REDUCING LITIGATION | RESTORING TRUST | SUPPORTING PHYSICIANS

Training Physicians in Medical Error Disclosure

*The Case for
A Strategic Investment*

Why Training Physicians in
Error Disclosure is a Strategic Investment

**Hospitals today face an unavoidable truth:**

Despite every safeguard, medical errors sometimes occur. What distinguishes organizations that maintain trust and financial stability from those that spiral into costly litigation is not the error itself, but how the error is disclosed.

Evidence is overwhelming: immediate, compassionate, clinician-led disclosure reduces malpractice claims, shortens resolution times, lowers legal costs, and preserves family trust. Yet the central challenge remains: how do we train over one million physicians and healthcare providers to master this vital skill at scale? This paper reviews landmark research, outlines broader evidence, and introduces The Orsini Way's proven, scalable solution.

The University of Michigan Health System's disclosure program data from the 2010 Annals of Internal Medicine study shows the following verified statistics:
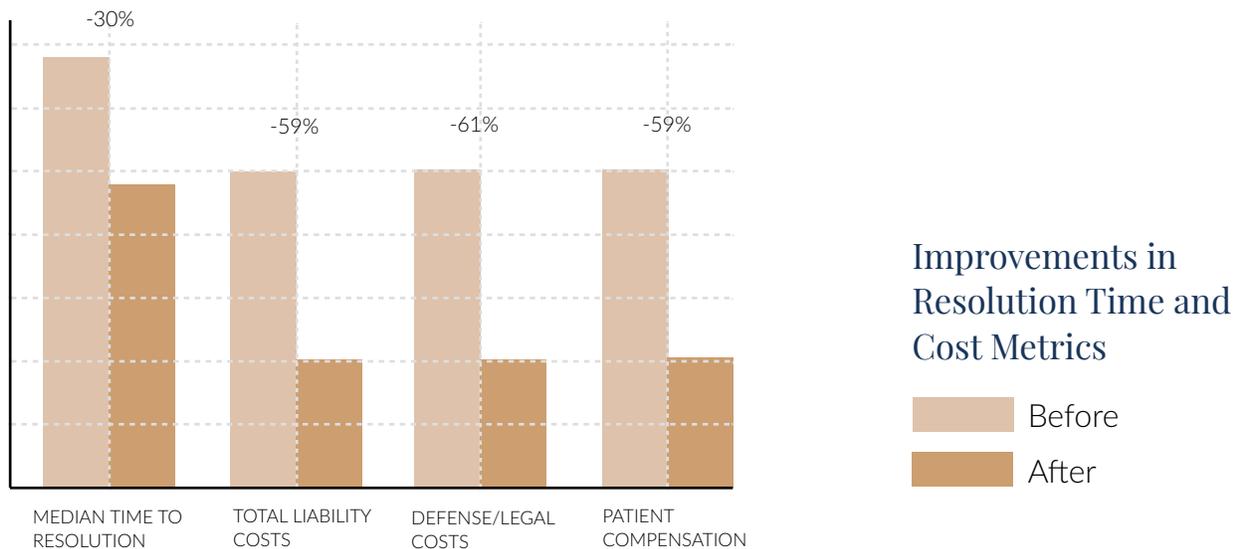
Claims and Lawsuits:

- New claims decreased from 7.03 to 4.52 per 100,000 patient encounters (36% reduction)
- Lawsuits decreased from 2.13 to 0.75 per 100,000 patient encounters (65% reduction)

Reduction of Claims and Lawsuits per 100,000 Patient Encounters

-36%

-65%

RATE PER 100,000 PATIENT ENCOUNTERS

Before
After

NEW CLAIMS
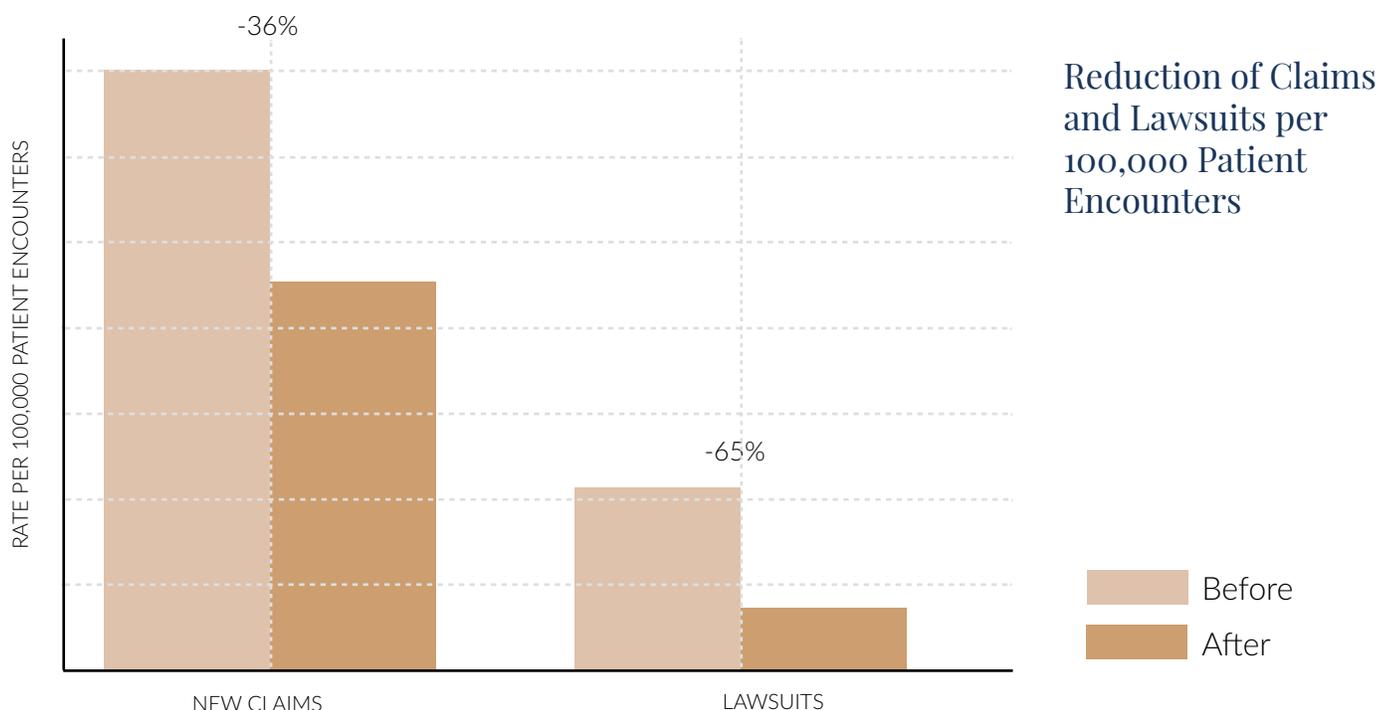
LAWSUITS

Time and Costs:

- Median time to resolution decreased from 1.36 years to 0.95 years (30% reduction)

- Total Liability costs decreased by 59%

- Patient compensation reduced by 59%

-30%

-59%   -61%   -59%

Improvements in Resolution Time and Cost Metrics

Before

After

MEDIAN TIME TO RESOLUTION | TOTAL LIABILITY COSTS | DEFENSE/LEGAL COSTS | PATIENT COMPENSATION

Legal and Risk Mitigation

- Average cost per lawsuit decreased from $405,921 to $228,308 (44% reduction)

- Annual defense spending decreased 61%

- The number of lawsuits dropped from about 38.7 per year to about 17 after implementation

Average cost per lawsuit decreased from

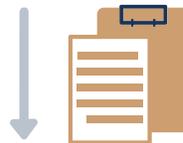BEFORE $405,921

AFTER $228,308
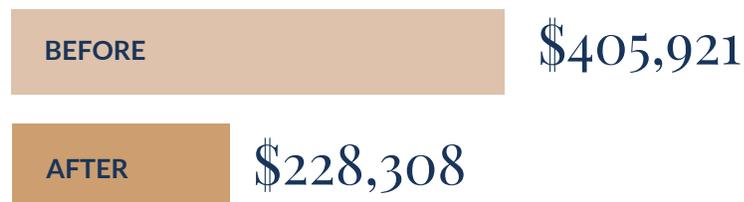
Success Stories from Major Healthcare Systems

1. Seven Pillars Program - University of Illinois

The University of Illinois Hospital and Health Sciences System implemented the "Seven Pillars" approach and achieved:

Nearly doubled incident reports

Halved the number of claims

Reduced legal fees and total costs per claim

Decreased settlement amounts and self-insurance costs

More specific data showed:

✓ Significant increases in adverse event reports, patient communication consults, and root-cause analyses

✓ Decreases in malpractice claims, legal fees, settlement amounts, and total liability costs

✓ Self-insurance fund moved from a $30 million deficit to a $40 million surplus

2. Massachusetts CRP (CARe Program)

Four Massachusetts hospitals (Beth Israel Deaconess and Baystate facilities) implementing Communication, Apology, and Resolution (CARe) programs showed:

Only 5.1% of events resulted in claims

Median compensation was $75,000

No worsening of liability trends after implementation

Improved trends in new claims rates and legal defense costs at some hospitals

Out of 989 reported events:

✓ 140 met criteria for liability insurer referral

✓ Compensation was offered in only 24 cases

✓ The approach didn't trigger new litigation or costs

3. AHRQ CANDOR Implementation

The AHRQ CANDOR (Communication and Optimal Resolution) toolkit has been adopted by multiple healthcare systems nationwide, moving away from "deny-and-defend" to early disclosure and proactive resolution.

As of 2025, new CMS requirements ask hospitals to attest to whether they have a defined, evidence-based communication and resolution program in place, with CANDOR listed by name as one example. A key component of CRP recommendations is the training of Risk Managers and Physicians on how to disclose medical errors properly.

Medical Errors – Scale and Impact

The Unsettling Reality

The widely cited figure that medical errors are the third leading cause of death comes from a 2016 BMJ study estimating 251,000 deaths annually.

However, this figure has been critiqued as potentially inflated due to methodology issues and potentially fatal coexisting factors.

More conservative estimates suggest approximately 50,000 patient deaths annually from preventable medical errors, with healthcare costs of $20-45 billion annually directly attributed to medical errors.

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Second Victim Syndrome – Impact on Healthcare Providers

Second victims are healthcare providers traumatized by involvement in adverse events, experiencing guilt, depression, and questioning their clinical skills.
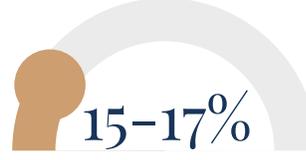
PREVALENCE DATA SHOWS:

25% of emergency physicians experience significant second victim symptoms

22% of ICU nurses and surgery residents experience significant second victim symptoms

27% of emergency nurses experience significant second victim symptoms

15–17% of trauma surgeons and anesthesiologists experience significant second victim symptoms

92% of physicians report involvement in events from near misses to serious errors

81% reporting job-related stress linked to these events

Second victim effects include anxiety, depression, guilt, sleep disturbances, loss of confidence, and decreased job satisfaction and even suicide - with residents being particularly vulnerable given their high workload and limited support.

Key Learnings to Share with Your Team, Board and Leaders:

1. Multiple healthcare systems have replicated success with disclosure programs, providing strong evidence base.

2. CMS now requires hospitals to report on disclosure programs, creating urgency for implementation.

3. The human toll is profound - both patients and providers suffer significantly from medical errors.

4. Disclosure programs address multiple goals:

- reducing litigation costs
- improving patient safety
- supporting provider wellbeing
- maintaining trust

Background Research and Original Sources of Information:

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- Waterman, A. D., Garbutt, J., Hazel, E., et al. (2007). *The emotional impact of medical errors on practicing physicians in the United States and Canada.* Joint Commission Journal on Quality and Patient Safety, 33(8), 467–476. https://doi.org/10.1016/S1553-7250(07)33050-X

Our Newest Program:

Mastering Medical Error Disclosures

How your entire team communicates, especially after an error occurs will dramatically impact litigation risk, organizational liability and patient outcomes - including HCAHPS.

Delivered as a Signature Workshop and on-demand E-Learning course, Dr. Anthony Orsini and our team have developed this program to equip all levels of your organization with the effective and essential skills and tools for properly handling medical error disclosures.

Completing this program and deploying The Orsini Way resources as part of your CRP will leave your team fully prepared to carry these conversations with empathy and clarity.

Other Programs Offered by The Orsini Way:

Breaking Bad News®

It's All in the Delivery®

Difficult Dialogues

LEARN MORE

Inquire About Availability and Timing

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SCHEDULE TIME WITH LIZ

Liz Poret-Christ
MANAGING DIRECTOR

in **CONNECT ON LINKEDIN**

Liz leads organizational partnerships, program implementation, and client success at The Orsini Way®.

With over 20 years in healthcare education and leadership development, she ensures every client engagement reflects the empathy and excellence the company teaches. Liz is known for building trusted relationships and ensuring every team we train feels seen, supported, and equipped to succeed.

Anthony Orsini, DO
PRESIDENT AND FOUNDER

in **CONNECT ON LINKEDIN**

Neonatologist, international keynote speaker, author, and founder of The Orsini Way, with 25+ years of experience helping healthcare and pharmaceutical organizations transform complex medical conversations into meaningful, compassionate communication. His work equips clinical and commercial teams with practical, evidence-based strategies that improve patient experience, trust, and physician well-being.