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Doctors Say 'I'm Sorry' Before 'See You in Court'

By [KEVIN SACK](#)

CHICAGO — In 40 years as a highly regarded [cancer](#) surgeon, Dr. Tapas K. Das Gupta had never made a mistake like this.

As with any doctor, there had been occasional errors in diagnosis or judgment. But never, he said, had he opened up a patient and removed the wrong sliver of tissue, in this case a segment of the eighth rib instead of the ninth.

Once an [X-ray](#) provided proof in black and white, Dr. Das Gupta, the 74-year-old chairman of surgical oncology at the [University of Illinois](#) Medical Center at Chicago, did something that normally would make hospital lawyers cringe: he acknowledged his mistake to his patient's face, and told her he was deeply sorry.

“After all these years, I cannot give you any excuse whatsoever,” Dr. Das Gupta, now 76, said he told the woman and her husband. “It is just one of those things that occurred. I have to some extent harmed you.”

For decades, malpractice lawyers and insurers have counseled doctors and [hospitals](#) to “deny and defend.” Many still warn clients that any admission of fault, or even expression of regret, is likely to invite litigation and imperil careers.

But with providers [choking](#) on malpractice costs and consumers demanding action against medical errors, a handful of prominent academic medical centers, like Johns Hopkins and Stanford, are trying a disarming approach.

By promptly disclosing medical errors and offering earnest apologies and fair compensation, they hope to restore integrity to dealings with patients, make it easier to learn from mistakes and dilute anger that often fuels lawsuits.

Malpractice lawyers say that what often transforms a reasonable patient into an indignant plaintiff is less an error than its concealment, and the victim's concern that it will happen again.

Despite some projections that disclosure would prompt a flood of lawsuits, hospitals are reporting decreases in their caseloads and savings in legal costs. Malpractice premiums have declined in some instances, though market forces may be partly responsible.

At the [University of Michigan](#) Health System, one of the first to experiment with full disclosure, existing claims and lawsuits dropped to 83 in August 2007 from 262 in August 2001, said Richard C. Boothman, the medical center's chief risk officer.

"Improving patient safety and patient communication is more likely to cure the malpractice crisis than defensiveness and denial," Mr. Boothman said.

Mr. Boothman emphasized that he could not know whether the decline was due to disclosure or safer medicine, or both. But the hospital's legal defense costs and the money it must set aside to pay claims have each been cut by two-thirds, he said. The time taken to dispose of cases has been halved.

The number of malpractice filings against the University of Illinois has dropped by half since it started its program just over two years ago, said Dr. Timothy B. McDonald, the hospital's chief safety and risk officer. In the 37 cases where the hospital acknowledged a preventable error and apologized, only one patient has filed suit. Only six settlements have exceeded the hospital's medical and related expenses.

In Dr. Das Gupta's case in 2006, the patient retained a lawyer but decided not to sue, and, after a brief negotiation, accepted \$74,000 from the hospital, said her lawyer, David J. Pritchard.

"She told me that the doctor was completely candid, completely honest, and so frank that she and her husband — usually the husband wants to pound the guy — that all the anger was gone," Mr. Pritchard said. "His apology helped get the case settled for a lower amount of money."

The patient, a young nurse, declined to be interviewed.

Mr. Pritchard said his client netted about \$40,000 after paying medical bills and legal expenses. He said she had the rib removed at another hospital and learned it was not cancerous. "You have no idea what a relief that was," Dr. Das Gupta said.

Some advocates argue that the new disclosure policies may reduce legal claims but bring a greater measure of equity by offering reasonable compensation to every injured patient.

Recent studies have found that one of every 100 hospital patients suffers negligent treatment, and that as many as 98,000 die each year as a result. But studies also show that as few as 30 percent of medical errors are disclosed to patients.

Only a small fraction of injured patients — perhaps 2 percent — press legal claims.

"There is no reason the patient should have to pay the economic consequences for our mistakes," said Dr. Lucian L. Leape, an authority on patient safety at [Harvard](#), which recently adopted disclosure principles at its hospitals. "But we're pushing uphill on this. Most doctors don't really believe that if

they're open and honest with patients they won't be sued.”

The Joint Commission, which accredits hospitals, and groups like the [American Medical Association](#) and the American Hospital Association have adopted standards encouraging disclosure. Guidelines vary, however, and can be vague. While many hospitals have written policies to satisfy accreditation requirements, only a few are pursuing them aggressively, industry officials said.

“We're still learning the most effective way to have these most difficult conversations,” said Nancy E. Foster, the hospital association's vice president for quality and patient safety. “It's a time of high stress for the patient and for the physician. It's also a time where information is imperfect.”

The policies seem to work best at hospitals that are self-insured and that employ most or all of their staffs, limiting the number of parties at the table. Such is the case at the Veterans Health Administration, which pioneered the practice in the late 1980s at its hospital in Lexington, Ky., and now requires the disclosure of all adverse events, even those that are not obvious.

To give doctors comfort, 34 states have enacted laws making apologies for medical errors inadmissible in court, said Doug Wojcieszak, founder of The Sorry Works! Coalition, a group that advocates for disclosure. Four states have gone further and protected admissions of culpability. Seven require that patients be notified of serious unanticipated outcomes.

Before they became presidential rivals, Senators [Hillary Rodham Clinton](#) and [Barack Obama](#), both Democrats, co-sponsored federal legislation in 2005 that would have made apologies inadmissible. The measure died in a committee under Republican control. Mrs. Clinton included the measure in her campaign platform but did not reintroduce it when the Democrats took power in 2007. Her Senate spokesman, Philippe Reines, declined to explain beyond saying that “there are many ways to pursue a proposal.”

The Bush administration plans a major crackdown on medical errors in October, when it starts rejecting [Medicare](#) claims for the added expense of treating preventable complications. But David M. Studdert, an authority on patient safety in the United States who teaches at the University of Melbourne in Australia, said the focus on disclosure reflected a lack of progress in reducing medical errors.

“If we can't prevent these things, then at least we have to be forthright with people when they occur,” Mr. Studdert said.

For the hospitals at the forefront of the disclosure movement, the transition from inerrancy to transparency has meant a profound, if halting, shift in culture.

At the University of Illinois, doctors, nurses and medical students now undergo training in how to respond when things go wrong. A tip line has helped drive a 30 percent increase in staff reporting of irregularities.

Quality improvement committees openly examine cases that once would have vanished into sealed courthouse files. Errors become teaching opportunities rather than badges of shame.

“I think this is the key to patient safety in the country,” Dr. McDonald said. “If you do this with a transparent point of view, you’re more likely to figure out what’s wrong and put processes in place to improve it.”

For instance, he said, a sponge left inside an patient led the hospital to start X-raying patients during and after surgery. Eight objects have been found, one of them an electrode that dislodged from a baby’s scalp during a Caesarian section in 2006.

The mother, Maria Del Rosario Valdez, said she was not happy that a second operation was required to retrieve the wire but recognized the error had been accidental. She rejected her sister’s advice to call a lawyer, saying that she did not want the bother and that her injuries were not that severe.

Ms. Valdez said she was gratified that the hospital quickly acknowledged its mistake, corrected it without charge and later improved procedures for keeping track of electrodes. “They took the time to explain it and to tell me they were sorry,” she said. “I felt good that they were taking care of what they had done.”

There also has been an attitudinal shift among plaintiff’s lawyers who recognize that injured clients benefit when they are compensated quickly, even if for less. That is particularly true now that most states have placed limits on non-economic damages.

In Michigan, trial lawyers have come to understand that Mr. Boothman will offer prompt and fair compensation for real negligence but will give no quarter in defending doctors when the hospital believes that the care was appropriate.

“The filing of a lawsuit at the University of Michigan is now the last option, whereas with other hospitals it tends to be the first and only option,” said Norman D. Tucker, a trial lawyer in Southfield, Mich. “We might give cases a second look before filing because if it’s not going to settle quickly, tighten up your cinch. It’s probably going to be a long ride.”