Patient Safety Tip of the Week

January 3, 2017 What's Happening to "I'm Sorry"?

We thought we were done doing columns about disclosure and apology following medical errors. Most hospitals seem to have come on board and recognize that transparency and honesty, when accompanied by sincere apology, are the right things to do following medical errors.

But what about physicians? Are they also on board?

A recent survey with two hypothetical vignettes was presented to primary care physicians (Mazor 2016). The first involved a delayed diagnosis of breast cancer. The second involved a care coordination breakdown causing a delayed response to patient symptoms. In both cases, multiple physicians shared responsibility for the error, and both involved oncology diagnoses. A majority of respondents would not fully disclose the errors in either situation. Things that predicted intent to disclose were perceived personal responsibility, perceived seriousness of the event and perceived value of patient-centered communication.

A 2016 survey done by Medscape also shows a disturbing trend (Lowes 2016). 78% of respondents to the Medscape survey said that it is never okay to cover up or avoid revealing such an error. Sounds pretty good. However, the percentage who answered that way was down from 91% in 2014 and almost 95% in 2010. To be fair, only 7% actually answered "yes" (yes, it is okay to cover up or avoid revealing an error) and the other 14% said "it depends". But the direction of the trend is bothersome. Here's the link to the full Medscape Ethics Report 2016 (Reese 2016).

In our August 9, 2016 Patient Safety Tip of the Week "More on the Second Victim" we discussed a study of how surgeons address adverse clinical events with their patients and/or patient families (Elwy 2016). Elwy and colleagues surveyed surgeons in the Veterans Affairs medical system about their experiences in disclosing adverse events. Most of the respondents to the survey used 5 of 8 recommended disclosure items:

- why the event happened (92%)
- expressed regret for what happened (87%)
- expressed concern for the patient's welfare (95%)
- disclosed the adverse event within 24 hours (97%)
- discussed steps taken to treat any subsequent problems (98%)

But use of the other 3 recommended disclosure items was less frequent:

- apologized to patients (55%)

- discussed whether the event was preventable (55%)
- discussed how recurrences could be prevented (32%)

They found that surgeons who reported they were less likely to discuss preventability of the adverse event, those who stated the event was very or extremely serious, or who reported difficult communication experiences were more negatively affected by disclosure than others. Those surgeons with more negative attitudes about disclosure at baseline reported more anxiety about patients' surgical outcomes or events following disclosure. The study clearly highlights the need for training for disclosure and apology and development of skillsets to use for such. Logically, it might be anticipated that development of those skills might reduce the negative experiences with disclosure and apology on the part of surgeons and perhaps be a first step in aiding the "second victims", too.

The American Academy of Pediatrics just released a policy statement "Disclosure of Adverse Events in Pediatrics" (AAP 2016). It notes that physicians and residents are in agreement that it is an ethical obligation to their patients to disclose preventable adverse events but that, in practice, this is not often done. It notes that in an anonymous survey among pediatric residents and attending pediatricians (Garbutt 2007), pediatricians in private practice were less likely to report errors than other attending pediatricians (72% vs 92%) and that most attendings and residents agreed that disclosing a serious error would be difficult. It also showed that residents were more likely than attending pediatricians to have received education about how to disclose errors (57% vs 29%). The new AAP policy statement discusses the barriers to disclosure and legal issues and ways to facilitate better disclosure. It emphasizes the need for education and training in disclosure skills, including use of simulation in such training.

Very timely is a Health Services Research theme issue (Ridgely 2016) that deals with communication-and-resolution programs. While you'll find multiple articles of interest in that issue, you'll probably most appreciate the one by Lambert et al. (Lambert 2016). They implemented their own version of a communication and optimal resolution (CANDOR) program, which they named the "Seven Pillars" program, at the University of Illinois Hospital and Health Sciences System. We discussed CANDOR in our June 2016 What's New in the Patient Safety World column "Disclosure and Apology: The CANDOR Toolkit". The 7 pillars are:

(1) incident reporting
(2) investigation while holding hospital bills and professional fees
(3) early communication with patient/family
(4) full disclosure, apology, and rapid remedy if appropriate
(5) system improvement
(6) data tracking and evaluation
(7) education and training

Using an interrupted time series analysis, they were able to show the program was associated with increases in the frequency of incident reports, event analyses, and post-event communication consults, and reductions in claims, legal fees, legal expenses, costs

per claim, settlement costs, and self-insurance costs. Their results were both clinically and financially significant and persisted for more than 7 years after the initial intervention. Annual contributions to their self-insurance fund declined dramatically, and the self-insurance fund moved from a $30 million deficit to a $40 million surplus. Those results are reassuring and in keeping with the promise seen after the original University of Michigan success that we described in our September 2010 What's New in the Patient Safety World column "Followup to Our Disclosure and Apology Tip of the Week".

Meanwhile, results from a demonstration project in New York City were less impressive (Mello 2016a). The communication-and-resolution program implemented in surgical departments of 5 NYC acute care hospitals was quite successful in handling events not caused by substandard care, but less consistent in offering compensation in cases involving substandard care. But one striking finding in that study was that clinician awareness of the communication-and-resolution program was quite low and many felt the program did not likely help avoid a lawsuit. The authors felt that, in those cases where there were violations of standard of care, there was difficulty adhering to the principle that compensation should be proactively offered.

Some of the other papers in the theme issue describe some of the challenges and barriers in establishing disclosure and apology or CANDOR programs. A study of a communication-and-resolution program (CRP) involving six hospitals and clinics and a liability insurer in Washington State (Mello 2016b) found that sites experienced small victories in resolving particular cases and streamlining some working relationships, but they were unable to successfully implement a collaborative CRP. Barriers included the insurer's distance from the point of care, passive rather than active support from top leaders, coordinating across departments and organizations, workload, nonparticipation by some physicians, and overcoming distrust.

Two very important parts of any CANDOR program are (1) understanding the perspective of patients/families following adverse events that impact them and (2) training healthcare professionals on how to do disclosure and apology with those patients and families. Gallagher and colleagues used a patient-created simulation exercise to help accomplish both (Gallagher 2016). Their experience showed that many stakeholders felt that the current responses to adverse events were complex, siloed, and uncoordinated and thus failed to meet the needs of patients and families. Participants suggested creating a patient navigator-like role to help support the patient/family throughout the process. They also found that the interest of the patient/family might not be the top priority for many stakeholders. They note that risk managers and defense attorneys care about patients and families but their primary role is to protect the institution or providers and that plaintiff attorneys and Boards of Medicine may serve as structural barriers that hamper CANDOR programs. Experiencing how a patient felt in reading a hospital's response to her complaint about a delayed cancer diagnosis elicited both intellectual and visceral responses in many stakeholders. And patient advocates were impressed by the desire of stakeholders to better understand the patient/family perspective and improve the response to adverse events. The article has good recommendations on using this type of simulation exercise in other organizations.

Another study provided very interesting insights regarding the involvement of patients and families in investigating adverse events (Etchegaray 2016). We've always said that the patient perspective should be important and have sought ways to involve patients/families in such investigations. However, we've had a hard time figuring out how to do so and have met resistance from both clinicians and administrators. But the Etchegaray study is a real eye opener. They recruited patients and families (roughly 50% for each group) who had been involved in an adverse patient event and did semi-structured interviews with them.

All the participants identified at least one factor contributing to the adverse event that they or their family member had suffered. In fact, the average number of contributing factors identified was 3.67 factors. The most common categories of contributing factors noted were staff qualifications/knowledge (such as unfamiliarity with a drug) identified in 79%, safety policy/procedures (such as failure to adhere to hand hygiene) identified in 74%, and communication identified in 64%. While there were a variety of ways such factors were identified, a full third were identified by direct observation and, in some cases, would not likely have been identified by others during a root cause analysis (RCA). And some of the "human" factors they identified as contributing will surprise you! Those included things like greed, anger, and one-upsmanship, factors that almost certainly would not have been revealed during our traditional RCA's.

Yes, there was likely some degree of selection bias in the results in that the participants voluntarily agreed to participate and many were involved in patient safety advocacy groups. They also clearly wanted to foster learning from their events to help others. But the findings have merit regardless of any selection bias.

We understand the reluctance of many healthcare professionals and administrators to have patients or families sit in on a formal RCA meeting. However, we think that when disclosure and apology are offered to a patient or family, that is an appropriate time to also seek their input and perspective. You need to let them know that an investigation will be done to identify issues that can be corrected to prevent future similar events and that any observations they may have had will be helpful in that regard. We usually recommend that the physician do the disclosure/apology and let them know that a member of the RCA team will meet with them to get their input. That both gives them time to think about their direct observations and reinforces that we are committed to improve care and we truly respect their input into the process.

Levinson et al. recently presented a good practical discussion of what to do after a medical incident and how to handle disclosure and apology (Levinson 2016).

Not to be lost in the successes reported at the University of Illinois in the Lambert study is that they also included peer support in a "care-for-the-caregiver" program for professionals involved in serious incidents (see our Patient Safety Tips of the Week for December 17, 2013 "The Second Victim" and August 9, 2016 "More on the Second Victim"). In the latter column we noted Carolyn Clancy's editorial (Clancy 2012) which

suggested the evolving practice of disclosure and apology might be a means of alleviating the emotional trauma of both the first and second victims of patient safety events.

The case for disclosure-and-apology and communication-and-resolution programs is growing. Not only is such transparency the right thing to do but in the long run is likely mutually beneficial and leads to future improvements in patient care.

Some of our prior columns on Disclosure & Apology:

July 24, 2007	"Serious Incident Response Checklist"
June 16, 2009	"Disclosing Errors That Affect Multiple Patients"
June 22, 2010	"Disclosure and Apology: How to Do It"
September 2010	"Followup to Our Disclosure and Apology Tip of the Week"
November 2010	"IHI: Respectful Management of Serious Clinical Adverse Events"
April 2012	"Error Disclosure by Surgeons"
June 2012	"Oregon Adverse Event Disclosure Guide"
December 17, 2013	"The Second Victim"
July 14, 2015	"NPSF's RCA2 Guidelines"
June 2016	"Disclosure and Apology: The CANDOR Toolkit"
August 9, 2016	"More on the Second Victim"

Other very valuable resources on disclosure and apology:

- IHI's "Respectful Management of Serious Clinical Adverse Events" (Conway 2010)
- The Canadian Disclosure Guidelines (Canadian Patient Safety Institute 2008)
- The Harvard Disclosure Guidelines (Massachusetts Coalition for the Prevention of Medical Errors 2006)
- The ACPE Toolkit (American College of Physician Executives)
- Oregon Patient Safety Commission Oregon Adverse Event Disclosure Guide.

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