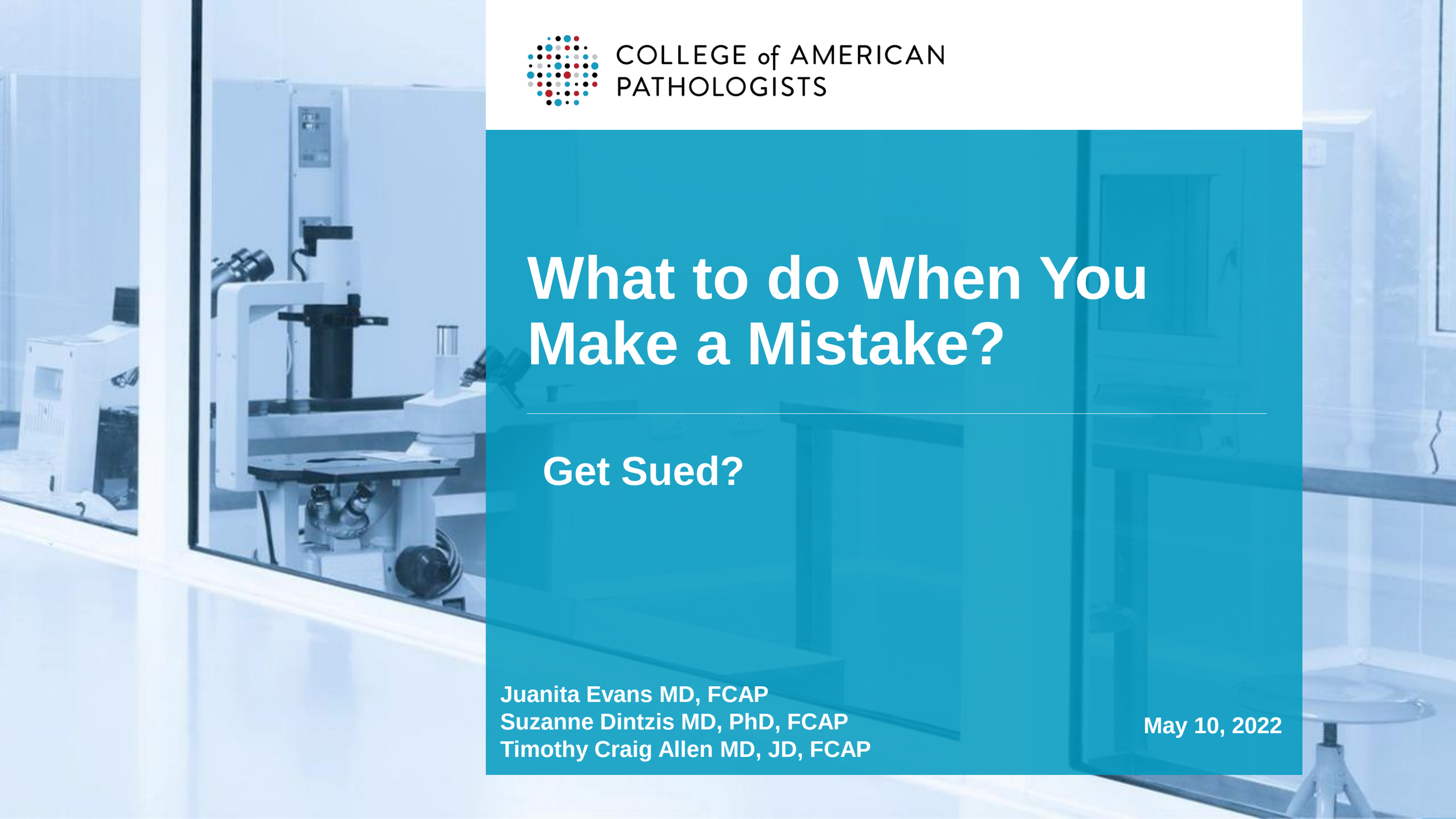

COLLEGE of AMERICAN PATHOLOGISTS

What to do When You Make a Mistake?

Get Sued?

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May 10, 2022

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- Vice Chair – Practice Management Committee
- Member: Diversity, Equity and Inclusion Committee
- Medical Director of Ascension Providence Novi
- AP/CP Board Certified with Hematopathology Fellowship

Disclaimer

The information presented today represents the opinions of the panelists and does not represent the opinion or position of the CAP.

This should not be used as a substitute for professional assistance.

The information in this presentation is provided for educational purposes only and is not legal advice.

Our plan together

- INTRODUCTION TO IOM REPORT ON ERROR IN MEDICINE (SD)
- CLASSIFICATION OF EVENTS (SD)
- WHY DO PATIENTS SUE? (TA)
- DISCLOSURE OF HARMFUL ERROR (SD)
- LEGISLATION AND REGULATION AROUND DISCLOSURE AND APOLOGY (TA)

Polls: Who are you?

Type of practice:

- Academic
- Medical center
- Private group
- Reference lab
- Other

Your role:

- Pathologist
- Medical trainee
- Non-physician practice manager
- Laboratory staff
- Admin
- Legal
- Between roles
- Other

Suzanne Dintzis MD, PhD, FCAP

- Vice-Chair DEI committee
- Member Digital and Computational pathology committee
- President Washington State Society of Pathologists
- Chair Washington State delegation to HOD
- Professor of Laboratory Medicine and Pathology
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Timothy Craig Allen MD, JD, FCAP

- Chair – CAP Constitution and Bylaws Committee
- Member – CAP Council on Membership and Professional Development
- Professor and Chair – Department of Board Pathology at the University of Mississippi Medical Center
- Board Certified AP/CP and Cytopathology
- Member – Board of Directors and Academic Advisory Board of the Crime Prevention Research Center
- Member – The National Association of Medical Examiners
- Associate Editor of the Archives of Pathology and Laboratory Medicine
- Series Editor of the Molecular Pathology Library Series

INTRODUCTION: IOM REPORT GOALS

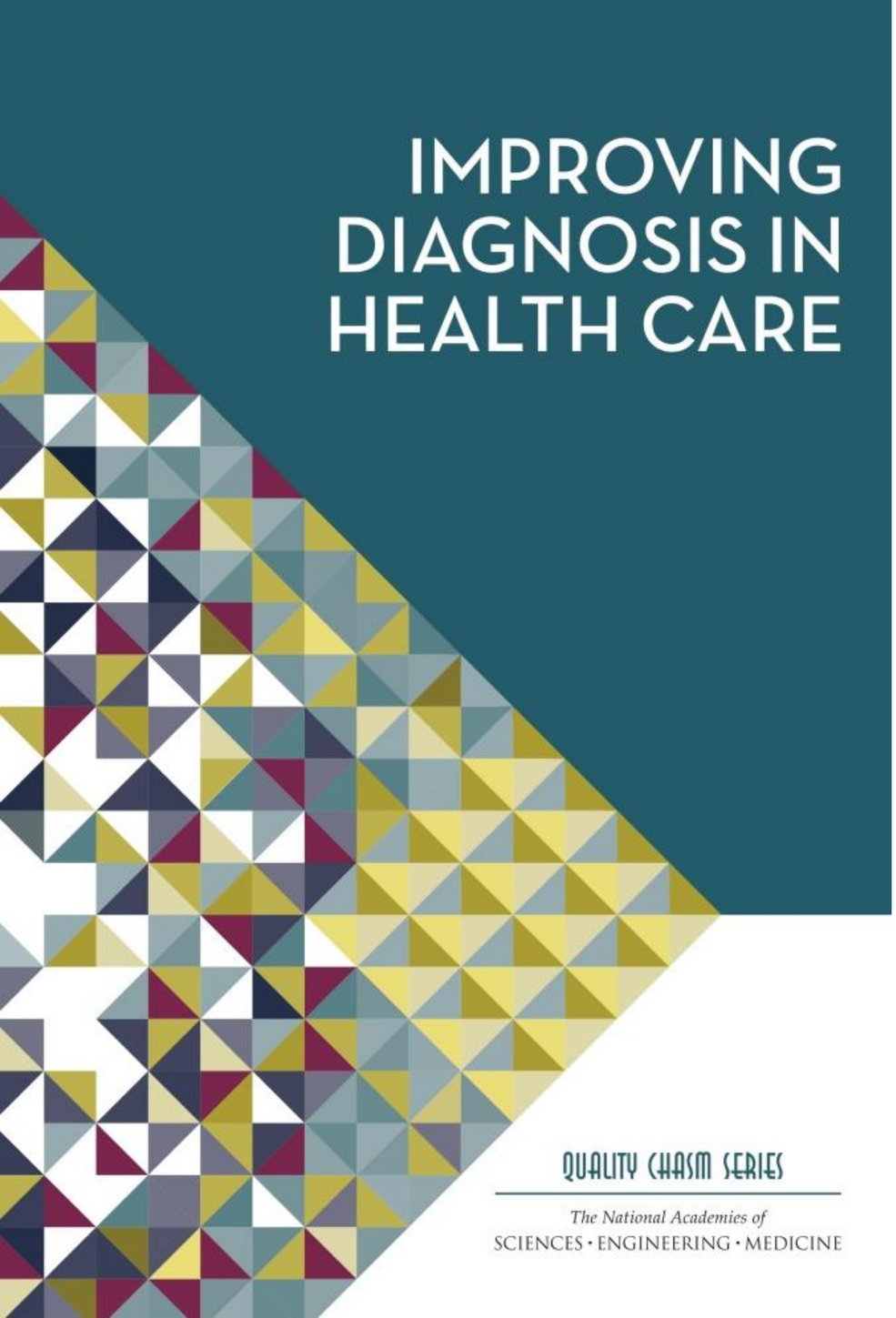
IMPROVING DIAGNOSIS IN HEALTHCARE

Landmark Institute of Medicine Report (1999)

98,000 deaths in the US each year result from medical errors

90% of these deaths due to failed systems and procedures, not individual providers

- **Kohn LT, Corrigan JM, Donaldson MS, eds; Committee on Quality Health Care in America, Institute of Medicine. *To Err Is Human: Building a Safer Health System. Washington, DC: National Academies Press; 2000***



16 years later: A Call to Action for Pathologists

Poll: What is the Institute of Medicine?

- Never heard of it
- Government established medical advisory group
- Not for profit, non-governmental medical advisory group

Key Report Themes

- Diagnostic errors are a **significant** and **underappreciated** health care quality challenge
- **Patients** are **central** to the solution
- Diagnosis is a **team sport**

Principles of Team-Based Health Care

- Shared goals
- Clear roles
- Mutual trust
- Effective Communication
- Measureable processes and outcomes

Implications for Pathologists

- Understand the diagnostic process and the pathologists' critical role
- Practice skills that enhance teamwork and interprofessional collaboration
- Prepare for increasing communication directly with patients about the diagnostic process

HOW DO WE CLASSIFY EVENTS?

OUTCOME

- Unsafe condition
- Near miss
- No harm-reached patient
- Harm

HOW DO WE CLASSIFY EVENTS?

ROOT CAUSE

- System-technical
- System-organizational
- Human

HOW DO WE CLASSIFY EVENTS?

TESTING PHASE

- Pre-analytical
- Analytical
- Post-analytical

How do safety professionals classify events?

STANDARD OF CARE

- Met?
- Negligence

How do clinicians and patients classify events?

THEY DON’T

Patients conceive of “error” broadly

WHY DO PATIENTS SUE?

Why do patients and families sue doctors?

- Emotions
- Disappointment, hurt, and anger often exist
- Can drive the litigation process
- A human response to unexpected or dramatic loss
- But emotions alone are usually not enough
- There is frequently another factor that catalyzes the emotions
- The combination then may result in medical malpractice litigation

Why do patients and families sue doctors?

- **Factors that may catalyze the patient's and family's emotions:**
  1) **Mishaps in communication—reduces trust**
  2) **An uncaring attitude—perceived lack of compassion**
  3) **Failure to assume responsibility—appearance of lack of diligence**

- **Other reasons:**
  - **Billing dispute**
  - **Litigious behavior as a response to extreme financial cost of an injury**

Why do patients and families sue doctors?

Patients' and families' reasoning:

1) **Concerns with standard of care—both patients and relatives wanted to prevent similar incidents in the future**
2) **the need for an explanation—to know how the injury happened and why**
3) **compensation—for actual losses pain an suffering or to provide care in the future for the injured person**
4) **accountability—a belief that the staff or organization should have to account for their actions**

Why do patients and families sue doctors?

- What about Pathologists' being sued?
- Infrequently patient-facing
- "Poor bedside manner" typically does not apply
- How do "mishaps in communication", "an uncaring attitude", and "failure to assume responsibility" apply?

Polls: Your experiences

Have you ever been involved with a harmful pathology error?

- Yes
- No

Have you ever disclosed a pathology error to a patient?

- Yes
- No

Why do patients and families sue doctors?

- Poor communication can take many forms, far beyond bedside manner
- The surgical pathology report remains the primary method of pathologists' communicating with their patients
- Patients and families typically sue pathologists for delay or change in diagnosis without an explanation as to why
- The importance of the surgical pathology report is emphasized in the College of American Pathologists Member Resources
  - Reducing Malpractice Risk in Pathology https://www.cap.org/member-resources/articles/reducing-malpractice-risk-in-pathology

DISCLOSURE OF HARMFUL PATHOLOGY ERROR

WHY DO PATIENTS SUE?

- Negligence
- Harmful outcome
- Lack of transparency
- Perceived lack of empathy
- Perceived withholding of essential information

WHY DO PATIENTS SUE?

- ~~Negligence~~
- ~~Harmful outcome~~
- Lack of transparency
- Perceived lack of empathy
- Perceived withholding of essential information

Disclosure of Harmful Laboratory Error

- Who?
- When?
- How?
- To Whom?
- By Whom?

Disclosure of Harmful Laboratory Error

- Someone who has an existing relationship with the patient
- Someone who can explain what happened
- Someone who can communicate clearly and empathically
- How to put these goals together?

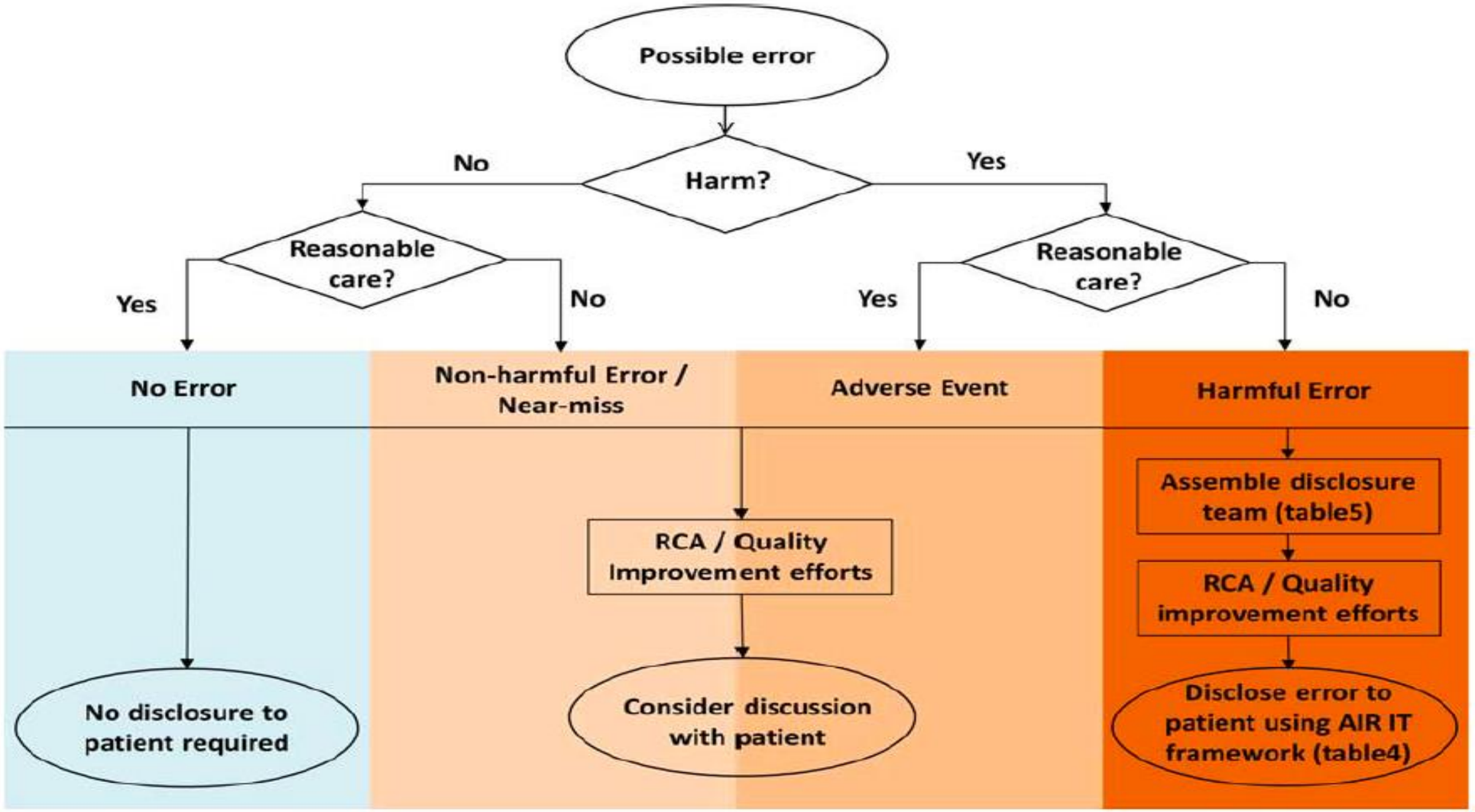
Who, When, How?

- Pathologists together with treating clinicians
- Timely first connection, but a process rather than an event
- Communication guidelines are key

Disclosure of Harmful Medical Error to Patients: A Review With Recommendations for Pathologists

Yael K. Heher, MD, MPH, FRCPC†‡ and Suzanne M. Dintzis, MD, PhD*†‡*

Adv Anat Pathol



Heher YK, Dintzis SD. Disclosure of harmful medical error to patients: a review with recommendations. Adv Anat Pathol 2018

AIR IT Disclosure Guideline

Apology—empathic statement

Information—what happened?

Root causes

Impact—implications for care & outcome

Targets for improvement

Heher YK, Dintzis SD. Disclosure of harmful medical error to patients: a review with recommendations. Adv Anat Pathol 2018

Resources for disclosure

- Institutional policy for when to disclose
- Disclosure training for pathologists and clinicians
- Risk management, health care quality
- Patient relations
- Supportive malpractice insurers
- Legal ‘safe havens’ for standard of care met
- Peer support programs for the ‘second victim’

Heher YK, Dintzis SD. Disclosure of harmful medical error to patients: a review with recommendations. Adv Anat Pathol 2017

LEGISLATION AND REGULATION OF DISCLOSURE AND APOLOGY

Legislation & regulation of disclosure and apology

- Transparency is integral to quality patient care
- Disclosure of harmful errors is integral to transparency
- The Joint Commission issues the first nationwide disclosure standards in 2001, and additional guidelines have followed
- Guidelines advise physicians to express regret to the patient when there is an adverse outcome
- Premise is that apologies are integral to human communication and can repair damaged relationships

Legislation & regulation of disclosure and apology

- Common law holds that an apology that admits fault is ordinarily admissible to prove liability
- All statements made in the course of settlement negotiations, including an apology, can be admitted into evidence
- As such, an apology can be admissible as evidence at trial, and once entered in to evidence is considered an admission
- Depending on wording, the court may view an apology as an innocent expression of sympathy versus an overt, highly probative admission of wrongdoing; however, wording probably cannot be depended upon for protection, as courts have found differently with various wordings

Legislation & regulation of disclosure and apology

- In response to litigation concerns, many state legislatures have passed apology laws, that aim to reduce medical malpractice lawsuit rates by encouraging physician apology
- Currently 39 states, the District of Columbia, and Guam have some rendition of an apology law
- Six states' apology laws have provisions specifically related to accidents
- Disclosure laws also exist; however, these typically require only a minimum statement that an unanticipated outcome occurred

Legislation & regulation of disclosure and apology

- Unfortunately, while apology laws may shield physicians from legal liability for apologies, state laws generally do not protect a physician's admission of an error, a giant stumbling block to full disclosure
- And so while physicians may desire to apologize, they may not due to fear that disclosing errors increases the likelihood of a medical malpractice claim, or of an unsuccessful defense of a claim

Legislation & regulation of disclosure and apology

- These laws have yet to show any rate reduction, very likely because the laws protect merely the expression of regret and not the disclosed error
- As such, they may lead to unclear or inadequate disclosure, partnered with vague or general expressions of sympathy
- May actually provide an outcome opposite of that desired, with even more discouraged and angry patients and families
- Patients want to know about all errors that occur, how and why they occurred, and what is being done to prevent the errors in the future

Legislation & regulation of disclosure and apology

- Possible next step:
- Institutional or hospital disclosure and apology programs
  - May reduce risk of litigation
  - An institutional process, not an occurrence—Initial conversation, listening, apologizing, discussing next steps, supporting the patient and family
  - Requires training to have difficult conversations with patients and families
  - Apology is seen as not only words, but actions
  - Apology is simply the right thing to do
- Yet without additional legal protections, defense attorneys will often discourage all forms of post-event communication

Legislation & regulation of disclosure and apology

- The word “sorry” is ambiguous:
- Expression of sympathy (sharing)—“I’m sorry for your loss; please know I am here for you.”
- Expression of empathy (understanding)—“I’m sorry you failed your test. It’s a tough subject and we have all struggled with it. Keep studying and you will get it!)
- Expression of an admission of fault—“I’m sorry for taking the last piece of pie; I know you said at dinner you wanted it for desert later.”

Legislation & regulation of disclosure and apology

- Where do we stand today?
- Patients have a right to full disclosure of adverse events caused by medical management
- To do otherwise would constitute culpable deception

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Resources

- **Practice Management**
  - https://www.cap.org/member-resources/practice-management
- **Reducing Malpractice Risk in Pathology**
  - https://www.cap.org/member-resources/articles/reducing-malpractice-risk-in-pathology

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