LEGAL VIEW

How will disclosure affect future litigation?

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INTRODUCTION

Disclosure to patients of unanticipated outcomes is a directive to the health care industry given by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) through the Patient Safety Standards. How disclosure is done, what impact it has both on the culture of the organization as well as on the patient, and how it impacts future malpractice litigation are all areas of concern for the health care provider and entity.

Responding to consumer and government pressure (especially the delivery of the 1999 Institute of Medicine report, "To Err is Human: Building a Safer Health System"), JCAHO added to its survey standards a requirement that each facility have a policy of full disclosure to their patients of "unanticipated outcomes" of care that would correlate to sentinel events.(1) The JCAHO Patient Safety Standards address the need for entity leadership to be focused on safety; for the facility to have processes in place to identify potential safety issues and to prevent reoccurrence; to inform patients and families about outcomes of care, including unanticipated results or outcomes; and to encourage patients to facilitate their own safety while in the facility and to report potential safety situations.(2)

The JCAHO standards encourage clear, objective communication within the team of caregivers, as well as with the patient and family. This includes verbal notification of an unanticipated outcome, discussion of plan of care issues and changes, and documentation of the key points of those conversations. In the language of JCAHO, "error" means an unintended act, either of omission or commission, or an act that does not achieve its intended outcome. A "near miss" is any process variation that did not affect the outcome but for which a recurrence carries a significant chance of a serious adverse outcome.(3)

In situations where litigation is initiated, the disclosure conversation must be considered early in the case – in the discovery phase as well as during the trial strategy formulation.

It is now imperative that every health care facility and physician practice develop and implement a medical error disclosure policy. The policy should reflect the philosophy that the patient and physician are to have an open and honest relationship, including a constant dialogue on the patient's care, treatment, general health and well-being. This policy should then be distributed to all applicable staff for inservice education. This education should focus on skills so that patient needs can be recognized even if the patient directs questions or concerns to personnel other than his or her treating physician.

The policy should also indicate who documents the patient's records when an unanticipated outcome, treatment plan change or other important information needs to be relayed. In most instances, this should be the primary treating physician, since studies have shown that most patients want to hear from their physician when it comes to important information (including negative information) about their health and treatment plans. In addition, the policy should indicate who (and what) should be documented in the patient's records when a disclosure conversation takes place with a patient or family member.

Patient communication

Patient communication has always been an area of contention within the hospital environment, often with significant turf battles taking place between nurses and physicians. Where the nurses may feel obligated to "over communicate" with a patient in a more informal, frequent manner, very often the physician is found to "under communicate." The nurses' perspective is more social and interactive; the physicians' more science-based and formal. Often this does not cause a problem in patients' care or treatment. However, if they feel that the information conveyed is inconsistent, this communication imbalance can be one of the sole deciding factors in whether the patient or family pursues litigation against the providers and entity.

Communicated effectively and correctly, patient disclosure should be open, honest and limited to the information known to be accurate. Speculation on the cause, fault or even on the outcome, is never beneficial. Instead, the health care provider should give the patient *the information that he or she needs to understand what is happening in his or her treatment plan, why any changes have taken place in that plan, and what to be aware of in the form of reactions or consequences.* This way, patients have enough information to appreciate how the situation affects them, but do not

have enough information to shift their focus to external forces or blame. This is important as it gives patients the ability to make informed decisions on treatment plan changes, and bestows upon them the responsibility of communicating any changes in their condition to their health care providers.

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The disclosure conversation should be done in a patient's room, with the attending physician leading the conversation with family present, if possible. If this is not possible, then a provider with whom a patient has developed a relationship should begin the conversation, explaining that an unexpected outcome has occurred, that it will be treated in the best way possible, and that his or her treatment and care is of the utmost concern. Only when immediate concerns about a patient's care and treatment are resolved should the caregiver proceed to answer any questions on the process or system that allowed for the error. Oftentimes, it is sufficient to simply explain that the matter will be investigated and appropriate changes made, but the immediate concern is the patient's safety and well-being. Done incorrectly, disclosure may be an admission of liability (with possibly incorrect information) to a patient. It shifts the focus from the patient's condition, treatment plan or concerns to the blame of an individual or process. This benefits no one, and may even cause subtle changes in the patient's care to be missed due to the distraction of providers and the patient to the cause or event, rather than on the effect on the treatment plan.

Litigation and disclosure

It's unrealistic to think that every disclosure conversation will go as well as planned or that malpractice litigation will never result from these errors or occurrences. Indeed, there likely may be litigation resulting even without the disclosure conversation, since studies show that the primary factor in a patient's decision to pursue a malpractice case is lack of communication from the provider on an unexpected outcome or undesirable result.(4) Knowing this, one could speculate that having any conversation with the patient at all would *decrease the chance of litigation,* and may even alleviate any concerns (emotional, psychological or financial) and thus *prevent* litigation.

In situations where litigation is initiated, the disclosure conversation must be considered early in the case – in the discovery phase as well as during the trial strategy formulation. What was said, how it was documented, and who was present will all be key facts to consider and analyze once a case is filed. However, just because a disclosure conversation took place, it should not be assumed that a jury will immediately perceive this conversation as being an "admission" and find against the provider and entity. Instead, the defense team should decide how to use the conversation, the provider's concern and the information shared to the defendant's advantage.

Mock trial research on medication error case

In studying a case scenario with a disclosure component, a mock trial was developed based on an actual case involving a medication error made by a nurse who administered Lidocaine to a post-CABG patient when a different medication was ordered.(5) The patient was discharged with the residual cardiac damages (in a decreased health condition), but the physicians felt strongly that the decrease was due to the patient's underlying medical condition and not from the medication administered. Because the case had been previously resolved, the end result was known when the research was undertaken.

The case was presented in condensed format to two separate sets of potential jurors, who had been screened to be demographically similar to a potential jury in the actual venue. The first set of jurors heard the facts of the case, and then live testimony from a charge nurse who stated that while the physicians felt that the medication error did not cause the patient harm or change the patient's treatment plan, she (the nurse) felt it was appropriate and necessary to share the occurrence with the patient – even though she was essentially acting contrary to the hospital policy. She explained what had happened and that they would watch the patient closely for any residual effects from the medication, but added that it was the patient's duty to alert the hospital staff if he felt any change. The patient still chose to file the malpractice action, alleging that the residual damage was related to the medication erroneously administered rather than to his underlying condition.

The second jury heard the same set of facts, but with testimony from the charge nurse that the patient did not need to be informed of the medication error since the treating physicians had determined that there would not be any change in the patient's condition and that essentially there was no harm to the patient. Consequently, the patient only learned of the medication administration when another provider in treatment of his continuing medical needs reviewed his medical records.

The groups were then split for deliberation into subgroups: two groups deliberating the disclosure case and two deliberating the nondisclosure case. This better reflected the potential jury size, and also allowed small group dynamics to be evaluated.

The differences in jury deliberations and finding were dramatic. (See **Figure 1**)

FIGURE 1 – The Effects of Disclosure: Juror's Group Verdicts

	No Disclosure		Disclosure	
	GROUP 1	**GROUP 2**	**GROUP 3**	**GROUP 4**
Was the hospital negligent?	12-Yes	12-Yes	12-Yes	11-Yes
Was the hospital grossly negligent?	12-Yes	12-Yes	11-Yes 1-No	1-Yes 10-No
Compensatory Damages	$1,000,000	$4,500,000	$2,000,000	$0 to $10,000
Punitive Damages	$3,000,000	$10,000,000	$1,000,000	$0

Source: Decision Quest, Inc.

Group 4 most significantly addressed the impact of the disclosure on the case, essentially finding for the defendants on liability and damages.

Group 3 felt that the mistake alone was still negligent, but worked to reduce the punitive damages because they felt that "mistakes happen."

Group 1 decided there was, in fact, information shared with the patient, and debated causation of the residual damage and its impact on the patient's continuing medical needs.(6) While the jurors did find liability, their review of the damages (in the form of future wage loss and medical costs) were dramatically lower than the other group. In fact, the dollar amounts awarded were less than that amount paid on the real case. The jurors extensively discussed the disclosure conversation, finding honesty on the part of the hospital and providers due to the disclosure conversation. The discussion among the jurors was calm and rational, discussing how the matter affected the patient and how they felt that the providers had done the right thing in disclosing the error.

Group 2, where no disclosure was made, immediately focused on a "conspiracy theory" within the hospital, and really never even reached causation in their deliberations.(7) It was sufficient for them to find wrongdoing by the hospital staff and providers (the medication error) and the "cover up" (lack of disclosure). Their deliberations focused on punishing the hospital and staff, forcing them to "learn the lesson" of disclosing information with patients in the future, and then awarded damages in multiples of that awarded by the first jury panel. The amount of emotion in the deliberations tracked with the jury's finding that the defendants were in a "conspiracy of silence" in the nondisclosure case. The jurors were incensed that "vital information would be withheld" from a patient.

This second jury group, more typical of most medical malpractice juries in their findings, simply found sufficient basis to award large damages based solely on the existence of perceived injury, rather than needing to determine or debate the causal link between the amount of residual damage to the patient and his underlying medical condition. This deliberation, much different than the first, was emotional and accusatory against the hospital and health care providers.(8)

These findings are extremely important for both health care providers and members of the defense trial team confronted with the defense of a medical malpractice case with a disclosure conversation (or lack thereof). The ability to focus a jury on causation is essential, but typically very difficult due to overwhelming sympathy or empathy for the injured plaintiff. This is one of the many reasons that most medical malpractice cases will result in settlement versus being taken to trial.

Jury research confirms the findings in this mock case and suggests that patients now have an expectation that they will learn quite a bit more information from their providers than may typically have been presented to them in the past.(9) The consumerism in health care, illustrated in all of the media attention given to medical errors and the increasing sophistication of the Baby Boomer patient, means that the patients feel much more savvy and educated than generations before. They want, even demand, to be involved in all aspects of their care (and often the care of their family members). The mystique that may have allowed the surgeon to gloss over the explanation of a surgery in the past has been replaced by the awareness of the media generation, who often look for information (including surgical procedures, medication usage and dosing, treatment complications and the like) on the Internet, on cable TV or in magazines.

DISCLOSURE AS PART OF THE DEFENSE THEME

Getting the defense team, including counsel and insurers, comfortable with addressing the disclosure at trial is a must. The disclosure must be removed from the "smoking gun" characterization that the plaintiff's attorney will employ.

- If a disclosure took place, this must be presented early in the case.
- Use *voir dire* to set an expectation that disclosure does not equal negligence.
- The trial team must be comfortable with disclosure.
- Explain *why* things were told, as well as *what* was told.

Frequently, the media will feature "health segments" that focus on the risks of procedures, medications or medical advancements, encouraging the patient and family to ask questions, seek information and even demand background information on their providers like never before. However, while patients have increased their demands and understanding of the medical profession, the profession itself has not kept pace in teaching communication and conflict management skills to new and practicing physicians and providers. Some physicians who are confronted by a questioning patient may become defensive and evasive, only causing to raise the concern and suspicions of that patient (particularly where there was an unexpected or undesired outcome).

Disclosure as a claims avoidance strategy

From a legal perspective, why does disclosure work? Because it meets the *expectations* of the jurors. Nearly 90 percent of jurors polled felt that there should be disclosure when there is a medical error or mistake; and that this disclosure should be done regardless of whether the error or mistake resulted in any harm to the patient.(10) The disclosing provider is seen as very credible, and may indeed become a key witness at trial for the defense.

Indeed, organizations that have practiced open disclosure approaches with their patients have found that it actually decreases their litigation.(11) Often, the conversation with the patient results in a bill waiver or reduction, or facilitation of another medical resource (a continued stay, social services, discharge planning) to address the patient's resulting medical condition. Once these concerns are resolved, the patient no longer has the incentive to pursue litigation against the providers or facility. In fact, children's hospitals across the country have found this to be the case simply because they often spend much more time communicating with concerned parents over their child's condition than a physician in an acute care setting may spend discussing a care or treatment plan with an adult patient.(12)

Using disclosure to augment causation defenses

Taking malpractice cases to trial with a defense based solely on a causation theory is not a new concept, but may be underused and counsel may therefore not have trial experience in this regard. In some instances, defense counsel's concerns that a causation theory may equate to an admission of liability could be a stronger impediment to taking a case to trial than the facts of the case itself. Frank conversations should be undertaken with counsel, to discuss their experience and comfort with a causation defense, and to identify any special tools or skill updates needed before trial preparation begins.

Because jurors will spend more time discussing the causation of a case where disclosure has taken place, they must be given enough evidence to make reasonable, intelligent decisions based on the medicine involved. This will necessitate making the complex medical issues easy to understand, utilizing medical illustrations, graphics and possibly even animation in order to gain the jury's understanding and acceptance of medical procedures and risks. It is imperative that the illustrations be free of any blood or other prejudicial components, focusing only on the message to be conveyed objectively. There are hundreds of ways to communicate this information to the jury: boards on easels, presentation products like Trial Director or PowerPoint, to name a couple.

The use of such illustrative tools and demonstrative evidence works in more than one way to support the themes of the case. In addition to educating the jury on key medical issues, procedures and topics, it can also guide the jury in its decision-making. It is often difficult for a jury to spend time deliberating on a causal relationship if the jurors are not comfortable with the components of such; and typically in those cases, they may simply jump from facts to injury and damages. Therefore it is important that counsel give the jury the tools needed to understand just what the causal link (or lack thereof) is and how to comfortably argue for or against it during deliberations.

Counsel should feel comfortable presenting a causation defense to the jury, and should be confident that the information provided to them would allow them to focus on causation rather than to simply concentrate on the presence of negligence. The bottom line is that the defense lawyer wants the jury to come to the conclusion that the patient would have been in the same condition even without the medical mistake or unanticipated outcome. If needed, alternative causes for the injury may be presented rather than allowing the jury to rely solely on the theories presented by the plaintiff's counsel. Giving such alternative theories supports strong defense jurors in their discussions with other jurors, increasing the likelihood of a defense verdict. Jurors want to understand, and believe, in the reasons why errors or unanticipated outcomes occur without negligence or fault occurring.

HELPING JURORS ANALYZE DAMAGES

Jurors want to be given information to allow them to understand and address damages and relevant medical information. For an effective defense strategy, present a chart that defines the diagnosis and lists its symptoms; help the jurors conclude the patient had none of these symptoms. Then:

- Provide a defense expert on damages.
- Use exhibits to illustrate comparisons.
- Show damages in easy terms and references.
- Provide alternative damage numbers.
- Be sure counsel is comfortable with the approach.

Some juries find for the plaintiff rather than the hospital defendant in a medical malpractice case simply because the error took place at the hospital.(13) Those jurors have transferred a strong sense of responsibility to the hospital and its administrative policies, and often will have had a personal experience which causes them to feel that they are essentially protecting themselves when they take care of the plaintiff. This needs to be addressed in *voir dire,* to both eliminate potential jurors with this perspective, as well as to gain the panel's agreement that there needs to be more than this fact alone to equate to a finding of liability.

Addressing the disclosure in the case can defuse plaintiff's arguments, but it may not lead to a finding of "no negligence" if the jury feels that the mistake was serious and still should not have occurred. The goal is to enable the jury to understand that a mistake alone is not grounds for a negligence finding, unless the injury did contribute to the plaintiff's damages. (See **Figure 2**)

FIGURE 2 – What Disclosure Does NOT Change

	No Disclosure	Disclosure
Jurors who believe the mistake *contributed* to the patient's residuals	**91%**	**83%**
Jurors voting for the plaintiff because the mistake was *serious*	**97%**	**87%**
Jurors who believe the hospital should pay *even if it didn't cause the problem*	**79%**	**83%**

Source: Decision Quest, Inc.

CONCLUSION

Cases involving the disclosure of medical errors or unexpected outcomes can be won at trial – if the defense is prepared with the disclosure in mind. Being proactive in establishing both a policy on disclosure and working with counsel to anticipate disclosure defenses will allow the provider or facility to rest assured that they will be prepared, and protected, when the inevitable error occurs.

ABOUT THE AUTHOR

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SUGGESTED READINGS

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