THE OPEN COMMUNICATION MODEL: AN ALTERNATIVE APPROACH TO MEDICAL ERRORS

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INTRODUCTION

Each and every citizen of the United States of America will at some point or another receive medical care during the course of his or her life. A 2014 study conducted by the Centers for Disease Control and Prevention (CDC) showed that 83% of American adults[1] and 92% of American children[2] had contact with a health care professional during the past year. As the statistics indicate, a vast number of Americans place their trust in health care professionals to provide care and healing. However, no health professional is perfect, and mistakes do occur. One of the most important medical, legal, and ethical questions is how to handle such a situation.

The most widely used "approach to medical errors is 'deny and defend,'" a method oriented primarily towards avoiding provider fault.[3] The "deny and defend" approach contains several paramount flaws that do not best serve the interests of the United States legal system, the insurance company, the provider, and the patient.[4] Utilizing deny and defend can result in the breakdown of the physician-patient relationship, costly litigation, and inadequate patient compensation.[5] An alternative approach is the Open

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1. CTR. FOR DISEASE CONTROL AND PREVENTION, NAT'L CTR. FOR HEALTH STATISTICS, *Summary Health Statistics: National Health Interview Survey Table A-18(a)*, 1,1 (2014).

2. CTR. FOR DISEASE CONTROL AND PREVENTION, NAT'L CTR. FOR HEALTH STATISTICS, *Summary Health Statistics: National Health Interview Survey Table C-8(a)*, 1,1 (2014).

3. Daniel Rocke & Walter T. Lee, *Medical Errors: Teachable Moments in Doing the Right Thing*, 5 J. GRAD. MED. EDU. 550, 550 (2013).

4. *See id.* at 550–51.

5. *Id.*; *see also* Daniel P. Kessler, *Evaluating the Medical Malpractice System and Options for Reform*, 25 J. ECON. PERSP. 93, 93 (2011).

Communication Model, which includes discussion-based informed consent, a transparency policy, and an apology policy.[6]

Before presenting the Open Communication Model, it is important to note that while the Open Communication Model could be adapted to any medical facility, the target audience of this Note and the Open Communication Model are hospitals and health systems. The reason for this is not only do hospitals and health systems have to comply with federal and state law, but they must also meet the standards of private certification organizations. The most popular of these is The Joint Commission, a not-for-profit organization responsible for accrediting and certifying "nearly 21,000 health care organizations and programs in the United States."[7] The Open Communication Model strives to satisfy the numerous regulations and standards that hospitals and health systems must meet. In theory, the Open Communication Model can be implemented in other medical facilities that are not required to comply with as many regulations and standards. As this Note is intended for a widespread audience, specific state law will not be a governing source, but federal law, as promulgated by the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission Standards, will serve as binding authority.

As evidenced by the reasons presented in the remainder of this Note, the Open Communication Model better serves the goals and interests of all parties involved in medical malpractice situations. Part I will provide an overview of the current state of medical malpractice in the United States and explain how the current medical malpractice system has impacted medical care. Part II will explain the three prongs of the Open Communication Model: discussion-based informed consent, a transparency policy, and an apology policy. Part III will show through a hypothetical how deny and defend and the Open Communication Model differ in application.

PART I: MEDICAL MALPRACTICE IN THE UNITED STATES

At the outset, it is important to understand the current state of the medical malpractice system in the United States. Under American law, medical malpractice liability arises from the notion that every individual who enters into a learned profession should exercise reasonable care in accord with the

6. The Open Communication Model is an original development of the author that combines pre-existing concepts and processes in a new way that would serve as a comprehensive approach to handling medical malpractice claims.

7. *About The Joint Commission*, THE JOINT COMM'N, https://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx. (last visited Sept. 9, 2018).

professional skill and knowledge they possess.[8] A general definition of medical malpractice is "any act or omission by a physician during treatment of a patient that deviates from accepted norms of practice in the medical community and causes an injury to the patient."[9] In the United States, medical "malpractice claims are adjudicated in state court under state [tort] law."[10] Although the exact language of the law may vary from state to state, an injured patient must typically show the following four elements of negligence to prove that the physician is at fault: (1) a professional duty was owed by the physician to the patient; (2) the physician breached such a duty; (3) the physician's breach resulted in an injury to the patient; and (4) there were resulting damages.[11]

"The U.S. medical malpractice liability system has two [primary] objectives."[12] The first objective is compensation.[13] The system seeks "to compensate patients who [have been] injured through the negligence of healthcare providers."[14] The second objective is deterrence.[15] The system hopes that by holding physicians liable for negligent medical practice, other physicians will be deterred from practicing medicine in a same or similar manner in the future.[16]

There are several interested "parties" in medical malpractice situations. The interested parties include the insurance company, the provider, and the patient. The first interested party is the insurance company because doctors are required to obtain medical malpractice insurance that customarily includes a "cooperation" clause, which requires "insureds to cooperate with the insurer's efforts to defend the insured against [the] claim."[17] "A common stipulation in [the cooperation clause prevents] the insured from 'admitting

8. Sonny Bal, *An Introduction to Medical Malpractice in the United States*, 467 CLINICAL ORTHOPAEDICS AND RELATED RES. 340, 342 (2008).

9. *Id.* at 340.

10. Kessler, *supra* note 5, at 94.

11. *See* Bal, *supra* note 8, at 342.

12. Kessler, *supra* note 5, at 93.

13. *Id.*

14. *Id.*

15. *Id.*

16. *Id.*

17. John D. Banja, *Does Medical Error Disclosure Violate the Medical Malpractice Insurance Cooperation Clause?*, in 3 ADVANCES IN PATIENT SAFETY: FROM RESEARCH TO IMPLEMENTATION 371, 371 (Kerm Henriksen ed., 2005).

liability' to an injured or harmed party."[18] The cooperation clause has had a "chilling effect on the truthful disclosure of medical error."[19]

The second interested party is the provider. The term "provider" for purposes of this Note includes both the physician and the medical facility at which the physician is employed. As stated above, the provider is instructed by its medical malpractice insurance carrier on how to proceed.[20] Normally, the insurance carrier instructs the provider to use the 'deny and defend' method, which involves "deny[ing] that mistakes happened and vigorously defend[ing] against malpractice claims."[21] The deny and defend approach "shifts the physician-patient relationship from one of intimacy and trust to one of distance and opposition."[22] Even if the provider wanted to proceed differently in a medical error situation, no such action would be allowed, as the direction of the insurance company overrules the provider's intentions.[23]

The third interested party—and arguably the most important party—is the patient. When a medical error occurs, statistical studies indicate that patients have four primary goals.[24] First, the patient wants acknowledgement that an error occurred, followed by an explanation from their caregiver about what

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18. *Id.*

19. *Id*. (Section 8.6 of the American Medical Association's Code of Medical Ethics states:

> In the context of health care, an error is an unintended act or omission or a flawed system or plan that harms or has the potential to harm a patient. Patients have a right to know their past and present medical status, including conditions that may have resulted from medical error. Open communication is fundamental to the trust that underlies the patient-physician relationship, and physicians have an obligation to deal honestly with patients at all times, in addition to their obligation to promote patient welfare and safety. Concern regarding legal liability should not affect the physician's honesty with the patient.

American Medical Association, CODE OF MEDICAL ETHICS, 8.6 (2016). When the patient's adversity results from medical error, Section 8.6 is often disregarded in large part due to cooperation clauses that contain language like the following: "The insured shall not, except at his own cost, make any payment, *admit any liability*, settle any claims, assume any obligations or incur any expense without the written consent of the company." *Id*. (emphasis added). Truthful disclosure of medical error is a "slam-dunk admission of liability." *Id*. Therefore, while physicians are ethically obligated to disclose all relevant information to patients about their health condition—including conditions caused by medical error—cooperation clauses stifle such practice. American Medical Association, CODE OF MEDICAL ETHICS, 8.2 (2016); *see also* Banja, *supra* note 17, at 371–73).

20. Banja, *supra* note 17, at 371–73.

21. Rocke, *supra* note 3, at 550.

22. *Id.*

23. *See generally* Banja, *supra* note 17.

24. Lucian L. Leape, *Apology for Errors: Whose Responsible?*, 28 FRONTIER HEALTH SERVICES MANAGEMENT 1, 4–6 (2012).

happened.[25] Second, the patient wants his or her caregiver to take responsibility for the wrong that occurred.[26] Third, the patient expects the hospital to take serious steps to find out why the medical error occurred and to make changes if at all possible so as to ensure that a similar incident does not occur in the future.[27] Finally, the injured patient wants to be informed about the progress of the medical error investigation as well as the corrective measures being taken.[28]

The average jury award for medical malpractice cases is one million dollars, whereas the average out of court settlement amount is $425,000.[29] Despite the settlement's lesser payout, 90% of cases settle out of court.[30] This statistic is a reflection of the reality that although jury awards may have a larger overall payout, the settlement process costs less in fees, time, and takes less of an emotional toll.[31] The trial process takes an average of three to five years whereas settlement takes about six months.[32] Additionally, the long trial process is more emotionally taxing.[33] During the time spent waiting for trial, doctors are bogged down with worry about liability while injured patients await closure.[34] However, settlement is not entirely devoid of court procedure as it occurs after both parties have filed motions and gone through the court's discovery process.[35]

A. *Effects of the Current Medical Malpractice System on the Practice of Medicine*

A *Health Affairs* study surveyed 41,000 physicians and found that, assuming a physician's career will span forty years, the physician will have spent on average 50.7 months or 11% of their career with an open medical

25. *Id.* at 4.

26. *Id.*

27. *Id.*

28. *Id.*

29. Neil Chesanow, *Malpractice: When to Settle a Suit and When to Fight*, MEDSCAPE BUSINESS OF MEDICINE (Sept. 25, 2013), http://www.medscape.com/viewarticle/811323_3.

30. *Id.*

31. *See id.*; *see also Length and Process of Medical Malpractice Suit*, LAW FIRMS, http://www.lawfirms.com/resources/medical-malpractice/medical-negligence-lawsuits/length-process.htm (last visited Sept. 8, 2018).

32. *Id.*

33. *Id.*

34. *Id.*

35. *Length and Process of a Medical Malpractice Suit*, LAW FIRMS, http://www.lawfirms.com/resources/medical-malpractice/medical-negligence-lawsuits/length-process.htm (last visited Sept. 8, 2018).

malpractice case.[36] The statistic indicates that for physicians, the threat of facing a medical malpractice legal suit is highly probable.[37] As a result, physicians have begun to practice defensive medicine in an attempt to avoid malpractice situations and the arduous legal process that follows.[38]

"Defensive medicine can take two forms: positive and negative."[39] Positive defensive medicine entails "supplying care that could be unproductive" and cost effective, whereas negative defensive medicine involves "declining to supply care that could [potentially] be beneficial."[40] Both practices are motivated by fear of medical malpractice suits.[41] Not to diminish the magnitude of the situation, but in essence, providers are faced with a Goldilocks situation—trying to strike the balance of "just right" in order to avoid getting sued.

Historically, medicine was not practiced under such restraints. One of the most predominant texts in medical history is the Hippocratic Oath.[42] The oath, written by Hippocrates in ancient Greece, emphasizes that providing healing and treatment to the patient surpasses all other responsibilities or interests.[43] The "first, do no harm" principle is often attributed to the Hippocratic Oath.[44] The phrase is not actually included in the document.[45] However, this misconception is attributed to the fact that the phrase reflects the essence of the oath: the safety and well-being of the patient is always first priority.[46] The culture of modern medicine is reflected in the fact that medical schools no longer require new physicians to take the Hippocratic Oath, but instead require them to take a less robust oath that often does not contain language with an intense focus on patient safety.[47]

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36. Chesanow, *supra* note 29.

37. *Id.*

38. Kessler, *supra* note 5, at 95.

39. *Id.*

40. *Id.*

41. *Id.*

42. Frank A. Riddick, Jr., *The Code of Medical Ethics of the American Medical Association*, 5 THE OCHSNER J. 6, 6 (2003).

43. *See generally Oaths and Codes-Bioethics-Guides at Johns Hopkins University*, JOHN HOPKINS SHERIDAN LIBRARIES (Jun. 20, 2018, 6:02 PM), http://guides.Library.jhu.edu/c.php?g=202502&p=1334891.

44. Robert H. Shmerling, *First, Do No Harm*, HARV. HEALTH BLOG (Oct. 13, 2015, 8:31 AM), https://www.health.harvard.edu/blog/first-do-no-harm-201501138421.

45. *Oaths*, *supra* note 43, at 2.

46. *Id.*

47. GREEK MEDICINE, https://www.nlm.nih.gov/hmd/greek/greek_oath.html (Feb. 7, 2012). The text of the original Hippocratic Oath is as follows:

The current medical malpractice scheme has created a culture of medicine that is motivated by a fear of being sued rather than by a desire to provide healing and remarkable patient care. The legal system, burdened with the task of finding a just remedy, often falls short in satisfying the interests of all parties to the suit.[48] Providers are forced to give care in a manner dictated by the parameters of the law rather than medical principles.[49] Patients, harmed in the most intimate and grievous way, are left without the resolutions they most desire, even when the law declares them the victor.[50] The Open Communication Model provides a better way to handle medical malpractice claims.

PART II: THE OPEN COMMUNICATION MODEL

The Open Communication Model has three prongs: discussion-based informed consent, a transparency policy, and an apology policy. The first prong is preventative, attempting to mitigate medical malpractice claims from even arising by implementing an informed consent process that focuses on open and free-flowing discussion between the physician and the patient. The second prong of the model requires providers to be forthcoming about medical

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> I swear by Apollo the physician, and Asclepius, and Hygieia and Panacea and all the gods and goddesses as my witnesses, that, according to my ability and judgement, I will keep this Oath and this contract: To hold him who taught me this art equally dear to me as my parents, to be a partner in life with him, and to fulfill his needs when required; to look upon his offspring as equals to my own siblings, and to teach them this art, if they shall wish to learn it, without fee or contract; and that by the set rules, lectures, and every other mode of instruction, I will impart a knowledge of the art to my own sons, and those of my teachers, and to students bound by this contract and having sworn this Oath to the law of medicine, but to no others. I will use those dietary regimens which will benefit my patients according to my greatest ability and judgement, and I will do no harm or injustice to them. I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan; and similarly, I will not give a woman a pessary to cause an abortion. In purity and according to divine law will I carry out my life and my art. I will not use the knife, even upon those suffering from stones, but I will leave this to those who are trained in this craft. Into whatever homes I go, I will enter them for the benefit of the sick, avoiding any voluntary act of impropriety or corruption, including the seduction of women or men, whether they are free men or slaves. Whatever I see or hear in the lives of my patients, whether in connection with my professional practice or not, which ought not to be spoken of outside, I will keep secret, as considering all such things to be private. So long as I maintain this Oath faithfully and without corruption, may it be granted to me to partake of life fully and the practice of my art, gaining the respect of all men for all time. However, should I transgress this Oath and violate it, may the opposite be my fate.

48. *See Length and Process of a Medical Malpractice Suit*, *supra* note 31.

49. *Id.*

50. *Id.*

errors. The third and final prong calls for providers to not only admit that a wrong occurred, but to be apologetic about the incident as well. The Open Communication Model, while an unorthodox approach in the current medical malpractice scheme, will better satisfy the goals of the legal system, the insurance company, the provider, and the patient.

A. Prong I: Discussion-Based Informed Consent

Obtaining a patient's consent for a treatment or procedure reflects the law and society's high regard for the autonomy of the human person. The Centers for Medicare and Medicaid Services (CMS) established a patient's right to informed consent in 42 C.F.R. § 482.13(b)(2), which provides the following:

> The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment.[51]

Using the federal law as a guideline, The Joint Commission further developed the definition of informed consent in its Comprehensive Accreditation Manual as follows:

> Agreement or permission accompanied by full notice about the care, treatment, or service that is the subject of the consent. A patient must be apprised of the nature, risks, and alternative of medical procedure or treatment before the physician or other health care professional begins any such course. After receiving this information, the patient then either consents to or refuses such a procedure or treatment.[52]

As the name *informed* consent suggests, both CMS and The Joint Commission emphasize a patient's right to make educated and knowledgeable decisions about their care.[53] However, the common practice today is adhering only to the letter of the law rather than the spirit of the law.[54] The consent process has been reduced to merely obtaining the patient's signature rather

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51. 42 C.F.R. § 482.13(b)(2).

52. *Informed Consent: More Than Getting a Signature*, THE JOINT COMMISSION, https://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_Twenty-One_February_ 2016.pdf.

53. *See* 42 C.F.R. § 482.13(b)(2), *see also id.*

54. *See Informed Consent*, *supra* note 52, at 1.

than informed physician-patient discussion.[55] Physicians rely on the consent form to communicate the necessary information to the patient about their treatment or procedure.[56] As a result, "even after signing the consent form, patients often do not fully understand the risks, benefits[, or] alternatives involved in their . . . treatment or . . . procedure."[57]

A January 2000 study of informed consent processes found that patients were informed about the nature of the procedure and the risks, benefits, and alternatives only 26.4% of the time when they merely signed the consent form.[58] This is due to the fact that consent forms are often designed without considering the health literacy of patients.[59] What this means is that while the consent form contains all of the legally relevant information to create an "informed" consent, the complex medical terminology contained in the form is largely unfamiliar to the patient and is beyond the patient's scope of knowledge and understanding.[60] Often, the patient, who simply wants to get healthy, signs by the "X" without fully understanding the ramifications of their consent.

The Joint Commission states that communication issues between the physician and the patient are the most frequent cause of serious adverse medical events that are reported to The Joint Commission.[61] An informed consent process that relies on a form to communicate critical information to the patient no doubt perpetuates this trend. It is quite simple—ineffective physician-patient communication leads to more cases of malpractice.[62] Therefore, revising the informed consent process from signature-based to discussion-based is a crucial step to preventing medical errors.

An article published in *The New York Times* in June 2015, examined whether communication with the patient served to deter medical malpractice suits.[63] The article cited a study that showed that primary care physicians are

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55. *Id.*

56. *Id.*

57. *Id.*

58. *Id.* at 1, 3 (statistic from Bottrell MM, et al., *Hospital Informed Consent for Procedure Forms: Facilitating Quality Patient-Physician Interaction*, 135 ARCHIVES OF SURGERY 26, 26 (2000)).

59. *Id.* at 1.

60. *Id.*

61. *Id.*

62. *Id.*

63. Aaron E. Carroll, *To Be Sued Less, Doctors Consider Talking to Patients More*, N.Y. TIMES (June 1, 2015), https://www.nytimes.com/2015/06/02/upshot/to-be-sued-less-doctors-should-talk-to-patients-more.html?rref=collection%2timestopic%2FMedical%20Meical%20Malpractice&action=click&contentCollection=health&region=stream&module=stream_unit&version=latest&contentPLacement=4&pgtype=collection&_r=o.

sued for medical malpractice the least.[64] The author reasoned that this was due in large part to the fact that primary care physicians are more apt to educate their patients and develop a strong rapport with them.[65]

Further, the discussion-based process not only helps potentially prevent medical errors, it also helps resolve medical errors more effectively when they do occur. By facilitating a discussion between the physician and the patient, an opportunity is given to establish reasonable expectations about the proposed treatment or procedure.[66] This occurs through thoughtful and thorough communication.[67] When such intentional communication occurs, the patient will feel like the system is their advocate and they will not feel as strong a need to immediately seek legal counsel when a medical error occurs.[68]

For hospital and health system physicians who are juggling multiple patients simultaneously, the opportunity to communicate thoroughly for a lengthy amount of time with their patients is significantly reduced in comparison to a primary care physician.[69] There is no doubt that in the midst of a busy shift, relying on a written consent form for communication is far more convenient than taking the time necessary to engage in a discussion with a patient. However, sparing those few precious moments to establish a genuine relationship with the patient could prove to be incredibly beneficial in the long run, especially in the event that a medical error does occur.

Overhauling the informed consent process is a serious, but necessary undertaking. Implementation of a discussion-based process begins with a clearly written policy on the requirements and expectations of the informed consent process.[70] The policy would emphasize that informed consent is a process of effective communication between the provider and the patient and

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64. *Id.*

65. *Id.* ("Decades-old studies have shown that primary care physicians sued less often are those more likely to spend time educating patients about their care, more likely to use humor and laugh with their patients and more likely to try to get their patients to talk and express their opinions.").

66. Richard C. Boothman, et al., *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, 2 J. OF HEALTH & LIFE SCIENCES LAW 125, 135 (2009).

67. *Id.*

68. *Id.* at 136.

69. The common amount of time a physician spends with each patient is thirteen to sixteen minutes. Carol Peckham, *Medscape Physician Compensation Report 2016*, MEDSCAPE (Apr. 1, 2016), https://www.medscape.com/features/slideshow/compensation/2016/public/overview?src-wnl_physrep_160401_scpedit&uac=232148CZ&impID=1045700&faf=1#page=26; *see generally* Erin Brodwin & Dragan Radovanovic, *Here's How Many Minutes the Average Doctor Actually Spends with Each Patient*, BUS. INSIDER (Apr. 6, 2016), www.businessinsider.com/how-long-is-average-doctors-visit-2016-4.

70. *Informed Consent*, *supra* note 52, at 2.

not merely a signature on a form.[71] Additionally, the policy would contain language addressing health literacy issues. Such language would state that providers should not assume that patients understand the medical terminology contained in the consent form and that discussion is necessary before obtaining a signature on the form.[72] The policy would explicitly state that reliance on the consent form alone for communications with patients is insufficient and such practice will not be tolerated.[73] A system-wide formal training program regarding the discussion-based policy should be conducted to ensure as smooth a transition as possible into the new consent method.[74]

While shifting informed consent from form-based to discussion-based is a serious undertaking, the result of such a transition will be beneficial to both the provider and the patient. Discussion-based informed consent best fulfills the standards set forth by CMS and The Joint Commission that the provider is expected to meet. Further, the trusting relationship established during the consent process allows for open communication between the doctor and patient at all times, but especially so during medical error situations.

B. *Prong II: Transparency Policy*

Under the Open Communication Model, prompt transparency is the first step after a medical error occurs. Caregivers should be quick to acknowledge and report a medical error first to their employer, then to the patient when permission is given to do so by the employer. Not only does this serve as a platform for potentially derailing medical malpractice lawsuits, but also in an ethical sense, quick, truthful disclosure is demanded of the physician.

By and large, the transparency policy is the brainchild of the University of Michigan Health System (UMHS), located in Ann Arbor, Michigan.[75] UMHS has more than 26,000 faculty, staff, students, trainees, and volunteers, working in 3 hospitals, 40 outpatient locations, and 150 clinics. [76] Statistically speaking, UMHS has a relatively high risk of medical errors occurring.

Considered a leader in medicine, UMHS decided to also become a leader in properly handling medical errors by designing and implementing a

71. *Id.*
72. *Id.*
73. *Id.*
74. *Id.*
75. Boothman, *supra* note 66, at 137.
76. *Facts & Figures Patient Care Acitivity*, UNIVERSITY OF MICHIGAN, MICHIGAN MEDICINE, http://www.uofmhealth.org/about%20umhs/facts-figures (last visited Jan. 21, 2017).

transparency policy.[77] UMHS's transparency policy was created by attorney Richard Boothman.[78] Boothman, while trying his first medical malpractice case in 1981, realized that "sometimes patients just want to be heard."[79] The case involved a plaintiff who had suffered a major infection after abdominal surgery.[80] She had not spoken to her doctor in the six years that had passed between the surgery and the trial.[81] During her doctor's testimony at trial, the plaintiff realized that her doctor had done the best that he could.[82] The plaintiff won the case and as she exited the courtroom, she spoke to the defendant surgeon and said, "If I had known everything I know now, I would have never sued you."[83]

Boothman used what he learned in the courtroom to develop the transparency policy and remake UMHS's medical malpractice system.[84] Prior to Boothman's process, medical malpractice claims at UMHS were immediately outsourced to defense attorneys who tended to challenge all claims.[85] Boothman advocated that claims should be reviewed first by a committee of impartial medical providers.[86] If the committee determined unreasonable care was provided, the physician was encouraged to meet with the patient face-to-face and the health system quickly offered a reasonable settlement.[87] Boothman's transparency process proved to be effective and is still in place today.[88]

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77. *See* Boothman, *supra* note 66, at 138.

78. Dr. Darshak Sanghavi, *Medical Malpractice: Why Is It So Hard for Doctors to Apologize?*, BOSTON GLOBE (Jan. 27, 2013), https://www.bostonglobe.com/magazine/2013/01/27/medical-malpractice-why-hard-for-doctors-apologize/c65KIUZraXekMZ8SHlMsQM/story.html. Boothman "is the Chief Risk Officer at the University of Michigan Health System and Assistant Adjunct Professor in the Department of Surgery at the University of Michigan Medical School." Richard Boothman, MICHIGAN MED. DEPT. OF SURGERY, https://medicine.umich.edu/dept/surgery/richard-boothman-jd (last visited Oct. 8, 2017). In July 2001, Boothman left his position as a trial attorney at a "malpractice defense law practice in Michigan and Ohio and joined the University of Michigan Health System" where he developed a new approach to medical errors that is now known as the Michigan Model. *Id.* "In 2005, Rick advised then-Senators Clinton and Obama in the formulation of legislation called the MEDiC Act." *Id.* In 2006, "at the invitation of Chairman, Senator Michael Enzi (R-WY) Rick testified before the United States Senate Committee on Health, Education, Labor and Pensions. . . . *Id.*).

79. *Id.*

80. *Id.*

81. *Id.*

82. *Id.*

83. *Id.*

84. *Id.*

85. *Id.*

86. *Id.*

87. *Id.*

88. *See id.*

Michigan law also influenced the development of UMHS's transparency policy. Under Michigan state law, before a medical malpractice suit, the "plaintiff must provide the prospective defendants" with a written notice that details the "specifics of the intended claims."[89] Michigan law requires the following to be included in the pre-suit notice:

> (a) The factual basis for the claim;
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> (b) The applicable standard of practice or care alleged;
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> (c) The manner in which the applicable standard of care was breached;
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> (d) The alleged action that should have been taken to achieve compliance with the alleged standard of care;
>
> (e) The manner in which it is alleged the breach of the standard of care was the proximate cause of the injury claimed in the notice;
>
> (f) The name of all health professionals and health facilities the claimant is notifying under this section in relation to the claim.[90]

Plaintiffs cannot file suit for 182 days after serving the notice.[91] The purpose of the pre-suit notice is to allow defendants the opportunity to investigate the plaintiffs' claims.[92] Additionally, the defendants can interact with the patient and the patient's family in order to determine if there is a more appropriate resolution than litigation.[93] However, very few Michigan health care institutions and providers utilize the pre-suit notice period.[94]

UMHS, noticing the lack of utilization of the pre-suit notice, decided to make a change within its system.[95] Rather than relying on the pre-suit notice alone, UMHS's Risk Management Department invested in developing and implementing an online incident reporting system to prompt transparency and proactivity.[96] The online incident reporting system is an important invention because it allows providers in states without a pre-suit notice statute to have a model for a transparency system.[97]

Implementing a transparency program is no small task in any health system, let alone one that is as large as UMHS. To accomplish such a feat, UMHS's Department of Risk Management educated the entire health system

89. Boothman, *supra* note 66, at 137.
90. Mich. Comp. Laws. § 600.2912b(4) (1993).
91. *Id.*
92. Boothman, *supra* note 66, at 138.
93. *Id.*
94. *Id.*
95. *Id.*
96. *Id.*
97. *Id.*

staff about the system's use.[98] Additionally, Risk Management publicized system-wide the "importance of early notification of patient injuries."[99]

The transparency program has three primary goals. First, the policy seeks to compensate injured patients "quickly and fairly when unreasonable medical care" is given.[100] Second, when medically reasonable care is given, the policy encourages the health system to vigorously defend such care.[101] The final goal is to reduce patient injuries (and subsequently claims) by using patient experiences as an educational tool for how to proceed in the future.[102]

The key determination that needs to be made from the outset is whether or not the care rendered was medically reasonable or unreasonable.[103] Such a determination dictates what the institution's response will be to the situation, i.e. whether or not acting transparently to the patient is appropriate.[104] UMHS compiled committees of experienced caregivers ranging from nurses to health administrators who were charged with the task of performing detailed investigations into medical error claims.[105]

Committee members begin each claim review by asking two questions.[106] First, "was the care at issue reasonable under the circumstances?"[107] Second, "did the care adversely impact the patient's outcome?"[108] The committee also considers "every case for potential peer review, quality improvement, and educational opportunities."[109] The discussions, actions, and activities of the committee are protected from discovery as they are commenced in anticipation of litigation.[110]

After evaluation, if the committee determines that the care rendered was unreasonable, UMHS attorneys and Risk Management staff invite the patient

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98. *Id.* ("The Department of Risk Management undertook the ambitious dual tasks of educating the staff in the system's use and publicizing the importance of early notification of patient injuries toward maintenance of a comprehensive databank to evaluate trends and patterns. The staff increasingly utilizes the system; the number of reports grew from 3,891 in 2002 to 13,989 in 2006, and the growth continues. More potential claims are captured through the system than before its implementation—on more than one occasion, calls have been placed from the operating room.").

99. *Id.*

100. *Id.* at 139.

101. *Id.*

102. *Id.*

103. *Id.*

104. *Id.*

105. *Id.*

106. *Id.* at 140.

107. *Id.*

108. *Id.*

109. *Id.*

110. *Id.*

and their legal counsel to participate in an open and honest dialogue about the issues raised in the course of their medical treatment.[111] Discussions occur between the patient and their doctors and between doctors and the patient's attorney.[112] Experts are also invited into the discussion to give educated opinions on the events that occurred.[113] As a result of such forthcoming discussions, patients are more educated on what occurred and more often than not, agreements are reached to either dismiss the claim or to settle.[114] Less often, agreements to disagree and proceed to litigation occur.[115]

In conclusion, the transparency process serves the human dignity of the patient and provides a mechanism for deterring litigation. Transparency respects the human dignity of the patient because it provides the patients with full disclosure of events that gave rise to the grievous harm that occurred to their bodies. The transparency process, building on the open flow of communication established during discussion-based informed consent, facilitates fruitful dialogue between the parties that often results in settlement instead of litigation, which saves time, money, and other resources.

C. *Prong III: Apology Policy*

Children are taught to say "I'm sorry" when they hurt another person.[116] Similarly, when a wrong occurs, human nature inherently desires not only an explanation, but also an apology. These truths hold true in the practice of medicine as well.[117] A physician, emotionally invested in his/her patient, often feels compelled to apologize after a medical error.[118] Moreover, a study conducted by the Mazor group found that 98% of patients surveyed said that in the event of a medical error, they would want the doctor to sincerely apologize for the wrong that occurred.[119]

While an apology is often associated with a simple "I'm sorry," a sincere recognition of harm entails far more than a two-word phrase.[120] A proper

111. *Id*. at 142.

112. *Id.*

113. *Id.*

114. *Id.*

115. *Id.*

116. Nicole Saitta & Samuel D. Hodge, Jr., *Efficacy of a Physician's Words of Empathy: An Overview of State Apology Laws*, 112 JOURNAL OF AMERICAN OSTEOPATH ASSOCIATION 302, 302 (2012).

117. *See* Leape, *supra* note 24, at 3–8 (2012).

118. *See id.*

119. Jennifer K. Robbenolt, *Apologies and Medical Error*, 467 CLINICAL ORTHOPAEDICS AND RELATED RESEARCH 376, 377 (2009).

120. *Id*. at 376; Leape, *supra* note 24, at 5.

apology is defined as "a statement given by one who has injured another that includes recognition of the error that has occurred, admits fault and takes responsibility, and communicates a sincere sense of regret or remorse for having caused harm."[121] Psychologists have found that the benefit of apologies include decreased blame and anger, increased trust, and improved relationships.[122]

Apologies are not only respectful to the human dignity of the patient, but they are beneficial from a legal standpoint as well. In addition to the benefits stated above, psychologists have also found that apologies have the potential to decrease the chance of a medical malpractice suit being filed in addition to helping medical malpractice claims reach settlement.[123] Despite the beneficial aspects associated with apologies, a study found that only 33% of physicians would apologize in a manner that explicitly acknowledged the medical error, and that their inclination to apologize is diminished when the error is one that would be less apparent to the patient.[124]

When a medical error occurs, studies have found that many worries cross a physician's mind. Physicians worry about the harm that was caused to his or her patient.[125] They worry about what will happen to their reputation and fear that their patients and colleagues will no longer trust and respect them.[126] Physicians are consumed by feelings of distress and guilt.[127] Additionally:

> [a] considerable body of literature attests to how the threat of a malpractice action, along with feelings of inadequacy and incompetence, causes immense anxiety among health professionals, and how they adopt a variety of defensive mechanisms—including rationalization, distortion, blame shifting, and omitting mention of the error to the harmed party—when faced with the commission of a harm-causing error.[128]

As remarked throughout this Note, the culture of medicine is not one that fosters honesty about medical error, let alone one that establishes an environment where being vulnerable and apologizing is okay. Physicians are

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121. *Id.*
122. *Id.*
123. *Id.*
124. *Id.* at 378.
125. *Id.* at 377–78.
126. *Id.*
127. *Id.*
128. Banja, *supra* note 17, at 372.

afraid that any acknowledgment of error, even in an apologetic manner, will lead to litigation and a destruction of their career.[129] Aside from cultural pressures, physicians, like any human being, have an inherent psychological difficulty in facing their mistakes and taking ownership of them.[130]

Changing the culture of medicine to not only permit, but to encourage apologies in the event of medical error would be beneficial to the patient and the provider as well. The statistical data clearly shows that almost every patient who has been injured expects and desires an apology. Further, physicians need the closure and self-accountability that apologies bring.[131] Creating an environment where apologies for medical errors are not only accepted, but also encouraged, is in the best interest of the provider and the patient.

Appropriate apologetic communication may differ depending on the circumstances, and the language of the apology policy should clearly reflect this.[132] When it is clear that a medical error has occurred, an apology "accept[ing] responsibility for [the] error and the harm caused" is appropriate.[133] However, when it is clear that the adverse outcome was not caused by error, "an explanation of the cause of the complication coupled with an expression of regret for the outcome and sympathy for the patient's condition seems more appropriate."[134] When it is unclear what caused the outcome, "the caregiver should express regret and sympathy along with the assurance that an investigation will take place."[135] The apology policy should stipulate that caregivers should contact appropriate supervisors and administrative staff in making their determination about which apology is appropriate.

PART III: APPLICATION

To best understand the impact the Open Communication Model would have, consider the following hypothetical situations.[136] Both hypotheticals use

129. Robbenolt, *supra* note 119, at 379.

130. *Id.*

131. *Id.*

132. *Id.*

133. *Id.* at 380.

134. *Id.*

135. *Id.*

136. The hypothetical situations were developed in collaboration with Mary Roelant, RN, BSN, to ensure medical and experiential accuracy. Roelant is a nurse on the cardiac progressive care unit at Saint Joseph Mercy Hospital Ann Arbor located in Ypsilanti, Michigan.

the same fact pattern. The first hypothetical situation details what would happen in a medical error situation under the deny and defend approach. The second hypothetical situation details what would happen if the Open Communication Model were applied.

A. *Hypothetical #1: Deny and Defend*

Cindy Smith, 62, has been healthy all her life, but on Friday night she complained of chest pains. Her husband, Michael, called 911 and an ambulance promptly arrived, taking her to the local hospital. Once at the hospital, Cindy was treated for a heart attack.

After Cindy's heart attack had been treated, Cindy was transported to the cardiac progressive care floor. Her attending physician, Dr. Miller, told Cindy that she needed a cardiac catheterization. Dr. Miller briefly explained the procedure and told her that if he discovered blockage during the heart catheterization, he would need to perform other interventions. Dr. Miller handed the consent form to Cindy, told her that he would schedule the procedure for the next day, and departed from her room to attend to another patient.

Cindy, still overwhelmed by the quick exchange with her doctor, flipped through the consent papers. Most of the medical terminology was foreign to her. Trusting her doctor and just wanting to be well, she flipped to the signature page and scribbled her name on the line.

The following day, the patient population on the cardiac floor was high and Dr. Miller was responsible for several patients in addition to Cindy. When the time for Cindy's procedure came, he had already been working for seven hours straight without a break. Dr. Miller, having performed cardiac catheterizations many times before, began the procedure on autopilot.

During the catheterization, Dr. Miller discovered blockage and decided that a balloon angioplasty would be the most appropriate treatment. Like the heart catheterization, the balloon angioplasty was a procedure that Dr. Miller had performed many times before. Familiar with the task at hand, he continued to work on autopilot. However, this angioplasty would be different than the times before. This time, Dr. Miller made a mistake—he let the balloon inflate too long.

Immediately, Dr. Miller knew he had made a mistake. He tried his best to mitigate the situation, but he knew that Cindy's artery had already been damaged by the over inflation of the balloon. Dr. Miller finished the procedure, remedying the situation as best he could. Post-procedure, it was

discovered that because of the artery damage, Cindy had permanent numbness in her right arm where the balloon angioplasty had taken place.

Cindy wanted an explanation for the adverse outcome of her medical procedure. Dr. Miller, familiar with the terms of his malpractice insurance, declined to speak with her about the details of the error, fearing that any statement might be construed as an admission of liability. After being discharged, Cindy tried contacting the hospital multiple times for an explanation to no avail. She was left with no other option but to seek legal counsel.

Cindy contacted the hospital through her legal counsel initiating suit and offering to settle. The emotional pain of the situation had already taken so much time and all Cindy wanted was a resolution. The hospital rejected Cindy's offer and counteroffered with a significantly smaller sum. After negotiating for months, both parties were frustrated and could not reach a settlement amount.

Cindy's medical malpractice case proceeded to litigation. During trial, Dr. Miller and other witnesses for the hospital denied that any wrong had occurred because Cindy signed a consent form containing the risks of an angioplasty, which included damaged arteries. Ultimately, Cindy's suit took two and half years, resulting in a $750,000 jury verdict.

B. Hypothetical #2: Open Communication Model

Consider Cindy's case under the Open Communication Model. Under this hypothetical situation, Dr. Miller, although overwhelmed with a heavy patient load, has received extensive training on the importance of discussion-based informed consent. Rather than simply giving Cindy a form, he takes the necessary time to explain the angioplasty to her and details the various risks, benefits, and alternatives. Only after he has done so does he depart the room to check on his other patients. After the medical error occurs, Dr. Miller promptly logs the error in the hospital's reporting system. The evaluation committee receives the report and begins investigating, eventually determining that Dr. Miller's error was unreasonable care given the circumstances.

The hospital reaches out to Cindy about meeting and discussing the situation. Hospital administrators, Dr. Miller, and the hospital's legal counsel meet with Cindy to discuss what happened. Dr. Miller is given the opportunity to explain that his long shift and heavy patient load contributed to his careless act. Cindy is given a chance to respond and ask questions. After all the relevant information is disclosed, both parties discuss a reasonable settlement

in light of better understanding the other party's position. More likely than not, settlement is reached between the parties due to the open and honest flow of communication. Dr. Miller is also given the opportunity to apologize to Cindy for his carelessness and for the affect that it has had on her life. As a result of the discussions, Cindy is able to receive the compensation she desires most: an explanation and an apology. Through this process, both parties have saved resources while more effectively and efficiently achieving their respective goals.

CONCLUSION

The hypothetical above demonstrates how the Open Communication Model better satisfies the goals and needs of all the interested parties in medical malpractice situations. In the first hypothetical, the patient is left wondering and forced into utilizing legal counsel as she had no other option. Additionally, the physician is forced to subdue his humanity and remain distant from his patient. On the contrary, in the second hypothetical, the open flow of communication at all stages of care allows all involved parties to be involved in finding an effective solution to the medical error.

As demonstrated throughout this Note, the Open Communication Model is better for all involved parties. The insurance provider, seeking to avoid liability payouts, is benefitted by the committee review under the transparency policy because it better ensures that payouts are given only when the physician practiced unreasonable care as the committee is comprised of disinterested and experienced clinicians. Without committee review, the insurance company may make payouts when the physician did not in fact deliver unreasonable care.

The Open Communication Model benefits the hospital or health system because it facilitates better customer service by fostering and respecting the trusting relationship between the physician and the patient. Health care is ultimately a business of customer service, so providing excellent service is imperative for continuing a successful business. Additionally, the hospital is benefitted because the Open Communication Model encourages physicians to practice medicine under the science of medicine, not fear of the law. Again, this point comes back to customer service. Patients who receive remarkable care are more apt to come back and to encourage other individuals to come receive care there as well. Further, physicians are better psychologically in the event of a medical error because they are allowed to converse with and apologize to the patient after the medical error occurs.

Finally, the Open Communication Model benefits the patient, who has been harmed in the most intimate way, because rather than facing silence, the patient is afforded an explanation about the events that occurred giving rise to his or her injury. This gives the patient the compensation he or she truly desires, one that a high jury award or settlement payout cannot compete with.

In conclusion, while the deny and defend approach works, it is not the best approach to meet the various goals of the insurance company, the provider, and the patient. For the reasons explained in this Note, the Open Communication Model is an alternative approach to medical errors that better serves all parties.[137]

137. For an overview of the flow of the Open Communication Model, see *Figure 1*.

FIGURE 1: OPEN COMMUNICATION MODEL