‘I MADE A MISTAKE, AND I’M SO SORRY’

BY RON HARTUNG

THOSE ARE EIGHT OF THE TOUGHEST WORDS FOR PHYSICIANS TO SAY. MAYBE NO ONE TAUGHT THEM HOW. AT THE COLLEGE OF MEDICINE, IT’S PART OF WHAT STUDENTS LEARN.

JUNO LEE

Sixty-two-year-old Mrs. Thompson’s emphysema had flared up enough to send her to the hospital. Because she’s a diabetic, her physician wrote an order for 10 units of insulin. To the nurse, though, it looked like “100.” Which is how Mrs. Thompson got 10 times more insulin than she should have, her blood sugar plummeted and she wound up in ICU — where her physician, choosing words with great care, later tried to explain how she got there.

- **Doctor**: "People with diabetes can have wide swings in their blood sugars. This morning, yours was dangerously low. Fortunately we were able to get it back up to the normal range."
- **Patient**: "What caused it to go so low?"
- **Doctor**: "I'm almost positive it was a bad reaction to the insulin you got this morning."
- **Patient:** "What do you mean, 'bad reaction'?"
- **Doctor:** "It appears that you got more insulin than you needed."
- **Patient**: "How much did I get?"
- **Doctor**: "It appears the nurse gave you 100 units."
- **Patient**: "What kind of moron would give a patient who usually gets 10 units of insulin a hundred? That could have killed me!"
- **Doctor**: "I understand you're angry, Mrs. Thompson, but there's no need to yell."
- **Patient:** "You'd be yelling too if someone almost killed you! Do you people have any idea what you're doing around here?"

The case of Mrs. Thompson, based on an actual occurrence, is immortalized in the College of Medicine curriculum. She's part of a podcast that Ken Brummel-Smith, the Charlotte Edwards Maguire Professor of Geriatrics, sends to second-year students in preparation for a class on medical errors. As part of that class, he and other faculty members confess specific medical errors they've made. And a handful of staff members report what it's like to be on the receiving end of such errors.

It's not unusual for extreme medical mistakes to make news. In May, the headlines were particularly disturbing: A new study at Johns Hopkins estimated that medical errors are actually the nation's third-leading cause of death.

For students, Brummel-Smith's class is a wakeup call: *Yes, you'll serve the underserved, and you'll wear your white coat with honor. But you'll also make mistakes. Maybe serious ones. We're here to teach you how to avoid them, how to deal with the errors you make, and how to keep your focus on your patient rather than yourself.*

"There's a difference between saying 'I'm sorry' and apologizing," Brummel-Smith said during the March 14 class. "'I'm sorry' is a statement that we would use whenever something bad happens to a person, whether or not we had any role in its causation. Apology is an actual medical strategy for dealing with medical errors. It only occurs after you have vetted the issue and you know that it is a mistake that you made.

"That's a very important differentiation. It also is likely to involve both emotional responses and potential legal responses on the part of the patient. The evidence is that the legal response after an apology is usually better than the way we do it now, which is to hide-and-deny. Yes, it is often something that brings a lot of emotion out from the patient or their family, and it should. Part of this training is to try to help you learn to deal with the emotional response."

Brummel-Smith, former head of the American Geriatrics Society and highly respected physician and teacher, then admitted his own fallibility. He recently had written "30" instead of "3" on a prescription for melatonin, to help an older patient sleep. The patient reported that the melatonin was causing him to sleep excessively, so Brummel-Smith looked at the bottle.

"It was so embarrassing to say, 'I wrote the wrong number here. I don't know why I did it, but I'm so sorry about it,'" he told the students. "Fortunately, there were no long-term effects."

When you apologize to a patient, he said, it should be more heartfelt than a typical "I'm sorry."

"It's such a harmful thing that a medical error occurs," Brummel-Smith said. "Patients put us at such a high level of trust when they put themselves in our hands that it's incredibly scary to them to know that an error occurred."

The students heard the patient's point of view, too. Staff member Heather Smith, for example, described her two-year struggle to find someone who could diagnose the recurring pain in her hands, feet and facial muscles. Eventually it was Professor Bob Watson, who works down the hall from her, who solved the mystery within minutes: hypocalcemia. (After her gastric bypass surgery in 2001, her doctor should have had her taking calcium chews and B12 shots — so her body was seriously low on Vitamin D and more.)

Staff member Karen Chavez talked about the unbearably long first year in the life of her son. Sick all the time, tired easily, slept a lot, never seemed to get well. Her pediatrician attributed it to day care. Pneumonia landed the boy in the hospital, but after returning home he still wasn't well. She asked the doctor to review the whole record, but he didn't. Shortly after she switched pediatricians, her son was diagnosed with congenital heart disease. He's doing well now, she said.

In both cases, the women said, the doctors didn't listen to them. In fact, Brummel-Smith confirmed, the No. 1 cause of malpractice suits is patients' feeling that they weren't heard. Too often, he said, physicians cling too long to a diagnosis that just doesn't stand up to scrutiny.

"I see this happening in the Clinical Learning Center with you," he told the students. "You jump to a diagnosis, and then you look for every sign that proves your diagnosis, rather than sticking with, 'This is weird.' 'This doesn't fit.' That hesitancy that you have in your mind is a very important clinical tool. You have to really trust that."

The podcast discussed "medical narcissism," as in: "This is my diagnosis, and I've got to be right!" Instead, the College of Medicine teaches its students to acknowledge any uncertainty and to tell the patient, "We're going to work together to figure this out."

Students also learn that a physician is part of a complex system — and that often mistakes are *system* mistakes.

"I wrote a prescription for melatonin for 30 mg; I started the mistake," Brummel-Smith said, returning to his prescription error. "But why did the pharmacist fill that without calling me and saying, 'Hey, this doesn't really

fit. How come you're using so much?'"

The ideal response, he said, is to say: "Let's look at the system and make sure that we catch each of the steps, not just let one person be the fall guy."

Brummel-Smith cautioned the students that the medical bureaucracy doesn't always embrace apologies, nor do some malpractice companies. But he thinks the tide is turning. In the podcast, he cited one study showing that 37 percent of patients suing providers reported they wouldn't have sued if they'd received an apology.

Then he demonstrated how the physician in Mrs. Thompson's case could have communicated with her far more effectively.

- **Doctor**: "Mrs. Thompson, I wanted to talk with you a bit about what happened this morning and why you had to go into the intensive-care unit. This is going to be hard for me to say and probably hard for you to hear. We made a mistake by giving you 100 units of insulin instead of 10 units that you should have received. I can't express the depth of my regret that this happened, and I apologize that it happened. Would you like me to discuss it in more detail now, or would you rather talk about it at a different time?"

- **Patient**: "What? A hundred units? You're kidding me! What kind of moron would give a patient who usually gets 10 units of insulin 100? That could have killed me!"

- **Doctor**: "Mrs. Thompson, this should not have happened, and we're sorry beyond words that it did. I can't imagine how you feel right now, and you have a perfect right to be angry. The problem was that I didn't write the order clearly, and so the nurse misread the dose as 100 instead of 10. This has nothing to do with anything that you did. It was our mistake."

A LAWYER RESPONDS

It's not unusual for College of Medicine classes to consider both medical and legal viewpoints. In fact, one faculty member's job is to explore creative ways to do just that. Marshall Kapp, J.D., MPH, directs the Center for Innovative Collaboration in Medicine and Law, a joint project of FSU's medical and law schools.

We asked Kapp to look over the accompanying article, and he elaborated on two points:

1. Brummel-Smith told his class, "The evidence is that the legal response after an apology is usually better than the way we do it now, which is to hide-and-deny." Kapp agreed with that statement, "but with the emphasis on 'usually.' The small amount of evidence we have on the impact of apology on the filing of malpractice lawsuits is equivocal, but we are able to say with confidence that, on average and accepting that there are some exceptions, physician apologies do not increase the risk of lawsuits being filed. Even if a lawsuit is brought, most states (including Florida) have statutes that make the apology inadmissible in evidence as proof on the issue of whether negligence occurred."

2. When Brummel-Smith said "the No. 1 cause of malpractice suits is patients' feeling that they weren't heard," Kapp concurred. Then he provided further context, noting that such suits are only one of many ways to measure dissatisfied patients. "Malpractice lawsuits that get filed represent fewer than 5 percent of the people who walk into a lawyer's office with thoughts of suing a physician," he said. "In other words, plaintiff lawyers turn away 19/20 people who walk into their office. That means there are a lot of upset patients, and malpractice suits are just the tip of that iceberg."