When a patient experiences adverse medical events, the patient and family look to their physician for compassion and for guidance on how to understand the events. If the physician does not communicate well or timely with the patient and family, the scene is set for misinterpretation and hard feelings to arise. The combination of failed physician communications and adverse events is the single most common cause of medical malpractice claims.

Physicians may postpone, delay, or delegate this important conversation in these difficult situations. They may even hesitate to extend condolences for fear it will be taken as an admission of guilt or acceptance of blame.

For the sake of the patients, families and physicians, it would be better to remove the basis for that fear and promote empathetic and compassionate communications. That is the basis for “I’m Sorry” legislation.

**Louisiana “I’m Sorry” Legislation in 2 Parts**

The Louisiana Legislature passed Act 63 in 2005, known as the “I’m Sorry” Act. Louisiana and now 34 other states have apology laws on the books. The intention is to protect compassionate statement and condolences from being used against physicians in a court of law. It is hoped that this protection will encourage physicians to make such empathetic and compassionate communications.
The first section of the Act (La RS 3715.4) provides protection from discovery for risk management data generated by insurance companies such as LAMMICO, other insurance types of organizations such as the State Office of Risk Management or various public liability trusts. This protection is similar to that provided to Risk Management and Peer Review data generated in hospitals.

The purpose of the first section is to encourage organizations to use their professional claims and risk management information to facilitate the identification of underlying causes of unanticipated, adverse patient outcomes or a professional liability loss. The Legislative intent was to encourage the use of such data to conduct studies, review data, and promote practice changes for the purpose of improving patient health care quality or reducing professional liability claims.

The second section of the Act (La RS 3715.5) and the focus of this monograph is to allow and encourage physician and patient communications after an untoward event. The spotlight is on any communication including but not limited to, oral or written statements, gestures or conduct by a healthcare provider expressing or conveying regret, grief, sympathy, commiseration, condolence, compassion or a general sense of benevolence.

These emotions or verbal support can be made to the patient, a relative of the patient, an agent or representative of the patient. The communications shall not constitute an admission or statement against interest and shall not be admissible in evidence to establish liability in Medical Review Panel, Arbitration or a civil suit alleging medical negligence.

“I’m Sorry”, Not “It’s My Fault”

An important Word of Caution: The law provides that any statement of fault, which is part of, or in addition to, the empathetic discussion may be admissible in a civil action or lawsuit.

The State Legislature intended to encourage healthcare practitioners to communicate with their patients and the patient’s family subsequent to an untoward or unexpected medical event or outcome.

But care must be taken to make sure that this communication does not include discussion or speculation as to fault or blame.

As medical professionals we deal with the potential for untoward events on a regular basis. Webster’s Dictionary defines untoward as unfortunate or hard to control. Such risks do not generally occur but statistically speaking there is always a possibility that they may occur.
Studies have demonstrated that patients and families need more communication from their physician when in the course of medical care an unexpected, unusual or untoward event occurs.

Differing Points of View

Patients should be made aware that medicine is not an exact science and that untoward events do occasionally occur—untoward events occur even when everyone does what they were supposed to do. Unfortunate outcomes occasionally occur despite our best efforts. Possibilities of untoward events can be explained by giving examples such as:

- Patient develops drug reaction
- Patient develops sterile abscess

Explain to the patient/family how you handle such events.

Keep in mind that there are various perspectives from which an untoward medical event will be viewed. The patient or family will have a different perspective than the physician in charge of the patient’s medical care; the physician’s view may be different from the hospital’s view. Generally the patient will have an acute need for an empathetic exchange with his or her physician. The patient’s point of view will be more psycho-social giving rise to three basic questions.

After untoward medical event patients want answers to the following questions;

- What is being done to correct the problem I now have?
- How will this affect my health in the short and long term?
- Am I going to be responsible for the cost caused by the untoward medical event?

The physician generally will be driven by the need to complete a bio-medical analysis of the untoward event. The hospital, in addition to being concerned about the patient’s care, will be concerned about their various regulatory requirements.

The “I’m Sorry” law will help physicians to meet their patient’s acute need for an empathetic conversation with his/her physician subsequent to an untoward medical event.
Preparing for the Discussion

While it is important to conduct the empathetic discussion as soon as possible after learning of an untoward medical event, the discussion should not be rushed or made in haste.

Prior to the discussion with the patient/family

- Collect your thoughts; make sure your purpose is to communicate an expression of empathy and not a defensive explanation; carefully think through the wording of the empathetic expression you are about to make to your patient.
- Make sure you address the three questions patients typically need answered.
- Coordinate your discussion with appropriate individual at your healthcare institution especially as it relates to additional hospital charges.
- LAMMICO's Risk Management department is available if you need to discuss a unique situation.

Remember you, the patient’s physician, are in control of the discussion. But before the discussion takes place you need to decide...

When should the empathetic discussion take place?

- The discussion should take place as soon as possible after the discovery of the occurrence of an untoward event.
- Set aside appropriate time to have the discussion. A rushed discussion made in apparent haste can be worse than no discussion at all.

How should the discussion be conducted?

- The physician should set tenor of the discussion from the outset.
- Body language must be in synch with your words and tone of voice.
- Sit in a chair placed within touching distance and maintain appropriate eye contact.
- You recognize that your patient is upset due to the news of an untoward event.
- Take control by not becoming defensive and offer an empathetic expression such as, I’m sorry you’re upset—I’m upset about this too. I am doing everything I can to understand how and why this happened.
An expression of regret validates the patient’s anxiety, pain and fear. A simple statement such as...

- I really regret this has happened. I know it’s not what either of us wanted or expected and I’d like you to know how very sorry I am for what you are going through.

- Note the use of I not we in this example, the use of “I” – as opposed to “we” – keeps the discussion on a very personal level and it reinforces the fact that you are in control of the patient’s healthcare.

Taking responsibility for directing your patient’s care does not imply that you are responsible for an untoward event.

- I am responsible for your care and will find out what happened. If possible, why it happened. I will keep you posted of what I learn and how it can be used to prevent such events in the future.

Taking responsibility for drug reaction.

- I am responsible for your care. The drug reaction you experienced has been reported, but it is very uncommon. I have checked with other authorities and it does not appear that anything could have been done to anticipate your reaction.

Patients who experience an untoward medical event want to know what will be done to correct their new medical problem and that it will not happen again.

- I am personally going to do everything in my power to understand why and how this happened, and I will keep you informed on what I find out. In the meantime, I have ordered appropriate treatment that will help. While it is still a little too early to tell, I don’t think this will result in any long-term health problems, but I will verify that with lab tests in a week or two. I want you to know this problem occurred because of a communications problem and I am already looking into making changes to prevent similar occurrences in the future.

All of these examples were taken from *Healing Words: The Power of Apology in Medicine* by Michael S. Woods, M.D. As risk management professionals we have found this book to be an excellent resource for physicians seeking more information regarding the use of empathetic communications in modern healthcare.

Again, we need to stress:

- Avoid discussions related to fault or blame
- Focus discussion on patient’s and the physician’s primary area of concern—the patient’s medical care
Be careful of your choice of words:

- Saying “I’m sorry you were hurt” is protected communication
- Saying “I’m sorry I hurt you” may not be protected communication

**Empathetic I’m Sorry – Example**

The family can play an important role in the patient’s evaluation of the quality of his medical care. When appropriate, and with the patient’s permission, include the family in discussions of your plan of care.

**Example:** “Mrs. Jones, the surgery is over and I know you were looking forward to taking your mother home in a few days... But, I’m sorry to tell you she’s in the ICU... the surgery didn’t work out the way we expected. I’m so sorry... I can only imagine how upsetting this must be for you. Please know we are looking into what happened and will have some initial answers for you in the next two days...”

**What was said...?**

- Speed: “I’m sorry” should be provided as soon as possible after adverse event
- Empathy: personalized and feelings of patient/family acknowledged
- Say “I’m sorry”
- Taking the situation seriously
- Customer service elements
- Staying connected!

**What was NOT said?**

- No Admission of Fault. Do NOT prematurely admit fault or play retrospection game.
- No jousting or speculation – this is not the time to throw colleagues under the bus!

**How do you document in the chart after the empathetic conversation?**

- The truth, the whole truth, and nothing but the truth.
- Write down what you said, anything the patient or family said, and promised next steps.
- No emotional statements or speculation and no derogatory remarks about patient, family, or colleagues.
Patient Perceptions

A review of Risk Management’s claim database demonstrates that 26% of claims filed were filed by the deceased patient’s family—this demonstrates how important it is to establish rapport with the patient’s family. Keep in mind that the patient and family make a psychosocial evaluation of medical care which is distinctly different than the biomedical evaluation typically made by the physician. This sometimes creates a communication barrier between the physician and the patient and family. In these situations, an empathetic conversation is more important to the patient/family than a scientific evaluation of the untoward medical event.

Several studies have been published that demonstrate the patient’s perception of an uncaring physician when dealing with an untoward medical event.

- A March 1992 study published in JAMA demonstrated that 24% of patients in the study who filed claims against their physician did so in part because they perceived an attempt to “cover-up” an untoward medical event, and 20% filed claims because they needed more information about the untoward medical event.

- A similar study published in June 1994 in the Archives of Internal Medicine and a 2000 study conducted by LAMMICO’s RM department produced similar results.

- 32% of the patients interviewed for the 1994 study stated they felt that the physician had deserted them, and 29% felt that the physician devalued their views.

The 2000 LAMMICO study of patient/family depositions attempted to determine why the patient decided to file a claim against their physician. Over 1000 patient/family depositions were reviewed to determine why the patient or family elected to file a claim against their physician:

- 36% felt the physician did a poor job providing information,
- 20% stated that they felt their physician had deserted or abandoned them and
- 25% stated that the physician had devalued or dismissed the patient/family views.

All of these studies demonstrate the need for empathetic communications between the physician and patient subsequent to an untoward medical event.
Unrealistic Expectations

A patient’s unrealistic expectations may result in patient dissatisfaction even when there is an acceptable medical outcome. Managing unrealistic expectations will reduce the potential for patient dissatisfaction. It will also make communication with your patient after an untoward medical event much easier. There are many reasons that patients have unrealistic expectations.

We live in the era of entrepreneurial medicine—many physicians are seeking ways to improve their cash flows—part of this effort may involve advertising. As risk managers we recognize advertising as a possible source of patient’s/family’s unrealistic expectations.

Occasionally the physician’s office staff will encourage unrealistic expectations by assuring patients that “our doctor never has any problems with this procedure.” Statements such as these, while made with good intentions, can result in patients assuming that there is no chance of any problems associated with a given medical or surgical procedure.

Part of the competitive nature of many modern day medical practices may encourage unrealistic patient expectations. “Puffing” or hyperbole—that all parties know or should know is in fact exaggeration—may also result in unrealistic expectations.

Another possible source of the patient’s unrealistic expectations is the informed consent process. During this process, the material risks of procedures are disclosed and discussed. In an attempt to allay fear that might arise from the discussion of possible complications, the physician may over assure the patient by stating something similar to “I’m required to tell you about these things but they never really happen—you will be just fine.” Such an unqualified assurance should be avoided because they may cause the patient and family to have unrealistic expectations regardless of what was written on the informed consent form.

Use the informed consent process as an opportunity to educate patients regarding the possibility of the occurrence of a material risks associated with a proposed procedure. Be sure to question your patient about their understanding, and remember that patients do not always hear or understand the details of medical explanations.

For informed consents obtained in your office, consider having an employee question the patient about their understanding of what the physician has just explained to them. If the patient states that he/she does not understand, take the time to return and clarify with the patient. Be sure to document your conversation with the patient in the progress notes and have the employee document their conversation with the patient also.

Related online CME resource: www.lammico.com, “Beyond Informed Consent (Louisiana)”
Traditionally the physician’s role is to direct, coordinate, and evaluate the patient’s medical care. In this traditional role the physician has had very limited focus on the psychosocial aspects of medical care—such as providing the patient with empathetic communications after an untoward medical event.

Clear communications between the physician and patient can be difficult under these circumstances because the same words may have completely different meanings or importance to each party in the communication, and each party is concentrating on different aspects of the same problem—the physician concentrates on understanding and explaining the bio-medical aspects while patients are seeking, or expecting, answers to their psychosocial concerns.

There are numerous educational opportunities to help you break down the barriers to effective communication with your patient. Dr. Wendy Levinson published an article titled A Study of Patient Clues and Physician Responses in Primary Care and Surgical Settings in JAMA. 2000; 284 (8), giving excellent advice on how to recognize patients needing additional information from their physician.

The Hospital’s Perspective

The hospital’s perspective on untoward medical events is different than either the patient’s or the physician’s perspective. The hospital is responsible for specific requirements under Joint Commission standards related to patient safety, and sentinel event reporting. The hospital also has a legal duty to fulfill its corporate obligation regarding credentialing, quality monitoring, peer review and medical staff bylaws.

The hospital’s performance of its duties and Joint Commission requirements should not be part of the physician’s empathetic communication with his/her patient under the “I’m Sorry” law. Maintaining patient rapport after an untoward medical event is the goal of the “I’m Sorry” law – fulfilling hospital regulatory requirements or even avoiding a medical malpractice claim is NOT the primary goal of the “I’m Sorry” law. As risk management professionals we believe that empathetic communications will promote physician patient rapport and good will. It may very likely help prevent some medical malpractice claims and it will also make it easier for the hospital to fulfill its regulatory requirements. However, this is secondary to the primary goal of maintaining patient physician rapport via empathetic communications subsequent to an untoward event.
Roadblocks to Empathetic Communication

What are some of the roadblocks to empathetic communications? One roadblock is fear that any discussions subsequent to an untoward medical event may be used against the physician should a legal claim be filed at a later date. The “I'm Sorry” law was passed in order to overcome this roadblock.

Similarly some professional liability insurance companies have recommended to their insureds that the insured not talk to anyone about an incident without first clearing it with a representative of the insurance company. The passage of the “I’m Sorry” law will now allow an insured to have an empathetic conversation with their patient.

Denial can also be a roadblock to disclosure. In the case of an untoward medical event, the physician should exercise authority as the individual responsible for the coordination of the patient’s healthcare. An empathetic discussion should be initiated subsequent to the occurrence of the untoward medical event. The “I'm Sorry” law does not allow for the delegation of this responsibility—the discussion must be done by the patient’s physician.

It is very important to understand that saying “I'm sorry” is not the same as saying “It is my fault.” Remember that any admission or inference that the untoward medical event was your fault may become admissible should a legal claim be filed at a later date.

The law encourages and protects empathetic physician/patient communications. It does not protect discussion of fault. Fault indicates an act to which blame, censure, impropriety, shortcoming or culpability attaches. During the empathetic discussion the physician must avoid discussion of fault. Aside from the legal considerations, avoiding discussions of fault is a matter of common sense because at the time of the empathetic discussion it is unlikely that a complete assessment of the circumstances would have been completed and therefore complete knowledge of the facts involved would not be available. An attempt at this time to assign fault would be speculative at best. The “I’m Sorry” law clearly states that: “A statement of fault, however, which is part of or in addition to, any such communication, shall not be made inadmissible pursuant to this Section.” In other words any statement or admission of fault may later become admissible.

It is a fundamental ethical requirement that a physician should at all times deal honestly and openly with patients. Patients have a right to know their past and present medical status and to be free of any mistaken beliefs concerning their conditions. Situations occasionally occur in which a patient suffers significant medical complications that may have resulted from the physician’s mistake or judgment. In these situations, the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred.
Only through full disclosure is a patient able to make informed decisions regarding future medical care.

Concern regarding legal liability that might result following truthful disclosure should not affect the physician’s honesty with a patient (AMA Code of Ethics, Current Opinion E8.12 updated October, 2005).


Summary

- After an adverse event, patients and families look to their physician for compassion and guidance in understanding what happened.

- Providing an explanation of the facts as presently known and making as empathetic statement of condolence such as, “I'm sorry you were hurt” can help the physician maintain rapport with patient/family in the face of an untoward medical event.

- Failure to provide such condolence and understanding may cause the patient/family to become suspicious and question whether or not the physician really cares about the patient.

- Adverse events in combination with physician failures of communication are the single most common cause of medical malpractice claims.

- Louisiana’s “I'm Sorry” law protects from discovery those physician-to-patient communications conveying “regret, grief, sympathy, commiseration, condolence, compassion, or a general sense of benevolence”.

- In communicating to patient/family, the physician should avoid any speculation regarding fault or attempts to identify who was responsible for the untoward medical event.

- In communicating to patient/family, you should assure the patient that his or her medical care is your primary concern.

- The staff of LAMMICO's Risk Management Department is available to discuss the “I'm Sorry” law if you have additional questions.

This educational material is not intended to substitute for individualized clinical judgment. It does not dictate an exclusive method of care, and it is not applicable to all circumstances and all patients.
Bibliography - “I’m Sorry”: How Louisiana Legislation Protects Compassionate and Empathetic Expressions

Note: Web links can change over time. If link no longer works, web-search the article by title.

Other Resources


References

5. LAMMICO Risk Management unpublished claims study.

Louisiana “I’m Sorry” Legislation

Two Parts: La RS 3715.4 (risk management confidentiality part) and 3715.5 (“I’m Sorry” part)

§3715.4. Confidentiality of risk management and other information
A.(1) The legislature finds and declares that medical professional liability insurers, health care provider professional and public liability trusts created pursuant to R.S. 22:46, the office of risk management, and the Patient's Compensation Fund have professional liability claim information that would facilitate identification of an underlying cause of an unanticipated, adverse patient outcome or a professional liability loss, or both. The purpose of this Section is to encourage a medical professional liability insurer, health care provider professional and public liability trust created pursuant to R.S. 22:46, the office of risk management, and the Patient's Compensation Fund to use professional liability claim information to conduct studies, review data, and promote practice changes for the purpose of improving patient health care quality or reducing professional liability claims, or both.

(2) Information of any kind, whether created, generated, or compiled by a medical professional liability insurance company, health care provider professional and public liability trust created pursuant to R.S. 22:46, the office of risk management, or the Patient's Compensation Fund, including but not limited to a third-party administrator or risk manager thereof, to identify an underlying cause of an unanticipated, adverse patient outcome or a professional liability loss, or both, and any risk management or loss prevention conclusion or recommendation shall be deemed confidential and shall not be subject to discovery, produced in response to court subpoena or court order, admitted into evidence in any civil action, or subject to the provisions of R.S. 44:1 et seq., the Public Records Act. The foregoing notwithstanding, factual information that is otherwise discoverable from the health care provider, subject to subpoena to the health care provider, or admissible in evidence shall not be deemed confidential because it has been reviewed or used for purposes of risk management or loss prevention, or both, by a medical professional liability insurer, health care provider professional and public liability trust created pursuant to R.S. 22:46, the office of risk management, or the Patient's Compensation Fund.

(3) No individual or person involved in creating, generating, compiling, or analyzing such confidential information or who was in attendance at any meeting in which such information is discussed, created, generated, compiled, or analyzed shall be required to testify in any medical review panel proceeding, arbitration proceeding, or civil action as to any discussion, finding, recommendation, opinion, proceeding, or other action of the medical professional liability insurer, health care provider professional and public liability trust created pursuant to R.S. 22:46, the office of risk management, or the Patient's Compensation Fund.

B. Any court order or judgment ordering production or admissibility in evidence of any information described in the provisions of this Section, except an order for an in camera inspection, shall be deemed to be an interlocutory judgment which may cause irreparable injury and shall be subject to appeal pursuant to the provisions of Code of Civil Procedure Article 2081 et seq.

http://www.legis.state.la.us/lss/lss.asp?doc=320824
§3715.5. Confidentiality of communication from health care provider

Any communication, including but not limited to an oral or written statement, gesture, or conduct by a health care provider expressing or conveying apology, regret, grief, sympathy, commiseration, condolence, compassion, or a general sense of benevolence made to a patient, a relative of the patient, or an agent or representative of the patient, shall not constitute an admission as defined in Code of Evidence Article 801(D)(2) or a statement against interest as defined in Code of Evidence Article 804(B)(3), and shall not be admissible in evidence to establish liability or for any other purpose, including impeachment, in a medical review panel proceeding, arbitration proceeding, or civil action brought by or on behalf of the patient or by or on behalf of an heir, survivor, statutory beneficiary, or agent or representative of the patient against the health care provider who made the communication. A statement of fault, however, which is part of, or in addition to, any such communication shall not be made inadmissible pursuant to this Section.

http://www.legis.state.la.us/lss/lss.asp?doc=320825