

Case Report

Patients disclosure in health plan: Quality of care and physician competence

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Medical error and tort reform have increasingly taken center stage in the health care debate in our region and all over the world. Patients, policy makers and health care professionals grapple with the striking prevalence and consequences of medical error, may result in patient injury from the health care providers. Fears of malpractice liability, difficulties in communicating with patients and their families, inattention to their problems in details and giving inadequate time to them in listening and discussion, in addition to confusion about causation and responsibility, all have long impeded comprehensive and bold initiatives designed to change the patient, family and clinician experience with medical error. Offering an apology with complete patient respect and transparency with full disclosure of harmful medical errors to the patients and their families can do much to defuse the hurt and anger that can lead to further emotional and physical trauma. Health care professionals including doctors need to communicate with patients or their parties in their day to day activities. It should be an essential habit of doctors. In the present medical curriculum in medical education, emphasis was placed on learning communication skills by the undergraduate doctors.

Key words: Kingdom of Saudi Arabia (KSA), discourse completion test (DCT), patients, health care.

INTRODUCTION

The growth in malpractice premiums and claims payments over the Kingdom of Saudi Arabia and internationally has been reflected passively on healthcare provider and health service.

The data of the cases submitted to the Medico-legal committee of the Ministry of Health in Riyadh, Kingdom of Saudi Arabia from various parts of the country for the period 1420 through to 1423 H (1999 to 2003), were increasing dramatically. A total of 2223 cases had been referred to the various committees over the country past few years for consideration (Alsaddique 2004; Samarkandi, 2006).

A recent French study by (Ligi et al., 2008), reviewed iatrogenic events in admitted neonates. A total of 388 neonates were studied during 10,436 patient days. They recorded 267 iatrogenic events in 116 patients. The incidence of iatrogenic events was 25.6 per 1000 patient days. 92 (34%) were preventable and 78 (29%) were severe. Two iatrogenic events (1%) were fatal. This kind of medical malpractice raised the importance of medical

disclosure of harmful events in the early stages when it happened. British survey, focusing on disclosure of harmful medical error revealed, 92% of patients believed that a patient should always be told if a complication has occurred, and 81% of patients believed that a patient should not only be informed of a complication but also be given detailed information on possible adverse outcomes (Hingorani et al, 1999).

In 2001, the Joint Commission on Accreditation of Healthcare Organizations, now called the Joint Commission, issued the first nationwide disclosure standard in North America. This standard requires that patients be informed about all outcomes of care, including "unanticipated outcomes" (Oakbrook, 2007). Furthermore, several states in USA have passed legislation that would make physicians' apologies; including admissions of fault, inadmissible in malpractice suits, and this inadmissibility law often included all other health professionals (Taft, 2005). Medical disclosure efforts in the United States took more important steps

forward. In March 2006, the Full Disclosure Working Group of the Harvard Hospitals released a consensus statement emphasizing the importance of disclosing, taking responsibility, apologizing, and discussing the prevention of recurrences.

The purpose of this article is to focus on enhancing the uniformity and quality of clinician-patient communication, also drawing attention within organizations delivering healthcare, about the increasing demand of “doctors who listen” and offering an apology to the patients or his relative with full respect. We like to promote health care providers to be able to say, “I am sorry for what happened or was expected” with full responsibility without fear of the consequences, and to encourage physicians to disclose medical errors on the proper time and location to avoid any negative burden on the health care system.

Communication Skills

In the aftermath of an incident, the primary objective of health care givers must be to support the patients and maintain the healing relationship. Patients and families are entitled to know the details of incidents and their implications. Communication should be open, timely, and sustained. Health providers must eliminate the adversarial relationship that a secretive, liability-focused approach to patient communication fosters (Laura, 2004). The caregiver’s role is to provide comfort and support and to consider the full extent of patient’s needs. However, not every conversation is necessarily effective, and there are many barriers that may place clear communication at risk. Some of these barriers include:

1. The anxiety and intimidation associated with the medical interaction between a highly trained medical professional and an unsophisticated patient
2. Patient stress associated with seeking health care services
3. Preconceived patient notions that make them less likely to listen to and understand important health care messages from their doctors
4. Cultural and linguistic differences between physicians and patients created by an increasingly diverse patient population
5. Physician time constraints that often result in brief patient interactions and cross-cultural misunderstandings (Laura, 2004).

Medical staff is committed to full disclosure of medical error, because it is the right thing to do. The patient and family have the right to know what happened also. In addition, honest communication promotes trust between the patient and health provider, so that the primary focus of the clinician-patient relationship remains the most important issue. Further, open discussion about errors can promote patient safety by encouraging clinicians to

seek systems improvements that minimize the likelihood of recurrence.

Medical faculty programs should stress on teaching and assessing medical communication skills, determining relevant knowledge and attitudes, and later evaluating educational outcome. Recognition of the need for faculty development grows in part from an abundant literature documenting the poor inter-rater reliability of faculty who assess communications (Lynch et al., 1992, Boulet, 1999, Naji et al., 1986).

To achieve uniformity of teaching and assessment in communications, first, there needs be a consensus about what is important. Consensus statements from Toronto and Kalamazoo provide such information (Makoul et al., 2003). The Toronto Consensus identified “the most important things that could be done now to improve clinical communications (Lynch et al., 1992, Boulet, 1999; Naji et al., 1986).

To achieve uniformity of teaching and assessment in communications, first, there needs be a consensus about what is important. Consensus statements from Toronto and Kalamazoo provide such information (Makoul et al., 2003). The Toronto Consensus identified “the most important things that could be done now to improve clinical communications.” These include physician-patient encounters in which patients get to identify all of their agenda items and concerns, eliciting patients’ perspective on illness and addressing feelings with empathy, information management (including appropriate use of open-ended questions and summaries), and the ability to negotiate to arrive at common ground. In addition faculty need to develop the ability to identify when these skills are performed, missing, or poorly performed. The faculty needs to acquire a set of instructional skills that are effective over a wide range of teaching situations, with widely varying communication performances and with learners who perform well and with those who perform poorly and finally we can reach to a consensus model of what we teach and how we teach it, from medical school to residency, from one discipline to another, from conceptual model to conceptual model, all begin to overlap, the field of communication will finally have come of age. (The Association of American Medical Colleges 1999) recommended the teaching and assessment of communication skills throughout medical school and residency programs.

Patient respect

“Respect” is a word like “empathy”, “love”, and “compassion”, that everyone agrees connotes a positive attribute; however, there are innumerable ideas about what respect means. Perhaps the reason it is so difficult to define is because it can mean different things to different people, depending on whether it is being used as a verb or as a noun, on the person’s cultural background

and the context in which it is being discussed. Making patients feel respected, or valued as a person, is a multifaceted task that involves more than recognizing autonomy. Patients believed that respecting persons incorporates the following major elements: empathy, care and autonomy, provision of information, recognition of individuality, dignity and attention to needs (Dickert et al., 2009). Respecting patient dignity and identity is the corner stone of the active communication skill of health care providers. Proficiency in communicating with patients results in increased patient and physician satisfaction, increased adherence to therapy, and reduced risk of malpractice claims. Listening carefully and respectfully to the patient without interruption will go a long way toward better outcomes for the patient. Effective listening means concentrating on what the patient says and trying to understand their feelings as they speak. Giving bad news requires time, a setting free from distractions or interruptions, empathy, humility and active listening and to say that you may not have the answers to certain questions.

Apologize

An apology is defined as “a speech act which is intended to provide support for the hearer who was actually or potentially affected by a violation” (Olshtain and Cohen 1983). The reactions of patients and their families to incidents are influenced both by the incident itself and the manner in which the incident is handled. Inadequate or insensitive management may cause further emotional trauma, while open acknowledgement of the injury, sensitivity, good communication, and skillful management of corrective actions may reduce emotional trauma. When there has been an error, one of the most powerful things a caregiver can do to heal the patients hurt is to apologize. Apologizing is an essential aspect of taking responsibility for an injury, even if, as is common, several systems failures are responsible for the error rather than one person. Explaining the event, communicating remorse, and making a gesture of reconciliation can do much to defuse the hurt and anger that follows.

Apologies and culture

Speech acts have been found to share certain characteristics in different cultures. However, to say that they share common features does not mean they do not differ in other aspects (Abrahams et al., 1972).

In cross-cultural comparisons of apology strategies, both similarities and differences are reported throughout the literature (Sugimoto and Naomi 1997). They addressed that Japanese students exhibited more readiness to offer (and receive) apologies than their American counterparts. She further found that the secondary strategies of compensation and promise not to

repeat offense were mainly used by the Japanese group who were also reported to offer elaborate manifestations of the promise not to repeat offense and were more open to requests of forgiveness. American respondents, who did not offer clear reparation most probably to avoid weakening their position, declaring responsibility, or fulfilling future obligations, were also reported to attribute the offense to forgetfulness or circumstances beyond their control while Japanese respondents, who strived more to save face, stressed the lack of malicious intention yet admitted responsibility for the offense. Saving face is important in apology-warranting situations which justifies the definition of apology as a “politeness strategy that pays attention to the addressee’s negative face” (Cameron et al., 1989) and “any utterance which aims at remedying the effect of an offense or face-threatening act and restoring social harmony and equilibrium” (Holmes et al., 1993). The human nature tends to favor in-group over other -group may be attributed to their feeling to blame circumstances or another party for any wrongdoing or commend a member of the group for any good deed.

Apologies in Arabic Culture

In Arabic, apologies are defined as the utterances and deeds a person attempts to offer to lift punishment or blame due him/her for a malicious deed he/she has committed (Al-Abdi et al., 1981). This definition may appear too simplistic by Western standards, which may be attributed not only to the fact that the reference is quite old (and probably one of the first on the subject) but also to the emergence of quite elaborate definitions for apology in recent literature. Using verses from the holy Quran and proverbs to mitigate the victim’s anger was also reported by El-Khalil et al., (1989), who attributed it to the impact “of the Islamic teachings and popular folklore” on speech acts.

Bataineh and Bataineh (2008) investigated the differences in the realization patterns of apology among native speakers of American English and Jordanian Arabic. Differences in the use of apology strategies were found between the two sample groups as well as the male and female respondents of each group. Differences involve using several manifestations of explicit apology among other less explicit apology strategies. The authors further examined the differences between male and female respondents in both groups and found that there were more differences between Jordanian male and female respondents than between American male and female respondents, which may be attributed to the fact that there is a greater similarity between how boys and girls are raised in the U.S. than between how they are raised in Jordan.

Another study from Sudan by (Nureddeen, 2008) she outlined the type and extent of use of apology strategies

in Sudanese Arabic and on the socio-cultural attitudes and values of Sudanese community. She examined 1082 responses to a Discourse Completion Test (DCT) that consisted of 10 different social situations of varying severity of offense, strength of social relationship and power between hypothetical speakers and hearers. The informants were 110 college educated adults in Sudan. The survey was written in Sudanese dialect to elicit responses that approximate verbal apologies that might be given in these situations. However, the selection of apology strategies in this study reinforces the culture-specific aspect of language use, despite the fact that a more restricted classification of apology strategies was used as a model for analyzing the data, the results confirm the great significance for understanding differences in language use and successful intercultural communication in Sudanese community.

Resistance to apologize

It is no accident that physicians often resist acknowledging offenses in the medical setting or fail to adequately apologize for them. An obvious and understandable reason for such resistance is the fear of consequences, such as an angry patient, a complaint sent to the court. Initial evidence now suggests that admissions of harm and apologies strengthen, rather than jeopardize relationships and diminish punitive responses (Leape, 2005).

Another important explanation for such resistance is the need for physicians to maintain a self-image for themselves and others of being strong, always in charge, unemotional, and a perfectionist. The feared loss of this self-image may lead to the unbearable emotion of shame and subsequent feelings of depression. An apology may expose vulnerability, remove emotional armor, and allow emotions to be exposed. Medical professionals and colleagues need to work at tolerating and supporting their own humanity and that of their colleagues. They need to regard apologies as evidence of "honesty, generosity, humility, commitment, and courage" (Lazare, 2004).

Responsibility

The overall responsibility and accountability for an adverse event rests with the hospital. Thus, following a serious event it is incumbent upon the organization and its leaders to also accept responsibility and communicate that responsibility and remorse to the patient and family. Because every event is unique, organizational leaders and clinicians should coordinate communications with them. On first consideration, it may seem odd that in situations where the physician had nothing to do with an adverse event, she/he should take responsibility for it. In this circumstance, taking responsibility does not mean assuming sole culpability for the adverse event. A host of

factors likely contributed to the adverse event many of them beyond any one person's control. Medical malpractice insurance offer a marginal value of security to health care givers and to the organization they belong to. Suitable medical malpractice insurance should be implemented to all medical staff personally or through their hospital leaders.

Explain what will be done to prevent future event

The patient must have confidence that the physician or facility is committed to correcting faulty procedures and avoiding similar offences in the future. Once the hospital investigation is completed and corrective changes are planned, it is important to inform the patient and family of these plans and explain what is expected or unexpected outcome. Injured patients have a strong interest in seeing to it that what happened to them does not happen to someone else. The patient must have confidence that the physician or facility is committed to correcting faulty procedures and avoiding similar offenses (Lazare, 2006). Caregivers need to explain unexpected complications in simple patient language without any complicated medical terminologies. They often underestimate the importance of this aspect of the response to an event. Knowing that changes were made and that some good came of their experience helps the patient and family cope with their pain or loss.

Conclusions

Effective communication channels and proper way of apology from caregivers and patients or their relatives may restore damaged relationships or even strengthen previously satisfactory and bidirectional respectful clear relationships. Offering an apology and making disclosure of harmful errors to patients may diminish guilt, shame, and the fear of retaliation and to restore the public's trust in the honesty and integrity of the healthcare system and quality of patients care. Medical staff is committed to full disclosure of medical error, because it is the right thing to do. The patient and family have the right to know what happened. By facilitating and encouraging full disclosure, managers help initiate healing process for all involved and can better ensure regulatory of proper compliance. Medical professionals and faculty staff should emphasize the importance of teaching medical students the value of proper communication skills as part of their curriculum in the under graduate programme.

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