'Sorry' Shouldn't Be the Hardest Word

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The following movies, in my opinion, are non-starters on first dates. In no particular order:

- *Sophie's Choice* (tragic)
- *Schindler's List* (depressing)
- *The Exorcist* (freaky)
- *The English Patient* (mind-numbing boredom)
- *Terms of Endearment* (heart-wrenching)
- and finally, *Love Story* (sappy).

You may, if you were born before 1960, remember the tagline and memorable quote in *Love Story*: "Love means never having to say you're sorry."

Oh please, even in 1970, when I was 10-years-old, I knew that was a bunch of crap. Maybe that holds true in the Walton's house; however, growing up in my family, not saying you're sorry was a quick way for me to get my ass kicked by my sister.

Medical providers in the past were much like Jennifer Cavalleri (Ali MacGraw) in *Love Story*. Medical errors, like love, meant you should never say you're sorry.

Well, to quote, Bob Dylan, "The times they are a-changin'." Many states have enacted the so-called "I'm sorry statute" which protects providers (with caveats) who apologize for medical errors. Today, more than 20 states have adopted some version of an I'm Sorry statute.

Even though the various state I'm Sorry laws have marked differences, they all attempt to permit healthcare providers to make an apology to patients and their families for errors without trepidation that their admissions will be used against them in court as admissions of their accountability.

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Virginia's version of the law provides:

> "In any civil action brought by an alleged victim of an unanticipated outcome of healthcare, or in any arbitration or medical malpractice review panel proceeding related to such civil action, the portion of statements, writings, affirmations, benevolent conduct, or benevolent gestures expressing sympathy, or general sense of benevolence, which are made by a healthcare provider or an agent of a healthcare provider to the patient, a relative of the patient, or a representative of the patient shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest. A statement of fault that is part of or in addition to any of the above shall not be made admissible by this section."
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> *Va. Code § 8.01-581.20:1 (2006).*

This statute, as well as others like it, permits a healthcare provider to apologize for a medical error without having that admission used as an admission of liability in a medical malpractice case. There is, however, one very important caveat: an admission of *fault* is admissible as a statement against interest in a medical malpractice case.

For example, a physician I know wrote the following note to a patient after the patient was subsequently diagnosed with a stroke post-discharge from the emergency department: "I am sorry I did not accurately asses (sic) you and correctly diagnose you (sic) stroke. I have never missed a stroke in the past, and will never fail to make an accurate diagnosis of stroke again."

Spelling errors not withstanding, he admitted fault in this letter and, no surprise, was served with a lawsuit about 15 days after he mailed the apology to the patient. The complaint

savings are possible through more centralized delivery and a more synergistic approach to sales and marketing.

General branding

Branding or creating a common brand name across multiple offerings within a clinic or clinic network in order to enhance the brand name provides a "halo effect" for each delivery component. Yet urgent care clinics often get in the way of pulling related services together by offering them separately even though they are branded similarly; this is an inherent contradiction in terms.

Branding, of course, is a good idea and an occupational health component is an ideal setting for pulling together and leveraging multiple services under a common banner. It is another example of effective integration.

New Alliances

Economic recessions tend to trigger new alliances, and a deep recession renders even more creativity in developing such alliances.

Alliances can be with other healthcare institutions (e.g., a local specialty group), non-institutional healthcare players (e.g., the local chapter of the American Heart Association), or even organizations outside of healthcare (e.g., the Chamber of Commerce).

Well-conceptualized alliances create win-win scenarios. Often, one organization can provide skills or expertise that the other lacks. Or, the alliance can generate economies of scale in such areas as sales and marketing, in which you basically double down on your sales and marketing effort.

Further, an alliance offers an opportunity to merge each organization's client or prospect base, thus creating a considerably larger and highly qualified client universe.

The aforementioned halo effect applies to alliance building, as well. For example, assume your clinic has created an alliance with the local Chamber of Commerce to jointly sponsor a community-wide wellness initiative. In most cases, the Chamber name would add credibility to your clinic name and your clinic would inherit much of the goodwill that the Chamber name is likely to represent in your community.

In sum, it would be foolhardy for most urgent care clinics to cast their lot with the old 1990s "go it alone" strategy. Challenging times call for innovative solutions. As we enter the second decade of the millennium, organizations that master leverage, integration, and alliance building are poised to significantly increase their likelihood of success. ■

had his photocopied note attached as an addendum.

What he should have written or said to the patient is, "I am sorry that you suffered a stroke and all the problems which go along with that condition." He may have even gone on to say, "We did everything medically indicated to rule out a stroke in the emergency department; however sometimes these can be very subtle or manifest themselves after a few days, which is why we caution you to follow up with your primary care doctor."

The other small issue he had was that he sent the later on April 15, and the law did not go into effect until July 1. Who knew?

To be effective, an apology should be:

1. heartfelt
2. genuine
3. remorseful
4. fully disclosed.

Here is the rub: medical providers should apologize as soon as the error is known, admit responsibility, not deflect blame, communicate all known information clearly and without medical jargon, and not make excuses. Statutes like the aforementioned do not protect providers who admit fault. Consequently, there is an inherent tension between offering a heartfelt, sincere apology and not hanging yourself out to dry.

If an apology is warranted, consider the following:

- Use an appropriate setting. Do not sit across from the patient or their family. Having a desk or table between you creates a barrier. Instead, sit on a couch next to the patient or pull your chair up so that you can sit side-by-side.
- Body language speaks clearly. Do not sit with your arms folded across your chest or your legs crossed. Again, this creates a barrier and appears defensive.
- Touch the patient when appropriate. Use your judgment; if you do touch the patient, be mindful of where your hand falls. Restricting the area you touch to an area between the elbows and hand is safe.
- Offer the patient the ability to manage the encounter. For example, let them choose the time to come discuss and also allow them to bring others into the discussion if appropriate.
- Don't make excuses. Excuses do not sit well with most people, and give the appearance that you are not sincere. Saying, "If the lab had not screwed up your results, this would have never happened" is not an apology.

At the end of the day, a sincere and honest apology is an appropriate way to begin the process of resolving untoward outcomes. However, before venturing down the path, consult with your attorney and your medical malpractice carrier. They will undoubtedly know the laws in your state and will be able to offer clear guidance on how best to offer an apology. ■