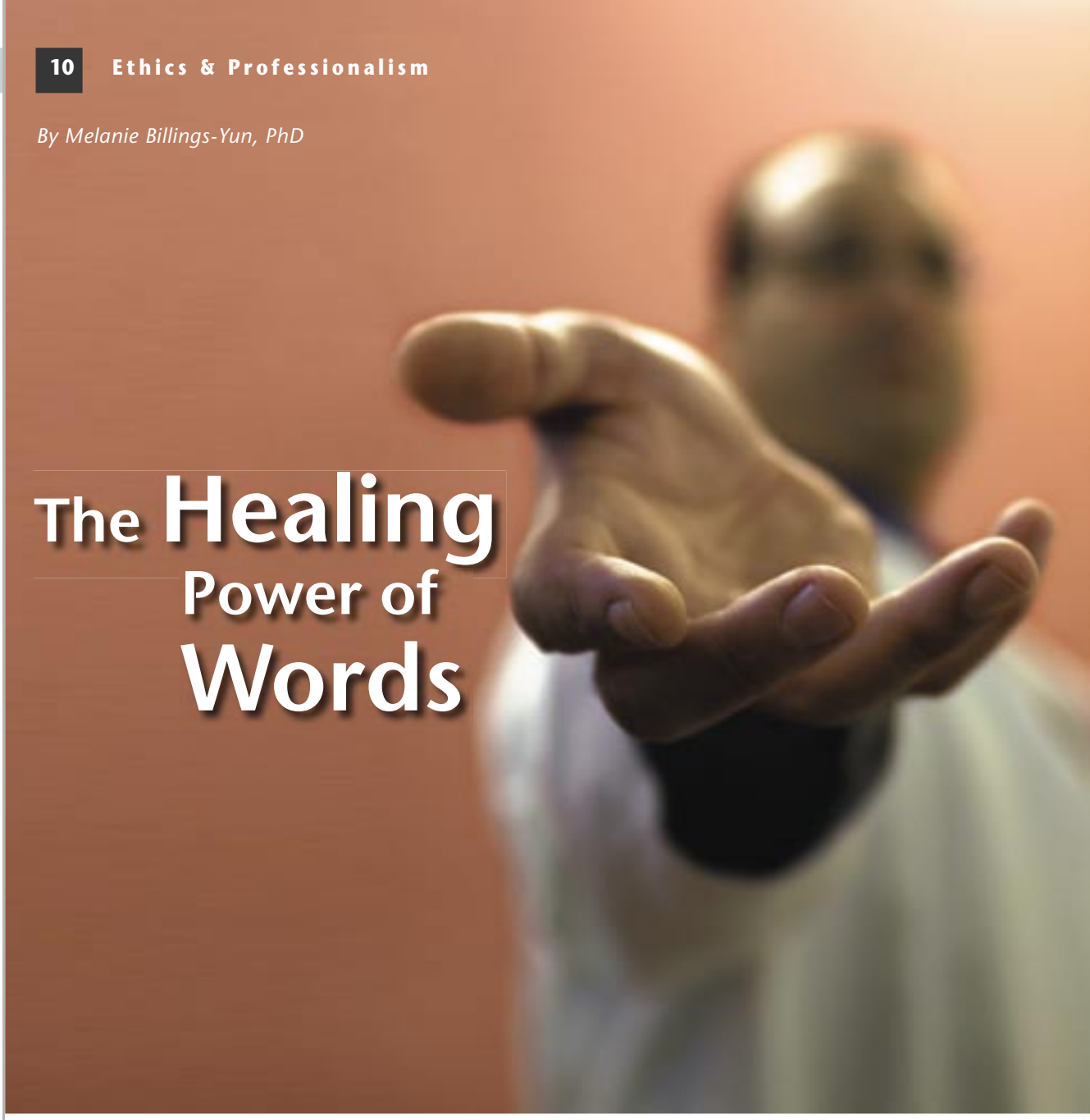
By Melanie Billings-Yun, PhD



The Healing Power of Words

Dr Melanie Billings-Yun (PhD Harvard; MSc London School of Economics) is Senior Partner in Global Resolutions, a Singapore-based international negotiation consulting and training firm, specialising in relationship management and conflict resolution (www.resolutions.com.sg). She invites your comments and questions at melanie@resolutions.com.sg.

Doctor-patient conflict is now a worldwide phenomenon, caused partly by the breakdown of the familiar family doctor-patient relationship of trust and partly as a result of the social upheavals of the information revolution. Because the cause is so amorphous and uncontrollable, many doctors and hospital administrators feel a sense of helpless inevitability. While some accept the new environment as a bitter pill one simply has to swallow, others turn to increasingly defensive medicine or, worst of all, leaving the profession altogether. Although understandable, this reaction is akin to feeling that if one cannot eradicate a virus, it is impossible to reduce its spread or cure individual victims. Defensive medicine is hardly a solution. It has only resulted in escalating insurance, healthcare and litigation costs and caused further mistrust between doctors and patients. Most importantly, when doctors practise defensive medicine, they often feel that they are prevented from fully reaching out to their patients and end up frustrated and constrained.

There is however, a growing movement from hospitals and medical facilities in the United

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States, Australia and, most recently, the UK that is markedly reducing this epidemic of anger by adopting a "*preventative* medicine" policy of open communication and apologising for errors. These policies go by various names but they all share one characteristic: they embrace the philosophy of the information revolution by inviting honest communication when things go wrong.

The statistics that launched all of these programmes are simple yet incredibly forceful: while there is a very low correlation between medical liability claims and actual negligence, there is a clear and significant link between poor communication and lawsuits.[1] Quite simply, the less a physician explains or shows audible concern for the patient, the more likely he is to get sued. This is not by any means a purely Western phenomenon. The largest single category of patient complaints filed with the Singapore Medical Association (SMA) in 2001 was for "alleged arrogance", including poor communication.[2] Who knows how many complaints of "dissatisfied outcomes", the second largest category, were actually attributable to the same cause?

The open communication policy begins from the realisation that the current litigation-based mode of "defensive communication" when something goes wrong actually creates more litigation than it prevents. That is because it is based on a false analogy to adversarial disputes. The relationship between a doctor and patient is *fundamentally* different from that between, say, two drivers involved in a car accident. In the latter case, the two parties neither know nor have any expectations of one another but they have a very clear and direct view of the occurrence that has resulted in their harm. Moreover, since traffic is a process which functions correctly if all rules are followed, the very fact that an accident occurred indicates that someone was at fault. Therefore, the most reasonable response for the two parties is to admit nothing while they call their insurance agents, lawyers or even the police to assess blame and negotiate compensation on the basis of liability.

The bond between doctor and patient, on the other hand, is a personal – even intimate relationship – and involves a high degree of trust on the part of the patient. Trust is not merely in believing someone has the ability to do something but holding "the positive expectations of the other's *motives* toward oneself in situations entailing risk".[3] Therefore, when a doctor ceases communication with a patient after an adverse outcome, the patient begins to question not merely the doctor's ability (as in the traffic accident) but also his motives. Left unchecked, that questioning can turn into a sense of enraged betrayal that eventually finds its only outlet in litigation.

Secondly, since the patient and his family rarely know what happened in an operating room or why the patient had a negative reaction to a certain treatment, they are utterly dependent on the doctor to explain things. When the medical team cuts off contact on orders of their lawyers or insurance company, the patient is left not knowing where to turn and will often draw the conclusion that information would only be hidden if there was something to hide. Indeed, one of the most common reasons patients say they sue doctors is because that is the *only* way they can learn "what went wrong".[4] A study of medical negligence lawsuits conducted by the UK Department of Health showed that once hospital records were released to patients, 70% dropped their claims.[5]

Most importantly, the adversarial system is based on fault. But in 80-85% of the malpractice cases, there is no fault to be found.[6] People are not traffic systems; they are highly fallible, unpredictable and temporal organisms. We get sick and we die. However, if doctors are forced by their lawyers or insurance companies to treat every adverse outcome as a dirty secret, is a patient or his family being unreasonable to imagine that fault *must indeed* lie behind the stone wall of silence?

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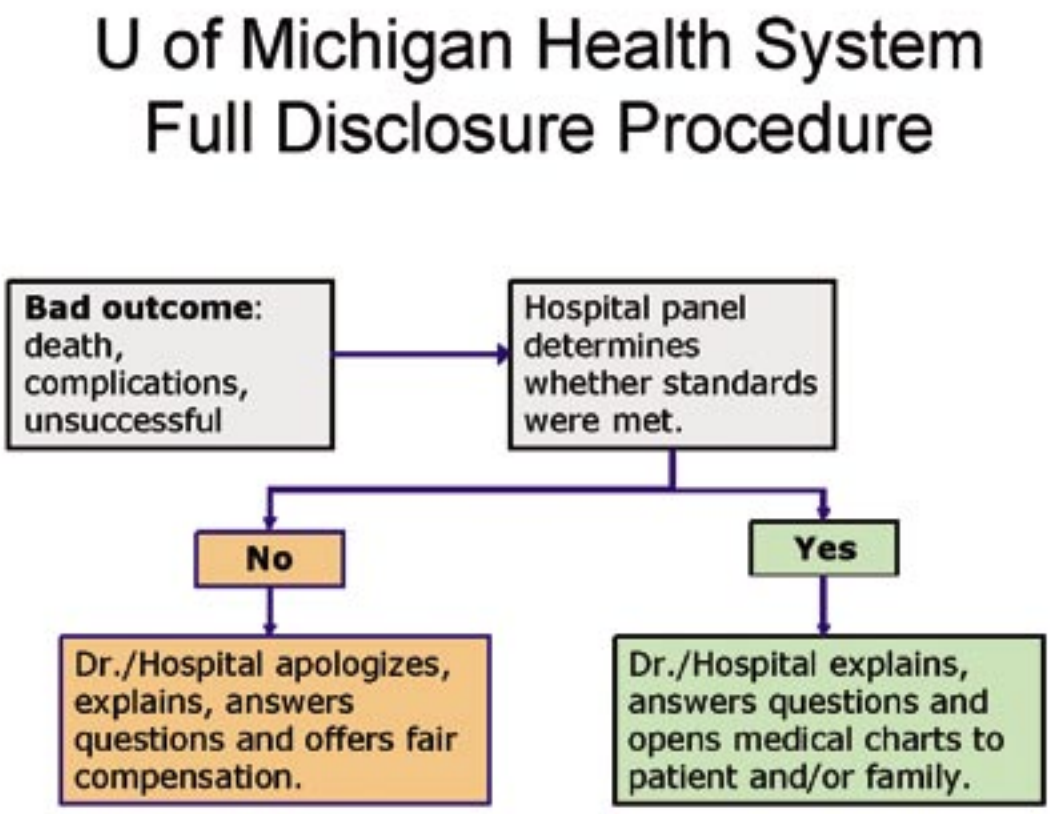
In medical systems that have adopted open disclosure policies, the results have been remarkable. The University of Michigan Health System, which launched its full disclosure policy in 2001, saw the annual number of malpractice suits decline by over half, from an average of 260 suits then to just 114 last year. Even more impressive, the time taken to conclude a typical case dropped from 1,160 days to 320 days, a 72.4% savings in time, stress and staff costs, and annual legal fees dropped from roughly US$3 million to US$1 million.[7] Similar results have been recorded in Virginia, Colorado, Minnesota and a dozen more US states that have enacted apology laws, creating such a compelling case that in late September last year, Senators Hillary Clinton and Barck Obama introduced the National Medical Error Disclosure and Compensation Act to encourage hospitals to apologise after medical errors and negotiate fair compensation as a way of stemming the national surge in medical liability claims.

Meanwhile, Australia and the UK have surged ahead. After judging the adversarial dispute resolution system to be "expensive and distressing for all parties, with many cases going to court where there has been no negligence", in 2004 the Australian National Healthcare Safety Council launched its Open Disclosure Standard.[8] Most recently, the UK National Health Service announced it will roll out its "Being Open" policy in June of this year, after recording a 70-fold increase (after inflation) in medical defense costs between 1975 and 2001.[9]

So, how does the open disclosure policy work? There are two basic permutations. Both start from the understanding that medical care providers need to be proactive. If they wait for the patient or his family to file a complaint, it may already be too late, as the bond of trust



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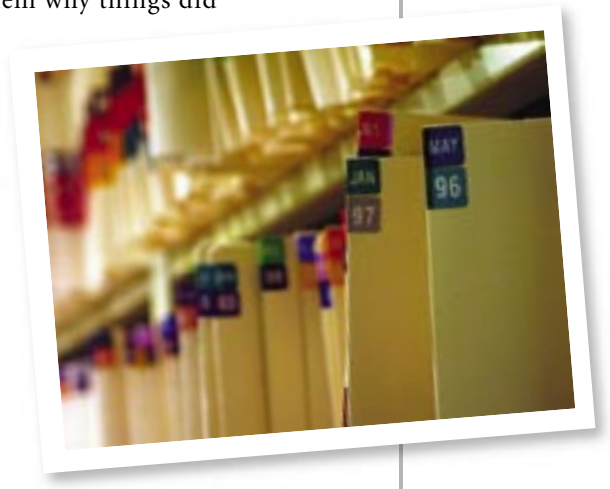
will have been broken and any efforts on the part of the doctor to explain things at that late stage will be viewed by the patient as a "forced confession". It is absolutely necessary that any open disclosure policy involve not merely an admission of error but also a willingness to apologise and, when deemed appropriate, an offer of compensation. Where the two systems differ is in *what* gets reported.

The UK "Being Open" policy mandates that when a medical error leads to moderate or severe harm or death – *whether the patient or his family is aware of it or not* – the hospital administration, working together with the doctor and medical personnel in charge, will provide them with:

- A "full and speedy disclosure" of what occurred;
- Acknowledgment of their distress;
- A "sincere and compassionate" statement of regret;
- A clear explanation of what happened;
- Information on what changes will take place to prevent recurrence.[10]

A somewhat more cumbersome but, I believe, ultimately more satisfying programme, particularly in the Asian face-based context, is the one pioneered at the University of Michigan (UM) Health System and now under active consideration by the Harvard Medical Institutions. Although the UM policy contains all the elements of the "Being Open" programme in case of actual negligence, what makes it especially attractive is that it *involves no presupposition of wrongdoing or blame*. Beginning from the understanding that ***the problem is not medical error***, per se, but rather a trust-breaking lack of communication and compassion following an adverse outcome, the UM "Full Disclosure" policy starts at the root cause.

Whenever there is an adverse outcome – whether it be an unsuccessful procedure, a complication or death of a patient – a dedicated hospital panel quickly determines whether correct medical procedures were met. If they were not, as in the UK system, the hospital informs the patient and/or his family, offers a sincere apology, explains how it happened, answers all patient questions and offers compensation. However, even if the panel decides that all standards were fully met, the hospital *still* invites the family in, to answer their questions, open medical charts and explain to them why things did not turn out as planned.



The clear advantage of the UM "Full Disclosure" system is that it benefits *all* parties. For the patient, it satisfies the need to understand why things did not work out as expected and, in so doing, helps him to rebuild a vital trust link with his doctor. For the doctor, communication becomes a natural part of the healing process, alleviating the sense of shame and guilt engendered either by a "cover-up" or by "admit" policies that start from a presumption of error. Finally, the hospital and insurer benefit from a considerable reduction in lawsuits, many of which are launched simply because it is the *only way* people can get access to their medical records.

Obviously, such policies cannot be *ad hoc*. Doctors would be ill-advised to rush into a full "confession". Rather, open communication must be part of an integrated hospital-wide system with clear and straightforward procedures. As a basis for establishing such a policy, the American Society for Healthcare Risk recommends the following:[11]

- A *short* policy that all hospital workers know and strive to follow;
- An uncomplicated and efficient support system for patients, family *and* staff;
- A culture that expects transparency;
- Adequate staff training and coaching in open communication and patient relationship management;
- Change mechanisms for correcting problems without blame.

Several weeks ago, I spoke to a group of doctors and nurses on the importance of saying "sorry". What I discovered was an overwhelming urge to "do the right thing" that was being stymied by a culture of fear created by hospital policies and lawyers' advice. A doctor was so fearful that he asked me whether he should apologise if he had

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done something that was patently wrong.

So let me end on a note of sanity. In the case of an adverse outcome, if the doctor has indeed done something wrong, then he is *already liable in any event* and precluded from seeking the protection offered by Bolam's law. An apology cannot mitigate liability. However, when the doctor communicates honestly and sincerely apologises, it goes a long way toward reducing the grief felt by the patient or his family, could mitigate a judicial determination on damages and in many cases may be sufficient to avoid a painful lawsuit altogether.

Where the doctor has done nothing wrong, he is clearly ahead. In most cases, honest communication will resolve the patient's anger without it ever going any further. In the rare case that a patient still pursues litigation, transparency will end the action quickly, shortcutting the embarrassing discovery process that can result in so much damage to nerves and reputation even when nothing is found.

No doctor or medical caregiver ever sets out to harm his patients and all patients want to trust and rely on their doctors. Yet, angry or ill-informed patients sue because they do not believe that they have been given the "whole-picture". The missing link therefore is honest and truthful communication between both sides. Defensive medicine only stifles information and leads to litigation.

With an open disclosure policy, doctors and nurses will no longer be made to hide as if they were criminals and, instead, can concentrate on what they do best – saving and rebuilding lives. Most important, they will find that their words have the power to heal their own wounds and to move forward confidently with a clear conscience. As Professor Lucian Leape of the Harvard School of Public Health writes, "Honesty is not just the best policy; it is also essential to ***our*** mental health."[12] ■

This article is based on a lecture given by the author to the Judges and Registrars of the Singapore Subordinate Courts on 15 February 2006. Written with the editorial assistance of Jonathan Yuen Djia Chiang, legal counsel, Global Resolutions.

References:

1. *Hickson, G.B., et. al., "Patient Complaints and Malpractice Risk," Journal of the American Medical Association, 2002 Jun 12;287:2951-7; Levinson, W., et. al. "Physician-Patient Communication: the Relationship with Malpractice Claims Among Primary Care Physicians and Surgeons," Journal of the American Medical Association, 1997 Feb 19;277:553-559.*
2. *SMA Ethics Committee, Case Management Report, http://www.sma.org.sg/whatsnew/ethics/ ethicsNov02/4profupdate/1chinjj.ppt*
3. *Das, T.K. and Bing-Sheng Teng, "Between Trust and Control: Developing Confidence in Partner Cooperation in Alliances," Academy of Management Review, 1990: 23(3), 491-512; see also Lewicki, R.J., D.J. McAllister, and R.J. Bies, "Trust and Distrust: New Relationships and Realities," Academy of Management Review, 1998:23, 438-458.*
4. *UK National Audit Office, "Handling Clinical Negligence Claims in England," 3 May 2001, http://www.nao.org.uk/publications/nao_reports/00-01/0001403.pdf*
5. *National Health Service consultation paper, "Making Amends," Report by the Chief Medical Officer, June 2003.*
6. *Hickson, ibid.*
7. *"Proposed Legislation Encourages Hospital Disclosure Initiatives," 7 October 2005, http://www.sorryworks.net/media40.phtml*
8. *See, for example, New South Wales, Clinical Practice Improvement Unit, "Open Disclosure," http://www.nsh.nsw.gov.au/teachresearch/cpiu/open_disclosure.shtml*
9. *NHS National Patient Safety Agency, "Being Open – Communicating Patient Safety Incidents with Patients and Their Carers," http://www.npsa.nhs.uk/health/resources/beingopen*
10. *For more detailed information on the program and how it works, see the "Being Open Academy" e-learning site at http://www.msnpsa.nhs.uk/boa/*
11. *American Society for Healthcare Risk Management, "Disclosure of Unanticipated Events: the Next Step in BetterCommunication with Patients," November 2003, http://www.hospitalconnect.com/ashrm/resources/files/DisclosurePart2.Policy.pdf*
12. *Leape, Lucian L., "Understanding the Power of Apology: How Saying 'I'm Sorry' Helps Heal Patients and Caregivers," Focus on Patient Safety, National Patient Safety Foundation, http://www.npsf.org/download/Focus2005Vol8No4.pdf*