Illustration by Eric Hart.

Giving Back the Pen

Disclosure, Apology and Early Compensation Discussions after Harm in the Healthcare Setting

Rob Robson and Elaine Pelletier

" If you take my pen and say you are sorry and don't give me back my pen, nothing has happened."
– attributed to Bishop Desmond Tutu.

Abstract

In her recently published book *After Harm*, Nancy Berlinger shares a story about Bishop Desmond Tutu as he comments on the importance of restitution or compensation after an event that has led to harm. Transparency and disclosure are very much on the healthcare agenda in Canada. The increased interest in training providers for difficult conversations and disclosure is a positive sign. Using honest disclosure and apology as important interventions, organizations are beginning to adopt a more open approach to the concept of rebuilding trust after a patient has been harmed. But there continues to be significant reluctance to take the next logical step to solidify the fiduciary relationship between provider and patient – the willingness to enter into early discussions about compensation, non-monetary and otherwise.

The Winnipeg Regional Health Authority has developed, with the participation of the facility insurers, a process to identify those cases in which it would be appropriate not only to offer an apology of responsibility but also to initiate discussions around the questions of restitution and compensation. The article describes the steps that led to the development of a detailed process map for such cases and shares the algorithm that has been adopted. As well, the potential challenges associated with such an approach when there are multiple liability and insurance providers are discussed.

In a recently published book on the ethics of forgiveness after medical error has harmed a patient, *After Harm* (Berlinger 2005), the author shares comments attributed to Bishop Desmond Tutu: "If you take my pen and say you are sorry and don't give me back my pen, nothing has happened." (page 61). This story was one of several influences that led the Winnipeg Regional Health Authority (WRHA) to review its approach to patients harmed as a result of breakdowns in the provision of care provided to the population it serves. In essence, it provided the philosophic stance from which to develop consensus on this question. This article describes the process developed by WRHA and reflects on some of the issues central to the question of compensating patients after harm.

Background

Dr. Lucian Leape, a pediatric surgeon and leader in the patient safety movement in North America, wrote an article on the question of disclosure and apology following patient harm (Leape 2006). In the article, he identified four key issues to be considered. He suggested that leaders should do the following:

> First, set expectations. Hospital policy should be clear and unequivocal (and in writing): patients are entitled to a full and compassionate explanation when things go wrong.
>
> Second, doctors and nurses, as well as risk managers and other support personnel, need training in communicating with patients after adverse events. They also need training on how to support colleagues when they are "second victims."
>
> Third, support systems need to be developed for all parties. Patients need help after an event, including after discharge from the hospital … And we need to help these second victims deal with their emotional trauma. Professional and peer support systems must be developed.
>
> Finally – and this is the tough part – after enlisting full support of the board of trustees, hospital leaders need to insist that liability carriers provide early settlements for injured patients. (Leape 2006: 18)

These four principles were accepted by the senior management group at WRHA in the summer of 2006. The WRHA Board of Directors approved the proposals in principle and asked staff to operationalize the concepts. The board also wrote to the minister of health to encourage the passage of an Apology Act, similar to that implemented in British Columbia (Oppal 2006).

Berlinger and Leape were not the first to raise the issues of disclosure and apology after harm. An excellent review of the subject has been written by a psychiatrist (Lazare 2005, 2006), and many penetrating analyses in the preceding decades (Sharpe 2000, 2004) have raised similar issues. Clearly though, a certain "tipping point" was being reached, or at least approached, with the proposal to move ahead expeditiously, as outlined by Leape (2006).

Adopting a Clear Position about Disclosure of Harm

The proclamation of Bill 17 (Legislative Assembly of Manitoba 2005) on November 1, 2006, created a positive legal duty for healthcare facilities in Manitoba to inform patients and/or family members, in a timely manner, of the facts surrounding critical incidents. The legislation also created legal privilege for the work of committees that are mandated to investigate the factors that led to a given patient being unintentionally harmed. This created a secure place to examine all aspects of a critical incident without fear that the discussions, opinions and speculation could surface during litigation or some other form of legal proceeding. In the past, this fear has been a notorious barrier to effective investigation of such events.

Coincidentally, the existing WRHA policy on disclosure was due for periodic revision. In the spring of 2007, a new policy was adopted, WRHA Policy 10.50.030 (WRHA 2007). The policy mandates the disclosure of pertinent clinical information, not only following critical incidents but in other situations, as part of normal patient-centred high-quality clinical care. While policy alone rarely leads to permanent changes in behaviour, the revision satisfies the first of Leape's four concerns – WRHA now has a clear policy and process for the disclosure to patients of the facts surrounding a critical incident.

Providing Training for All Levels of Providers

Patient safety colleagues from the Calgary Health Region shared their experience working with the US Institute for Healthcare Communication (IHC, http://www.healthcarecomm.org/; see also IHC-Canada at http://www.ihcc.ca/). The IHC had been extremely helpful in organizing train-the-trainer sessions in Alberta, with content that was adapted to the Canadian experience. Dan O'Connell (O'Connell and Reifsteck 2004) was the main contact and, in January 2007, 20 WRHA physicians, nurses and other managers participated in a three-day session.

The IHC course Disclosing Unanticipated Outcomes and Medical Errors emphasizes how to make effective disclosures with patients and family members (see http://www.healthcarecomm.org/index.php?sec=courses&sub=faculty). The Canadian version of the workshop is titled Disclosure of Unanticipated Medical Outcomes (DUMO; see http://www.ihcc.ca/workshops.asp). A distinction is made between those cases in which the standard of care was met and those cases in which the care was ultimately deemed to be unreasonable or substandard. The distinction is important in terms of the steps to be taken by the care providers involved in the disclosure and the type of apology to be provided.

An expression of sympathy or regret is appropriate in all cases of unanticipated patient harm.

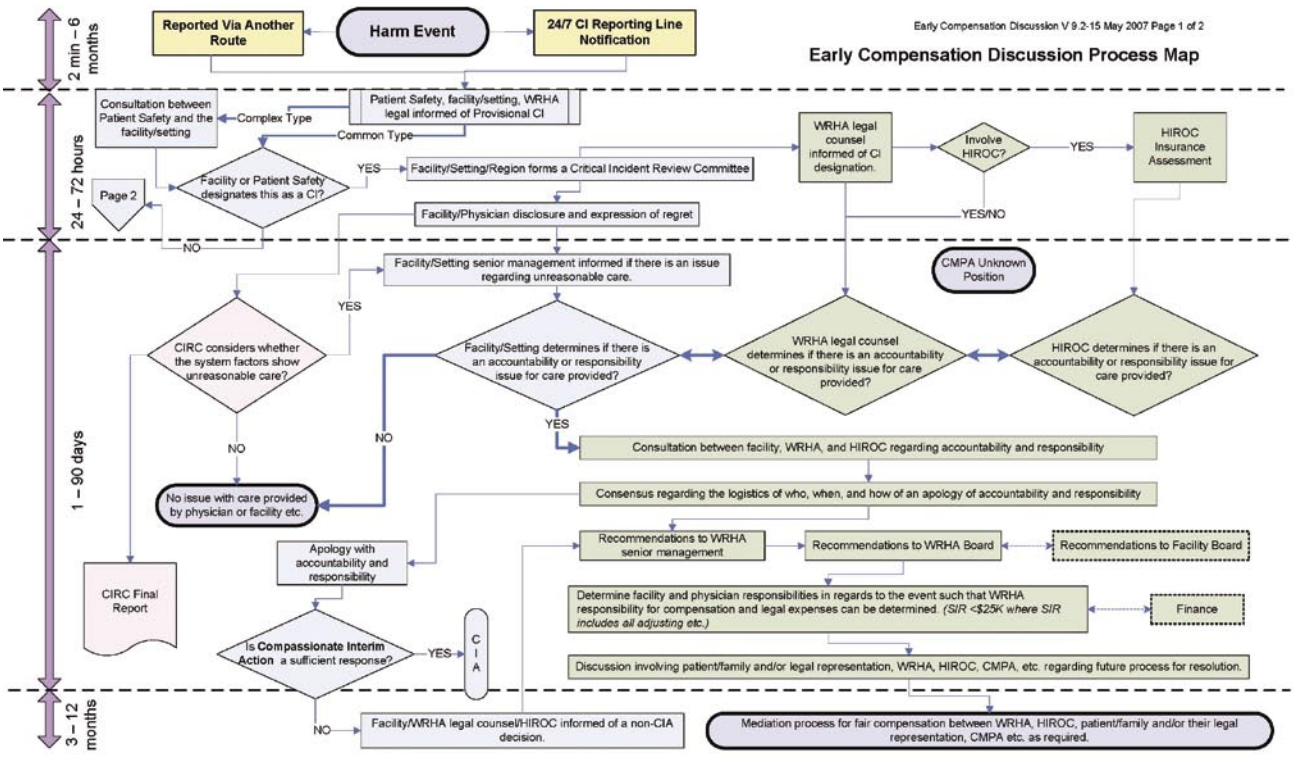
The DUMO workshop teaches that an expression of sympathy or regret is appropriate in all cases of unanticipated patient harm. When the care is also felt to be substandard or unreasonable, a more robust apology of responsibility is appropriate. This distinction is germane to the subject of this article as the analytic process proposed by IHC through DUMO helps to identify cases in which early discussion of compensation should be considered.

DUMO provides a framework for difficult disclosure conversations as well as concrete operational direction for the individuals involved. The half-day workshops have been provided more than 5,600 times in the past several years reaching 70,000 clinicians all over North America, and have been found effective in training more than 8,000 physicians associated with the Kaiser Permanente system in the United States (Boyle et al. 2006; O'Connell et al. 2003). Within Canada, the Health Quality Council of Alberta (see http://www.hqca.ca/index.php?id=58) and the Calgary Health Region (http://www.calgaryhealthregion.ca/) have been leaders in training large numbers of staff in the delivery of the DUMO workshop and have delivered it to more than 500 providers in the past year. WRHA now has 14 certified DUMO trainers and plans to offer the course frequently.

Providing Support for Staff and Patients following Critical Incidents

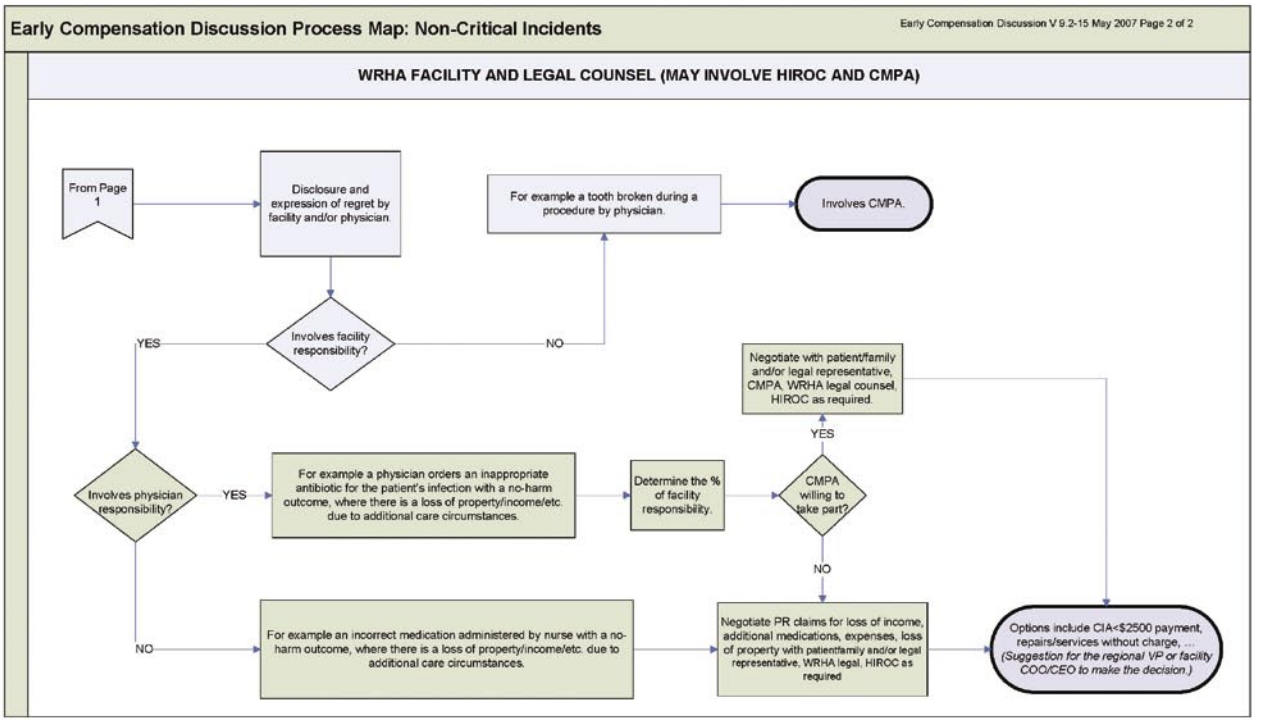
Providing support for staff and patients after critical incidents is a challenging and important issue. Patients and family members are not the only ones harmed following unanticipated medical outcomes. The concept of the "second victim" has been explored in some depth (Wu 2000) in recognition of the significant impact that critical incidents can have on providers, of all

Figure 1. Page one of the early compensation process map, addressing the process for critical incidents



CI = critical incident; CIA = Compassionate Interim Action; CIRC = Critical Incident Review Committee; CMPA = Canadian Medical Protective Association; HIROC = Hospital Insurance Reciprocal of Canada; SIR = Self Insured Retention; WRHA = Winnipeg Regional Health Authority.
Source: Winnipeg Regional Health Authority.

Figure 2. Page two of the early compensation process map, addressing the process for non-critical incidents



CEO = chief executive officer; COO = chief operating officer; CIA = Compassionate Interim Action; CMPA = Canadian Medical Protective Association; HIROC = Hospital Insurance Reciprocal of Canada; PR = Public Relations; VP = vice-president; WRHA = Winnipeg Regional Health Authority.

Source: Winnipeg Regional Health Authority.

kinds. It is also clear that the harm is not restricted to physical harm – significant psychological, emotional and stress-related symptoms appear after a critical incident.

The issue of harm inflicted on the provider-patient relationship as a distinct third level of harm has also been explored (Berlinger 2005). This recognition of a holistic and systemic level of harm is important in appreciating the fiduciary nature of the relationship between patients and providers/facilities. By better understanding the link between trust and healing, it becomes clearer why a comprehensive approach to disclosure, apology and compensation discussions is essential to advancing patient safety.

WRHA does not presently have a comprehensive approach to providing support in these difficult situations. At times, colleagues rise to the occasion and address the issues in a sensitive and humane manner, with both providers and patients. At other times, there is awkwardness, avoidance and a reluctance to face the implications that lie behind the harm arising from complex (albeit well-intentioned) healthcare delivery systems.

The origins of the discomfort that providers experience are explored by Dekker (2005, 2006). The perspective of a healthcare system that may be fundamentally unsafe is commonly rejected in favour of the belief that failures arise primarily from the actions of individuals rather than from combinations of systemic contributing factors. The belief that any one of us, as providers, in the same circumstances could easily have been involved in a similar critical incident is not easy to accept and may very well explain our reticence to support other colleagues involved in one of these events.

How would the distinction between reasonable and unreasonable care be accomplished?

Early Compensation Discussions

A number of practical issues arose as soon as serious consideration was given to developing a process for WRHA. We were unaware of any precedent in Canada that had attempted

to address the question of compensating patients for harm following healthcare system breakdowns, outside of the formal litigation system. While a number of examples existed in the United States (Berlinger 2005; Boothman 2006; Kraman and Boothman 2007; Kraman and Hamm 1999), there are significant differences between both the medical and legal environments in the two countries.

The issue of case identification was also challenging. Clearly, this could not proceed on the basis of sympathy or other subjective concerns. While the DUMO training program offered some hints, how would the distinction between reasonable and unreasonable care be accomplished? In what forum could such evaluations reasonably develop?

Finally, the issue of determining appropriate levels of compensation presented special difficulties. Compensation in such instances is traditionally provided by insurers. To what extent would such a new process be considered a fundamental undermining of the operating principles of such groups or companies? And how would the sharing of responsibility (and therefore compensation) be resolved when there are multiple insurers involved?

While WRHA and all its facilities are insured by the not-for-profit Hospital Insurance Reciprocal of Canada (HIROC; see http://www.hiroc.com/) most privately owned clinics are not insured by HIROC. Most of the physicians with privileges in WRHA facilities receive liability protection through the Canadian Medical Protective Association (http://www.cmpa-acpm.ca/); however, some do not. In a given case, there could be several parties in the compensation discussion. This would make for challenging discussions.

Some General Principles

After more than 10 meetings with representatives from HIROC in Toronto, WRHA in-house counsel, WRHA patient safety representatives and local HIROC provincial counsel, a process map was developed (see Figures 1 and 2) that addresses the fourth issue raised by Lucian Leape's 2006 article and fulfills the direction from WRHA's Board of Directors to operationalize the concepts outlined above. This was greatly facilitated by the convergence of several factors, including the newly proclaimed legislation from the Manitoba Government, the vision of patient safety leaders like Lucian Leape, the clearer understanding of the role of apology and early compensation discussions as means of promoting and reinforcing patient safety initiatives and, finally, the determined leadership within the WRHA to operationalize the concepts of trust and respect.

The concrete steps in the process include the following:

1. Early identification of all potential cases, initially applying the legislated definition of a critical incident to identify cases in which harm resulted from breakdowns in the healthcare system. The 24/7 call centre system in place for notification of potential new critical incidents provides an easy way to find appropriate cases.
2. Parallel evaluations of the care provided by two distinct and protected streams – by the Critical Incident Review Committee (CIRC – mandated by legislation to undertake safety reviews of critical incidents) and by WRHA in-house counsel (with participation of legal representatives of the insurer). In the case of the CIRC, the ability to consult clinical experts in a legally protected environment allows for an independent evaluation of the reasonableness of care provided.
3. Once a specific case is identified (through a consensus process) that fulfills the definition of a critical incident and is due at least in part to conditions under the control of the WRHA, notification of the chief executive officer or chief operating officer of the involved facility to arrange for an appropriate apology of responsibility. To the extent that this may involve the actions of individuals not under the direct control of WRHA (e.g., most physicians), an invitation to participate in the apology will be extended to all parties who may be involved.
4. At this point, there is divergence of the two streams: (1) CIRC continues its primary function of identifying systemic contributing factors that led to the critical incident in the first place and (2) the insurer's provincial counsel, with participation of WRHA in-house counsel, refines the potential issues of compensation (monetary and non-monetary) and considers the reasonable share between the various parties.
5. Before any other steps are taken, a final verification with the WRHA Board of Directors takes place. If there is agreement to proceed, efforts are made to involve all parties and insurers in discussions with the patient and legal representatives.

Clearly these discussions will be most effective if all parties are present and participating in good faith. Initially, the new process will be "field tested" on a range of simpler cases to identify process issues that may not have been anticipated by the original design group.

The Evaluation Process

An evaluation process will be developed to closely monitor the cases that follow this process map. The evaluation will examine not only the financial results of the process at several levels but will also seek feedback from all the participants, using an array of qualitative methods to assess the overall impact of introducing this process.

While it is reassuring that more than 50 organizations and facilities in the United States have embarked on analogous processes in recent years (Berlinger 2005), and several have published preliminary results, they have significant differences

compared with the situation in Canada. The WRHA evaluation will need to reflect the particular circumstances and objectives of the healthcare system in Canada as it strives to promote safer quality care for its patients.

Of course, the ultimate goal of patient safety programs and initiatives is to avoid "taking the pen" in the first place.

Conclusion

This article has described the factors that led WRHA to develop a process to identify cases involving patient harm following critical incidents in the healthcare system. As well, it describes the main steps that would lead to early compensation discussions with patients in those cases when preventable contributing factors were under the control of WRHA.

This may represent one way to begin "giving back the pen" to patients who have been harmed. Of course, the ultimate goal of patient safety programs and initiatives is to avoid "taking the pen" in the first place. We believe this process is unique within healthcare in Canada, and we will carefully monitor the results of our work. HQ

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References

Berlinger, N. 2005. *After Harm: Medical Error and the Ethics of Forgiveness.* Baltimore, MD: Johns Hopkins University Press.

Berlinger, N. and A.W. Wu. 2005. "Subtracting Insult from Injury: Addressing Cultural Expectations in the Disclosure of Medical Error." *Journal of Medical Ethics* 31: 106–8.

Boothman, R.C. 2006. *Medical Justice: Making the System Work Better for Patients and Doctors.* Testimony of Richard C. Boothman, Chief Risk Officer, University of Michigan Health System before the United States Senate Committee on Health, Education, Labor and Pensions, Thursday, June 22, 2006. Retrieved January 10, 2008. <http://help.senate.gov/Hearings/2006_06_22/boothman.pdf>.

Boyle, D., D. O'Connell, F.W. Platt and R.K. Albert. 2006. "Disclosing Errors and Adverse Events in the Intensive Care Unit." *Critical Care Medicine* 34(5): 1532–7.

Dekker, S.W.A. 2005. *Ten Questions about Human Error: A New View of Human Factors and System Safety.* Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

Dekker, S.W.A. 2006. *The Field Guide to Understanding Human Error.* Aldershot, United Kingdom: Ashgate Publishing Co.

Kraman, S. and R. Boothman. 2007. "Sorry Doesn't Work Alone." Glen Carbon, IL: Sorry Works. Retrieved January 10, 2008. <http://www.sorryworks.net/article31.phtml>.

Kraman, S.S. and G. Hamm. 1999. "Risk Management: Extreme Honesty May Be the Best Policy." *Annals of Internal Medicine* 131: 963–7.

Lazare, A. 2005. *On Apology.* New York, NY: Oxford University Press.

Lazare, A. 2006. "Apology in Medical Practice: An Emerging Clinical Skill. American Medical Association." *Journal of the American Medical Association* 296(11): 1401–4.

Leape, L. 2006 "Full Disclosure and Apology: An Idea Whose Time Has Come." *Physician Executive* 32(2): 16–18.

Legislative Assembly of Manitoba. 2005. *Bill 17, The Regional Health Authorities Amendment and Manitoba Evidence Amendment Act.* Winnipeg, MB: Manitoba Government. Retrieved January 10, 2008. <http://web2.gov.mb.ca/laws/statutes/2005/c02405e.php>.

O'Connell, D. and S.W. Reifsteck. 2004. "Disclosing Unexpected Outcomes and Medical Error." *Journal of Medical Practical Management* 19(6): 317–23.

O'Connell, D., M.K. White and F.W. Platt. 2003. "Disclosing Unanticipated Outcomes and Medical Errors." *Journal of Clinical Outcomes Management* 10(1): 25–9.

Oppal, W. 2006. Bill 16 – 2006. *Apology Act.* Victoria, BC: Queen's Printer. Retrieved January 10, 2008. <http://www.leg.bc.ca/38th2nd/amend/gov16-2.htm>.

Sharpe, V.A. 2000. "Behind Closed Doors: Accountability and Responsibility in Patient Care." *Journal of Medicine and Philosophy* 25(1): 28–47.

Sharpe, V.A., ed. 2004. *Accountability for Patient Safety: Medical Error and Policy Reform.* Washington, DC: Georgetown University Press.

Winnipeg Regional Health Authority. 2007. WRHA policy 10.50.030. Winnipeg, MB: Author. Retrieved January 10, 2008. <http://www.wrha.mb.ca/about/files/policy/10.50.030.pdf>.

Wu, A.W. 2000. "Medical Error: The Second Victim. The Doctor Who Makes the Mistakes Needs Help Too." *BMJ* 320: 726–7.