Consoling and Apologizing to Patients: What Should You Say?

By: Harry Nelson, Managing Partner

Dr. A. called me. He had received a voicemail message from the grief-stricken husband of a woman on whom he had performed cosmetic surgery just a week earlier. Dr. A. wanted to know what to do and say. He was frankly unsure what the cause of death was and what role, if any, his treatment had played. He had no reason to think he had done anything wrong. The patient had appeared to be recovering appropriately before this shocking news. He had many questions: Should he send flowers? Attend the funeral? What could he say? Dr. A wanted to give the patient's husband and family emotional support, but was wary of taking legal responsibility or being seen as feeling responsible.

Among the things that physicians and other healthcare providers generally don't learn in school is how to speak with patients and their families after bad outcomes and events, particularly when a medical error or possible error is involved. Uncertainty about the degree of responsibility, confusion about what kind of statements are legally protected, and feelings of fear, guilt, shame, or the overwhelming emotional state of upset patients (or grieving family members) only add to a combustible mix. At the same time, the growing belief is that more forthright and empathetic communication from physicians reduces the incidence of malpractice lawsuits and licensing complaints dramatically. (*E.g.* William Sage, Rogan Kersh, *MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM*, p. 151 (Cambridge University Press, 2006).)

So what can and should physicians say?

1. What does the law protect? California, like many states, has an "apology law" that provides that statement, writings, or benevolent gestures "expressing sympathy or benevolence relating to the pain [and] suffering" are inadmissible to prove liability. It is absolutely essential to check the individual state's law; some states protect even more and others protect less. It is also critical to consult with the malpractice carrier, attorneys, and colleagues for advice. California, for example, protects statements of sympathy, no matter who makes them, as long as they are made to a patient or family member, but does not protect statements of fault or that substantiate responsibility, which can be used against physicians.
    - In other words, physicians can – and should freely make – compassionate statements, *i.e.* "I'm so sorry that you are in so much pain"
    - At the same time, physicians in California cannot make acceptance-of-responsibility-statements without legal consequences, such as "I'm so sorry that I hurt you."

2. So how much should the physician say? What to express depends upon whether the circumstances call for expression of empathy or an acknowledgment of fault. It is beyond the

scope of this article when fault should be acknowledged. Expressions of empathy are very different from apologies. If fault is being admitted, then a "good" apology should express: (1) what I did was wrong; (2) I'm sorry I hurt you; and (3) how do I make it better? (Randy Pausch and Jeffrey Zaslow, *THE LAST LECTURE*, p. 162 (Hyperion 2008).) This model works for a case of unmistakable error, but *in any ambiguous circumstance where fault is not being conceded, physician apology needs to be more circumscribed and nuanced*.

- Regardless of fault or the lack thereof, we recommend that physicians always convey three protected elements of what Dr. Michael Woods, author of *Healing Words: The Power of Apology in Medicine* (Doctors in Touch 2007), calls the 5 "R's":
  - **Regret: (**"I am so sorry you are going through this");
  - **Recognition:** ("This has been so hard on you"); and
  - **Remaining engaged:** ("I am here for you.")
- On the other hand, Woods' other two "R's" – (taking) responsibility and (helping) remedy – should be reserved for cases where there is clear, conceded physician error. Based on the law above, physicians should expect that expressions of responsibility (*i.e.* Pausch's expressions that "what I did was wrong" or that "I hurt you" or expressions of remedy ("how I will help you through this" or why "it will never happen again") will be legally admissible.

3. <u>How should the physician say it</u>?

   - <u>Prepared</u>: If consolation is a new skill, physicians should write out the points they want to convey to be prepared and ensure the right message is conveyed with the right tone. Nervousness can lead to saying too much (*i.e.* expressing fault) or to inappropriate defensiveness or, worse, lightheartedness. The consolation or apology should not be read, just thought out carefully in advance.
   - <u>Informative</u>: It is critical to be clear, honest, and direct about what happened. At the same time, too much information can be overwhelming. The worst approach is evasion.
   - <u>In person</u>: Communication should take place face to face. At a minimum, the conversation should be over the phone. Email, which omits emotional tone, is the wrong way to offer consolation or apology.
   - <u>In private</u>: It is easier to speak in a place where the conversation will not be overheard (except by physician staff or colleagues who will be supportive witnesses in cases where litigation or complaints ensure).
   - <u>Informally</u>: It is better to speak in closer proximity, on the same level (*i.e.* both sitting or both standing, without a desk or bed in between doctor and patient).
   - <u>Without delay</u>: Physicians should not put off these talks. Patients (and families) need soothing and good communication most when their feelings are raw.
   - <u>Active listening</u>: As important as what is said, is how it is said. Before speaking, it is essential to defuse emotional or grieving patients or family members with active listening, *i.e.* focusing attention on the speaker, paraphrasing back what you hear, clarifying what is being said in nonjudgmental, without agreeing, disagreeing, or being defensive, conveying that you hear and understand the speaker. Active listening creates a collaborative, emotionally supportive environment. Patients or family members are often as desperate for emotional support as they are for information about what happened and why. Before discussing anything about the medical issues, the physician

must ask the patient (or family member) how he or she is feeling and, if appropriate, ask questions.

- Taking notes: It is important to document the communication and the patient (or families') reaction and to note any witnesses in the patient medical records. Writing down what is said goes hand in hand with active listening. It also is a helpful record if there is any malpractice suit or complaint.
- Sincere: The most important thing is to speak from the heart. It can be a challenge to convey the right tone while staying on message (*i.e.* expressing that you are sorry for what happened, not for having done anything wrong), but the expression must be genuine.

After working out talking points together, Dr. A. called back the husband to express condolences. He was careful to tell the husband how sorry he was for his loss, without saying anything to suggest that the loss had anything to do with Dr. A's treatment. Dr. A. sent a note and flowers, and made a point of checking in with the husband a week later. The husband did not make threats or question the physician, and the issue of a potential malpractice claim subsided without incident. Dr. A. asked us to share the checklist prepared above with other physicians as a guide to preparing for conversations with emotional patients and families.