



# How to Talk about Patient Safety

A FrameWorks MessageMemo

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# Table of Contents

<b>Introduction: Move to a connected solutions frame.</b> .....	<b>3</b>
<b>Evidence-Based Reframing Strategies</b> .....	<b>5</b>
Explicitly define the terms <i>patient safety</i> and <i>medical error</i> to increase understanding of the problem.....	8
Talk about <i>medical</i> care rather than <i>health</i> care to help people focus on safety. ....	9
Connect the dots between causes and solutions. ....	9
Use the <i>Aviation</i> metaphor to help people make sense of how errors arise and how they can be reduced.....	11
Use the <i>Fail-Safe</i> metaphor to help people grasp what solutions look like.....	13
Adopt an efficacious rather than a crisis tone. ....	14
Explain rather than assert the prevalence of medical errors. ....	15
Pan back to include the whole picture, rather than zooming in on one cause or solution.....	16
Explain the importance of patient involvement without talking about “empowerment.” .....	17
<b>Conclusion</b> .....	<b>20</b>
<b>Methods Appendix</b> .....	<b>21</b>

## Introduction: Move to a connected solutions frame.

Right now, Americans are simply not thinking about patient safety as a policy matter. And although organizations that focus on patient safety are working to change the public discourse, this critical aspect of health care receives scant media coverage.<sup>1</sup> This reality reveals both a risk and an opportunity for advocates seeking to reduce medical errors. The risk is policy inertia. Unless a more visible, more informed conversation on improving patient safety is cultivated and a broader constituency garnered, it will remain difficult to advance support for the systemic changes needed to reduce medical harm. The opportunity is the chance to define and explain the issue. Patient safety professionals, experts, and advocates are in a position that issue advocates rarely have the luxury of holding: introducing a little-known topic into the public discourse and consciousness.

The field understands that it faces a salience problem and often focuses on adverse events to draw attention to the issue.<sup>2</sup> To build a bigger constituency for more innovative, more robust approaches to reducing and preventing medical errors, however, FrameWorks' research and analysis suggests that patient safety experts and advocates expand their communications strategy. When talking with non-specialists, the field should understand that emphasizing the prevalence of medical errors is not enough to deepen non-expert understanding about patient safety. In the same vein, zooming in on instances of patient harm or failing to define basic concepts that non-experts struggle to understand, such as patient safety, the health care system, and patient empowerment, will not increase public engagement with the issue. These strategies lead people to see medical errors as problems that are too big and complex to solve and reinforce the sense that the only means of prevention is patient vigilance or harsh punishment for medical professionals. Framed this way, people have a harder time seeing the point of preventive policies and initiatives that move beyond individual responsibility.

The community of patient safety professionals can change the conversation by embracing a frame that focuses on explanation. An explanatory frame, on any issue, does not take non-expert understanding for granted, but rather defines, explains, and connects concepts at every point in communications. For the patient safety community, a *connected solutions* frame defines patient safety, establishes the prevalence of medical errors, and elaborates systemic-level causes, articulating how proposed solutions will effectively address the problem. It explains how medical care systems create conditions under which medical errors are more or less likely to occur and concretely illustrates how changes to that system can improve health outcomes and reduce patient harm. Rather than dwelling on medical errors that have already occurred, a *connected solutions* frame focuses on the more dynamic concept of prevention. It invites people to think of prevention as a shared project involving multiple actors and demonstrates a full range of policies and initiatives that can reduce medical errors.

The patient safety community can catalyze this needed shift in communications by adopting a set of concrete, easy-to-follow framing guidelines:

- Define terms like *patient safety* and *medical errors*.
- Connect the dots between causes and solutions.
- Use the *Aviation* metaphor to explain how medical errors arise and how they can be reduced.
- Use the *Fail-Safe* metaphor to help people grasp what solutions look like.
- Explain rather than assert the prevalence of medical errors.
- Adopt an efficacious rather than a crisis tone.
- Include the whole picture, rather than zooming in on one cause or solution.
- Explain the importance of patient involvement without talking about “empowerment.”

Each adjustment will make a difference on its own, but, taken together, the whole becomes more than the sum of its parts. Read on to learn more about the evidence behind these recommendations, what each involves, and how to put them into practice in communications.

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## What Communications Research Does a Sector Need to Reframe an Issue?

**What does the research on patient safety say?** To distill expert consensus on patient safety, FrameWorks conducted interviews from October to November 2016 with 12 leading patient safety experts. These data were supplemented by a review of relevant academic and advocacy literature and refined during a series of feedback sessions with leaders in the field.

**How do the public and health care professionals think?** To document the cultural understandings the public draws on to make sense of patient safety, FrameWorks conducted in-depth cognitive interviews and analyzed the resulting transcripts to identify the implicit, shared understandings and assumptions that structure public thinking. Twenty interviews were conducted in Springfield, Massachusetts; Boston, Massachusetts; Atlanta, Georgia; and Sacramento, California. In addition, 10 interviews were conducted with health care professionals by Skype or phone.

**Which frames shift thinking?** To identify effective ways of talking about patient safety, FrameWorks researchers developed and tested a set of candidate messages. Three primary methods were used to explore and refine possible reframes:

- On-the-street interviews involving rapid, face-to-face testing of frame elements for their ability to prompt productive and robust understandings of and discussions about patient safety. A total of 49 interviews were conducted in April and May 2018.
- A series of experimental surveys involving a nationally representative sample of 6,188 respondents to test the effectiveness of a variety of frames on public understanding, attitudes, and support for policies.
- A series of qualitative, group-based tests with a total of 36 people (12 health care professionals and 24 members of the public) to explore how the most effective frames worked in conversational settings. Peer discourse sessions and persistence trials investigated the frames’ effectiveness with members of the public and then separately with health care professionals.

All told, more than 6,300 people from across the United States were included in this research. See the Appendix for a more detailed methods discussion.

## Previous Research

[\*Safety Is More than Caring: Mapping the Gaps between Expert, Public, and Health Care Professional Understandings of Patient Safety\*](#) (2018). This report summarizes how members of the public and health care professionals think about and understand patient safety and explores the implications for strategic communications.

[\*Telling a Story of Safety: Media and Organizational Discourse on Patient Safety\*](#) (2018). This report summarizes how members of the public and health care professionals think about and understand patient safety and explores the implications for strategic communications.

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## Evidence-Based Reframing Strategies

To raise the salience of patient safety, communicators need framing strategies to dislodge unproductive public thinking and open new, more productive ways of thinking. Existing public understandings pose multiple challenges to patient safety advocates; reframing patient safety requires multiple *frame elements*, or different communications cues, that can be deployed for specific purposes.

To arrive at a set of such tools and tactics, FrameWorks researchers designed a series of qualitative studies and quantitative experiments to test the effects of different frames and narratives.

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### Which Frame “Works”? That’s an Empirical Question.

To arrive at a set of framing tools and tactics that advocates can use with confidence, FrameWorks researchers designed a series of qualitative studies and quantitative experiments that tested the effectiveness of different frame elements in communicating the expert perspective on patient safety. The frame elements tested included explanatory chains, explanatory metaphors, tone, and examples.

Qualitative methods tested frame effects by seeing how exposure to framed messages affected how participants talked about patient safety and medical errors. By exploring how participants picked up on and used the language of the messages and analyzing changes in talk, researchers were able to differentiate between more and less effective frames and to identify the features of messages that were most productive.

The survey experiment quantitatively tested frames using a large, nationally representative sample. Respondents were randomly assigned to receive a message treatment or to a control condition. Researchers first created a short description of a fictional policy initiative, which was given to participants in a control condition, and then created short messages that embedded the act within specific frames, which were given to “treatment” groups. Participants in the experiment were randomly assigned to the control or to a message treatment and then asked to complete a survey probing their knowledge, attitudes, and policy preferences about patient safety issues. A frame “works” when it leads to positive shifts on these outcomes. Sample survey questions are provided in *Table 1*.

**Table 1: Desired Communications Outcomes: Knowledge, Attitudes, and Policy Preferences**

Outcome Scales	Sample Questions
Support for fictional policy initiative designed to increase patient safety and reduce medical errors	How much do you favor or oppose the initiative? ( <i>Strongly oppose, Oppose, Somewhat oppose, Neither favor nor oppose, Somewhat favor, Favor, Strongly favor</i> )
Understanding the prevalence of medical errors	Medical errors are rare in the United States. ( <i>Strongly disagree, Disagree, Somewhat disagree, Neither agree nor disagree, Somewhat agree, Agree, Strongly agree</i> )

<p>Understanding the role of systems and protocols</p>	<p>Which of the following would be most effective in reducing medical errors?</p> <ul style="list-style-type: none"> <li>a) Requiring medical professionals to use step-by-step instructions every time they do a specific procedure.</li> <li>b) Punishing medical professionals who make errors.</li> <li>c) Allowing medical professionals to rely more on their experience and intuition and less on predetermined procedures.</li> </ul>
<p>Understanding the role of institutional culture</p>	<p>Which of the following do you think is most responsible for causing medical errors?</p> <ul style="list-style-type: none"> <li>a) Some medical professionals do not feel free to speak up about issues they observe.</li> <li>b) Some medical professionals do not follow their supervisors' orders closely enough.</li> <li>c) Some medical professionals simply do not care enough about avoiding errors.</li> </ul>
<p>Views on patient-doctor relationships</p>	<p>Which of the following is most important for the relationships between patients and doctors?</p> <ul style="list-style-type: none"> <li>a) Patients should feel comfortable asking questions.</li> <li>b) Patients should respect the doctor's authority and knowledge and follow recommendations.</li> <li>c) Doctors should remember details about patients' health and life in general.</li> </ul>
<p>Understanding the role of policies in medical facilities</p>	<p>What can leaders at doctors' offices and hospitals do to reduce medical errors?</p> <ul style="list-style-type: none"> <li>a) Set specific goals for decreasing errors.</li> <li>b) Monitor their staff more closely.</li> <li>c) Get to know their staff better as people.</li> </ul>
<p>Sense of collective efficacy</p>	<p>How optimistic or pessimistic do you feel that we, as a society, can reduce medical errors in this country? (<i>Extremely pessimistic, Pessimistic, Somewhat pessimistic, Neither optimistic nor pessimistic, Somewhat optimistic, Optimistic, Extremely optimistic</i>)</p>
<p>Sense of collective responsibility</p>	<p>In your view, how much of an obligation does our society have to reduce medical errors in this country? (<i>No obligation at all, A very small obligation, A small obligation, A moderate obligation, A large obligation, A very large obligation, An extremely large obligation</i>)</p>
<p>Open-ended questions</p>	<p>What kinds of things do you think would help reduce medical errors in our country?</p>

The answers of the control and “treatment” groups to the survey questions were compared to determine how frames affect thinking. Researchers controlled for a range of demographic variables (including age, race, class, and gender) by conducting a multiple regression statistical analysis to ensure that the effects observed were driven by the frames rather than demographic variations in the sample. A breakdown of the sample by demographics is included in the Appendix. A statistically significant difference between the control and a treatment group on a particular outcome is a sign that the frame the treatment group was given affects opinion about that outcome.

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## RECOMMENDATION

Explicitly define the terms *patient safety* and *medical error* to increase understanding of the problem.

Patient safety is not a concept that members of the public naturally use or readily access. They are not attuned to the importance of measuring or evaluating patient safety in a formal way or demanding that their health care is safe. They are also unclear about what does and does not constitute a medical error, despite somewhat greater familiarity with this term.

Patient safety experts and advocates should explicitly define both terms whenever possible. Our research suggests that definitions should include two key features:

1. Emphasize that harm is *preventable*. Orienting people toward the possibility of prevention upfront is important to avoid fatalism—the assumption that errors are inevitable. As discussed below, additional steps must be taken to get across this point, but orienting people toward prevention in defining the problem is an important first step.
2. Include a variety of concrete *examples* of medical errors. Because people lack a sense of what this issue involves, a range of concrete examples help people quickly grasp the nature of the problem.

### Before:

*Medical errors take place when patients experience harm in their care that could have been prevented.*

### After:

*Preventable medical errors include giving a patient the wrong dose of a medication, performing a procedure on the wrong patient, failing to follow-up on important lab results, and spreading infections because of poor hygiene.*



## RECOMMENDATION

Talk about *medical* care rather than *health* care to help people focus on safety.

When members of the public hear “health care,” they immediately think about health insurance. Once they’re thinking about insurance, conversations quickly turn to complaints about the high costs of health care, which makes it hard to focus attention on safety. Perhaps more perniciously, when the focus is on health care, people adopt a *Consumerist* perspective; when they do consider patient safety, they view it through the lens of business and consumer choice. When people are oriented toward consumer choices, they conclude that patients are responsible for making discriminating choices and struggle to think about the institutional and systematic factors that contribute to—or detract from—patient safety.

FrameWorks research therefore suggests that, when possible, patient safety advocates use the term “medical care” to circumvent people’s unproductive associations with health care. Even this small shift in terminology can open space for more systemic and policy-oriented conversations about patient safety.

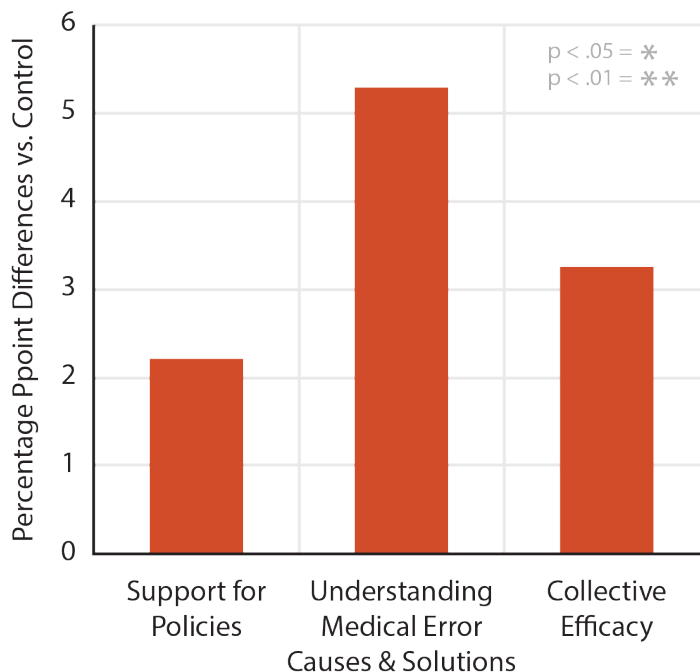
## RECOMMENDATION

Connect the dots between causes and solutions.

People struggle to understand *why* medical errors happen. Their top-of-mind explanation is that making mistakes is an unavoidable part of human nature, leading to a strong sense of fatalism when thinking about the possibility of preventing medical errors. The sense that “to err is human” is even further exacerbated when people think about medical professionals. People assume that, in our medical system, medical professionals are inevitably overloaded—something people see as unchangeable—and that this necessarily makes professionals even more error-prone. Because people see medical errors as an inevitable outgrowth both of human nature and of a medical system that is only vaguely understood, it is difficult for people to think about how errors can be prevented.

FrameWorks researchers hypothesized that helping people better understand the systemic sources of medical errors would make it possible for them to recognize that they *can* be prevented through systemic solutions. To test this hypothesis, researchers tested a message that

**Figure 1: Effects of Explanation**



connected the dots between causes and solutions and compared it to the control condition. *Figure 1* shows that this message effectively increased people’s understanding of causes and solutions and increased their sense of collective efficacy—the belief that we can reduce medical errors if we put the right systems and policies in place.

Explanation moves people beyond individual-level views of medical errors to an understanding of the factors that give rise to medical errors. And, by helping people understand the causes of errors, it helps them recognize that systemic solutions *can* reduce errors.

To reframe patient safety, advocates need to offer clear cause-and-effect explanations that fill in the picture, depicting ways that medical errors occur and how systemic solutions address these causes. Carefully crafted “what-affects-what” sequences can provide nonexperts with an alternative way of understanding the problem and lead them to more fully appreciate advocates’ suggested solutions.

**Before:**

*Diagnostic error has been in the news recently, labeled number one in a top ten list of patient safety concerns and a chief cause of medical malpractice cases in another assessment. . . . Diagnostic error is a particularly thorny challenge in that there are often multiple contributing factors—systems factors as well as cognitive. Yet many health professionals and researchers are putting innovative theories into action, including patient-centric models of primary care that extend the responsibility for diagnosis beyond the primary care clinician to include nurses, pathologists, radiologists, and others.*

**After:**

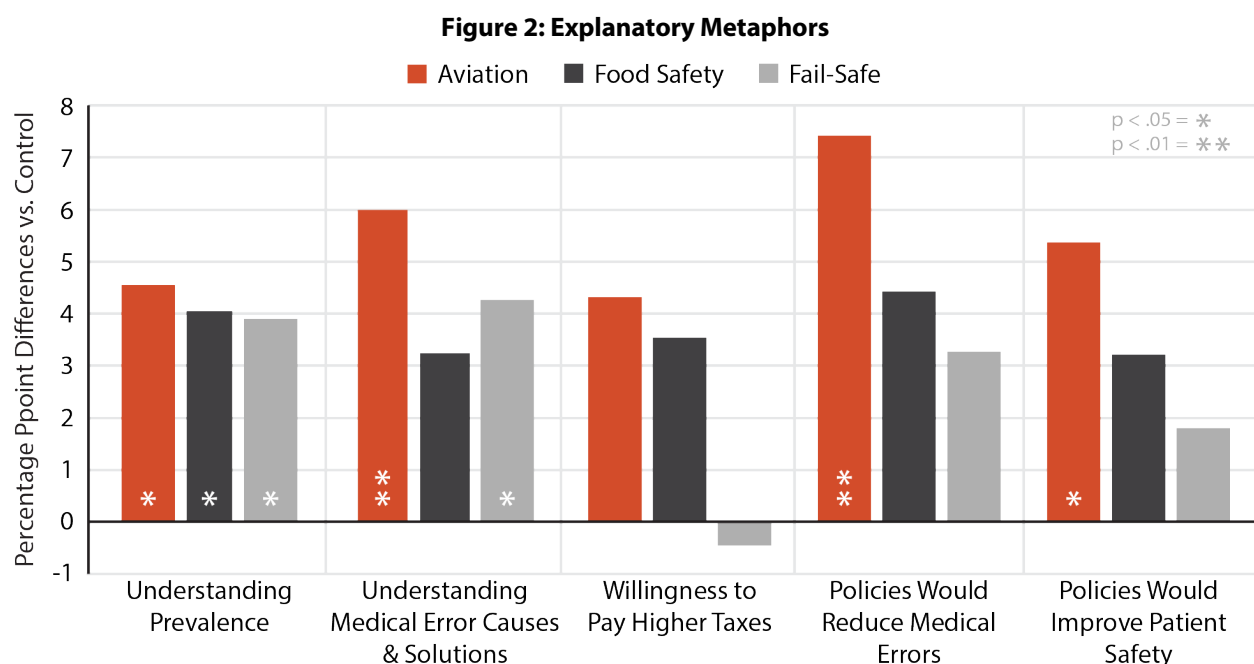
- *Getting the right diagnosis is critical for getting the right care. The health of patients who receive the wrong diagnosis can get worse—not better.*
- *When a diagnosis is wrong, it is called a “diagnostic error.” Right now, these errors are common. In fact, research suggests that thousands of patients die each year due to diagnostic errors.*
- *One reason diagnostic errors happen is because doctors do not have all of the information they need to make the right diagnosis.*
- *We can take steps to make sure doctors have the information they need to diagnose their patients. We can put systems in place that help doctors communicate more effectively with their patients so no information gets left out.*

## RECOMMENDATION

Use the *Aviation* metaphor to help people make sense of how errors arise and how they can be reduced.

While basic cause-and-effect explanations of the type discussed above are powerful, explanations that draw on effective *metaphors* are especially effective. Explanatory metaphors are powerful tools that communicators can use to expand thinking and create new mental pictures. Explanatory metaphors help people think and talk about complex concepts in new ways or see issues from new perspectives. By comparing an abstract or unfamiliar idea to something concrete and familiar, explanatory metaphors make information more understandable, ideas more accessible, and solutions easier to consider. Effective metaphors stick in people’s minds, and, through repeated use, generate new understandings that seem so intuitive they become a sort of new common sense.

But not all metaphors are created equal. In FrameWorks’ qualitative and quantitative research, researchers tested a range of metaphors, finding that some worked better than others. *Figure 2* shows survey experiment results for three metaphors—*Aviation*, *Food Safety*, and *Fail-Safe*—on select outcomes. The *Aviation* metaphor increased people’s understanding of systemic causes and solutions and, by helping people see that the sources of medical errors are systemic, led to an increased recognition that errors are frequent. In addition, compared to the control condition, participants who were exposed to the *Aviation* metaphor were marginally more willing to pay higher taxes ( $p = .06$ ), to implement policies that would reduce medical errors, and significantly more likely to agree that these policies would reduce medical errors and improve patient safety. This metaphor was the most effective of those tested in the survey experiment, producing larger effects than other metaphors and significant effects on more outcomes.



Significantly, in response to open-ended questions, participants who read the *Aviation* metaphor were more likely than those in the control condition to mention terms associated with the kinds of systemic policies for which patient safety professionals advocate. This provides further evidence that the metaphor helps people think about patient safety in more systemic terms.

In qualitative testing, the metaphor was easily understood and readily applied to think about why medical errors arise and what can be done to address them. For example, research participants mentioned the importance of standardized procedures and protocols, tools like checklists, and improved technology for reducing medical errors. Employing the *Aviation* metaphor, participants not only argued *that* these things would be helpful but also were able to explain *why* they would help reduce errors.

This metaphor proved effective not only with members of the public but also with medical professionals who are not experts in patient safety. In qualitative testing with these professionals, researchers found that the metaphor was already familiar to many professionals and that they were able to use it to talk about the value of systems already in use, especially in the operating room. Because the metaphor forefronts a system of safety rather than any one individual actor, medical professionals were less inclined to blame medical errors on patient noncompliance. Reasoning with the metaphor, they identified the deeper integration of systems as one solution to improving patient safety and focused on how systemic solutions could improve rather than impinge upon their ability to do their jobs well.

The *Aviation* metaphor moves people beyond extant and unproductive explanation of why medical errors occur by connecting the causes and solutions of medical errors to policies and practices in place in another field. The field of aviation is widely recognized to be safe because of the proactive measures that are in place to ensure safety. People recognize that these measures are embedded into the system and do not depend on any one individual's vigilance or are not caused by any one individual's negligence. People can easily map these entailments onto the field of patient safety, which helps them consider policy and systems-level changes designed to reduce medical harm.

The added benefit of the *Aviation* metaphor is that it is already in use by experts and advocates in the patient safety field. The above research, however, suggests that there are some potential pitfalls in using the metaphor. Most notably, because air travel is an industry, the metaphor can, if not used properly, lead people to think about travelers as *consumers*. As described above, *Consumerist* thinking is unproductive in a variety of ways. Communicators should follow the following guidelines when using the metaphor:

- *Refer to passengers instead of customers.* Communicators should refer to passengers on a plane—**not** to airline “customers.” The latter evokes people who have paid for pleasant, convenient, and comfortable service and is likely to inadvertently activate a *Consumerist* perspective about health care.
- *Downplay comfort and service and emphasize safety.* When describing standardization and protocols that exist for aviation, communicators should not bring up measures that promote comfort or service aspects of flying. These concerns divert people from thinking about safety.

- *Use the term “airline” with caution.* The term “airline” connotes the commercial use of flying in a way that is more likely to cue the *Consumerist* perspective than the broader, less customer-centric term “aviation.”
- *Forefront proactive solutions and background punitive actions.* Communicators should emphasize the proactive solutions employed in the field of aviation, like rigorous protocols and standards, that should be emulated to improve patient safety. They should avoid highlighting potential repercussions for airline employees who make mistakes.

These examples show the differences in how the *Aviation* metaphor is currently used by the patient safety field and a reframed use of that metaphor.

**Before:**

Patient safety should be on the front of everyone’s minds every day—from health care executives to front-line staff. The fact that we have a special week is probably a sign of the dreadful current state of patient safety. I don’t think the airlines have ‘Passenger Safety Awareness Week.’ While airlines aren’t perfect, air travel has gotten much safer over the past few decades, while health care has not...

**After:**

The air travel industry takes specific actions to avoid mistakes aren’t and ensure everything is as safe as possible. Ground crews use checklists to inspect planes and make sure that all the equipment is working. And air traffic control systems and professionals look out for hazards in the air and coordinate all the planes. The field of health care can adopt similar procedures to reduce errors. For example, doctors and nurses can use checklists for medical procedures, wash their hands to prevent infection from spreading, and always confirm patients’ identities to prevent errors.

**RECOMMENDATION**

Use the *Fail-Safe* metaphor to help people grasp what solutions look like.

The idea that we need to put in place “fail-safes” to prevent errors is a perfect complement to the *Aviation* metaphor. Our research found that the *Fail-Safe* metaphor was particularly effective in helping people grasp the importance of standardized systems to prevent medical errors. As *Figure 2* shows, *Fail-Safe*, like *Aviation*, expanded understanding of the causes and solutions for medical errors and increased participants’ recognition that medical errors regularly occur. Yet our analysis of responses to open-ended survey questions and our group-based qualitative research reveal that this metaphor has some distinctive strengths.

In responses to open-ended survey questions, participants who received the *Fail-Safe* message were more likely than those in the control condition to write about the role of technology, the importance of sharing medical records, and other systems that should be put in place to reduce medical errors. In group-based testing, researchers similarly found that the metaphor trained attention on things that can be done to *prevent* errors, rather than addressing them or coping with them after they have occurred. It elevates the

understanding that, while *humans* are fallible and often inefficient, *systems* do not have these same shortcomings and should therefore be more widely implemented and relied upon.

The *Fail-Safe* metaphor is flexible. It can stand on its own either as a fully developed metaphor or as a sort of “handle” that helps people quickly grasp the need for automatic, systemic solutions. It also can be used in conjunction with the *Aviation* metaphor. Research participants widely acknowledged that the field of aviation has numerous fail-safes, such as security and pre-flight checks of the plane.

#### **Metaphor as a handle:**

*To protect #patientsafety, we need fail-safes that kick in before medical errors happen. A new report out today discusses some of the fail-safes we can put in place: [LINK]*

*#Medicalerrors can be prevented. As #healthcare professionals, we can set up fail-safes that can warn us before medical errors happen. Learn more here: [LINK] #patientsafety*

#### **Elaborated version:**

*Procedures like checklists and confirming patient identities catch errors before they happen. If a professional initially overlooks a step in a procedure or confuses one patient for another, these fail-safes are triggered so errors are corrected before the patient is harmed.*

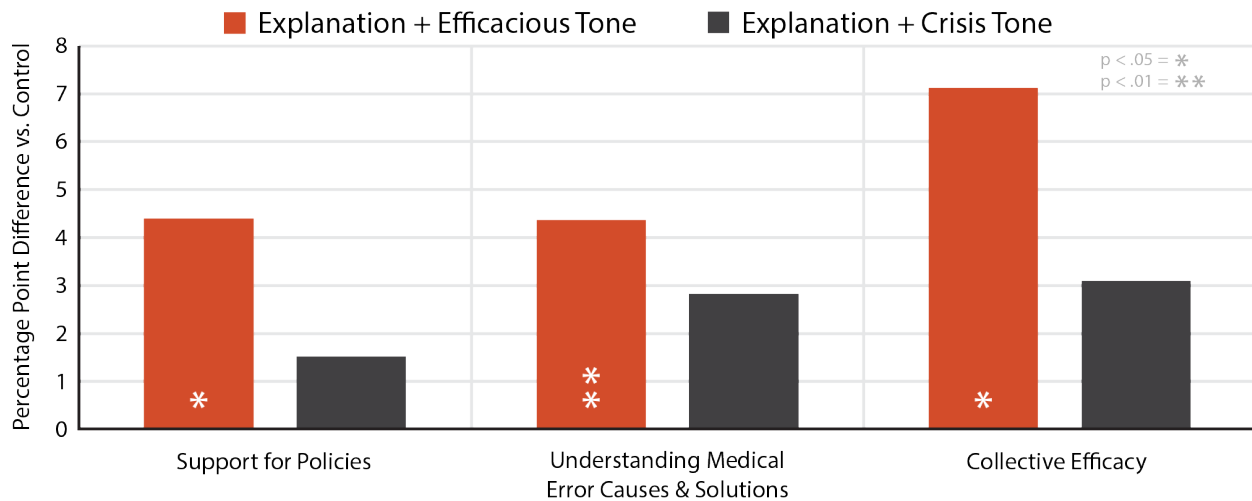
### **RECOMMENDATION**

#### **Adopt an efficacious rather than a crisis tone.**

The public can easily become fatalistic about the possibility of reducing medical errors. If, as people assume, errors are simply the result of human imperfection or an inevitable part of health care, then nothing can be done to prevent them. Even if people recognize there is a problem and are concerned about it, they will not necessarily support or demand policy changes. A sense of efficacy—the belief that changes are feasible and would improve matters—is also required. While explanation provides new understanding, the right tone is needed to increase people’s sense that proposed solutions can, in fact, be implemented and will result in greater levels of patient safety.

To test tone, we compared survey results from participants who were exposed to a message with an efficacious tone to results from participants who were exposed to a message with a crisis tone. The messages included an identical explanation that connected causes of medical errors to potential solutions. *Figure 3* shows that adopting an efficacious tone is much more effective. The message with the efficacious tone not only increased people’s sense of collective efficacy and their understanding of the causes of and solutions to medical errors, it also—critically—increased support for policies, including providing all medical facilities with improved technology and requiring medical facilities to collect data on errors. By contrast, the message with the crisis tone was ineffective across outcomes.

**Figure 3: Effects of Tone and Explanation**



To reframe the public conversation about patient safety, advocates and experts should adopt an efficacious tone. This means that communicators should not dwell on the horrifying costs of inaction but rather lay out a positive vision of the benefits that will come when effective policies are implemented.

**Before:**

*No one would disagree that every life is precious. Need proof? People from all walks of life dash into burning buildings, dig through rubble and plunge into raging waters just for the chance to pull someone back from the brink. And yet this shared societal commitment to preserving life seemingly doesn't extend to health care. If we truly value every life, why is the news that an estimated quarter of a million patients die each year from preventable medical errors met with a shrug... How much longer will you let that apathy continue? [\(LINK\)](#)*

**After:**

*We can save lives by reducing medical errors, but we can only do so together. Medical errors happen for a number of reasons, but we know they are preventable. An estimated quarter of a million patients die each year from preventable medical errors. By making a shared societal commitment to eliminating medical errors, we will see that number drop. Together, we can make a difference and make medical care safer for everyone*

**RECOMMENDATION**

**Explain rather than assert the prevalence of medical errors.**

People believe that medical errors are rare and do not have a robust sense of the prevalence of this problem. In earlier phases of the research, people expressed time and again that they did not believe that medical errors were common—at least not as common as media and anecdotes might suggest. Experts and advocates must provide concrete evidence that medical errors happen regularly. But *how* they present that evidence is critical.

Rather than presenting prevalence data alone, communicators must situate information about prevalence within an explanation of why medical errors happen and what can be done to prevent them. An explanatory approach provides context that helps people make sense of and process facts. With these guideposts to help people interpret data, they are less likely to dismiss prevalence data.

**Before:**

*Up to 98,000 patients die annually in hospitals due to medical errors. An estimated 1.7 million healthcare associated infections occur each year, leading to 99,000 deaths. Adverse medication events cause more than 770,000 injuries and deaths each year, at a cost as high as \$5.6 billion annually.*

**After:**

*Medical professionals and patients alike recognize that high-quality information is an essential feature of good medical care. Medical professionals should be able to access information about patients' conditions and treatments quickly and easily. This is necessary for medical professionals to make the right decisions about patient care. But right now, up-to-date information is not always shared efficiently. This can lead to medical errors—things like a wrong diagnosis or medication mix-up. Medical errors like these are too common, causing 250,000 deaths in the United States every year.*

**RECOMMENDATION**

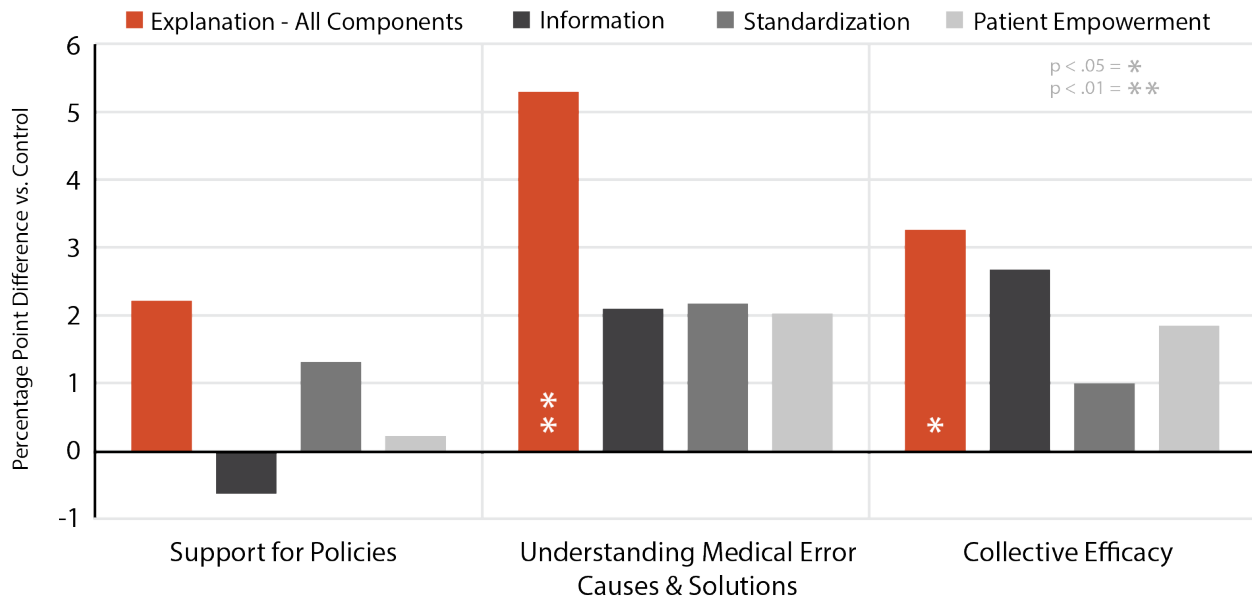
**Pan back to include the whole picture, rather than zooming in on one cause or solution.**

As discussed above, members of the public struggle to identify effective ways to prevent medical errors, and they tend to focus on individual-level solutions—like greater individual initiative—rather than systemic solutions. The recommendations above are grounded in the insight that people need to be given concrete examples of medical errors, causes, and solutions in order to think differently about this issue. One question that arises is *how* examples of causes and solutions should be discussed. Is it more effective to dig deeply into specific causes and solutions or to provide people with examples of a range of types of causes and solutions?

To answer this question, FrameWorks researchers conducted a controlled experiment that tested the effects of messages that explained multiple causes of medical errors and multiple solutions to improve patient safety, as well as messages that focused on one specific cause and solution for reducing medical errors (either information provision, general standardization, or patient empowerment). The study found that participants who received a full picture of causes and solutions were more likely to understand how medical errors come about and what should be done to address them. They were also more likely to feel a sense of efficacy that medical errors *can* be addressed (*Figure 4*).



**Figure 4: Effects of Whole Picture vs. Components**



Providing non-experts concrete examples of potential solutions to medical errors is crucial to building understanding. Communications that zoom in on one cause and solution, however, can limit people’s appreciation for the range and types of changes that need to be enacted to reduce patient harm. When focusing on specific solutions, experts and advocates should not present them as *the solution* to medical errors. Rather, communicators should situate specific policies or initiatives as a part of a range of efforts to improve patient safety.

### RECOMMENDATION

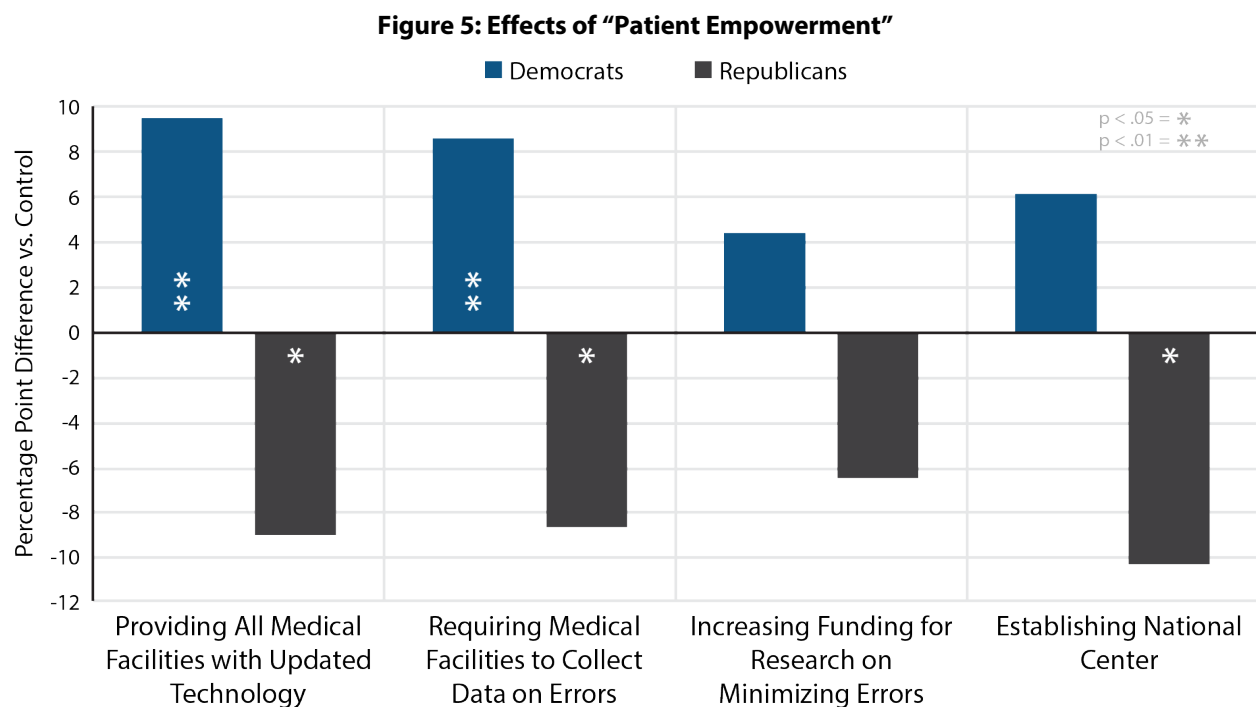
Explain the importance of patient involvement without talking about “empowerment.”

People come to the issue of patient safety with a very clear idea of what they believe to be the appropriate relationship between doctors and patients. Specifically, when thinking about the doctor/patient relationship, members of the public model doctors as figures are to be followed without question. People assign patients to a subordinate position in this relationship and believe that a patient’s primary job is to follow a doctor’s orders. The concept of “patient empowerment”—which is crucial to experts in the field—directly counters this dominant understanding of the doctor/patient relationship and is thus hard for people to process.

Survey experiment research found that it is possible to communicate the *concept* of patient empowerment as part of a broader explanation of what is needed; it was included in the “All Components” explanation in *Figure 4*. As with other specific solutions, people are able to process this concept when they hear about it within a message that paints a broader picture, which helps them see the point of the solution. Yet

results for the message that focused on “patient empowerment” indicate that communicators must be especially careful in how they communicate about this concept, because, when framed with the wrong language, talking about this can backfire.

Figure 5 shows that the message that focused on “patient empowerment” had several negative effects among Republicans. For participants who identified as Democrats, the frame increased support for several policies. But for those who identified as Republicans, this message significantly *decreased* support for many of those same policies. We suspect that the term “empowerment” is associated with left politics in ways that trigger this effect. The term frames policies in a way that makes it *harder* for Republicans to see these policies as consistent with their own ideological identity.



The research suggests the following guidelines when experts and advocates are trying to communicate the concept of patient empowerment:

- Communicators should avoid the term “empowerment.” This is likely to alienate ideological conservatives.
- Rather than simply stating that patients should be empowered, communicators should focus communications on specific things that need to be done. This means using concrete, colloquial language to talk about the specific activities that work to empower patients (e.g., “patients should feel comfortable asking questions”).
- Concrete activities that result in greater patient involvement in their medical care should be framed as *a* solution, not *the* solution.

**Before:**

*Medical professionals recognize that patients should be empowered to be full partners in their care. Good medical care requires patients to be treated as active participants. We can reduce medical errors by ensuring that patients are allowed and encouraged to play a role in their own care.*

**After:**

*We can do many things to prevent medical errors and reduce patient harm. One part of the solution is to make sure patients are encouraged to ask questions and give input on decisions. This way they can communicate to medical professionals anything that doesn't make sense or conflicts with other information patients have received.*

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## How to most productively engage medical professionals

Communicators can defuse defensiveness among professionals by emphasizing systems problems rather than describing errors as the result of individual mistakes. Medical professionals can quickly become defensive if a communication can possibly be interpreted as suggesting that individuals are responsible for errors. Furthermore, they feel overworked and overwhelmed by systems, so simply listing more protocols without clearly explaining why systems cause the issues in the first place is unlikely to encourage buy-in.

By talking about inadequate or faulty systems as the source of the problem, communicators can both make it clear that professionals aren't to blame and broaden understanding of why appropriate systems are necessary for reducing errors. Descriptions of the causes of errors should foreground the ways in which the technology, standards, and culture around medical professionals are the primary reasons for errors. Not only will this defuse the general public's unproductive understanding of why medical errors occur but it will also reduce the risk of alienating medical professionals who can serve as communications allies.

Finally, when medical professionals understand that specific systems that are not seen as clunky or too burdensome to implement (e.g., if a patient is prescribed allergy medication, an alert pops up in their electronic medical record), they are quick to agree that such a system was helpful. Communicators should therefore stress how proposed solutions will make them more effective in their work, not increase their workload.

Patient safety experts and advocates can also decrease the perception that medical professionals and patients are in conflict when it comes to medical errors by enlisting professionals as partners in framing and as important and visible messengers.

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## Conclusion

The framing strategy outlined in this MessageMemo offers a way for advocates to intentionally and strategically craft effective communications. By putting these recommendations together to paint a complete picture of patient safety, advocates can increase the salience of this issue without relying on crisis messaging (which will depress engagement). By harnessing the power of explanation, experts and advocates can move the public away from fatalism and toward a more engaged response.

The history of social movements shows that when advocates across organizations begin to share more effective frames, they begin to build momentum and start to see change. We invite and encourage you not only to adopt these reframing recommendations but also to amplify and echo them with your colleagues at your own organization and with allies in the field.

## Methods Appendix

To determine the effects of different frames, two online survey experiments were conducted between July 2018 and January 2019, which a total of 6,188 respondents completed. Each survey experiment was completed by a sample of adults (individuals over age 18) from the United States that was matched to national demographic benchmarks for gender, race/ethnicity, income, education, age, and political party.

In each experiment, respondents were randomly assigned to receive a message treatment or to a control condition. The control condition included information about a fictional legislative proposal (the “Patient Safety Initiative”), including four policies that experts say will reduce medical errors. The message treatments had this same information embedded in a candidate frame element, such as a metaphor. The initiative name was changed for consistency with the frame being tested. After reading the message, all respondents were asked an identical series of questions designed to measure knowledge, attitudes, and policy preferences relating to patient safety. Each battery consisted of multiple questions. With the exception of those measuring policy preferences, which came first for all respondents, the order of all questions was randomized. The batteries are listed in the *Table 2*, along with sample questions from each battery.

The first experiment tested eight message treatments to understand how they affect public opinion about patient safety. We tested four values (*Protection, Prevention, Innovation, and Patriotism*) and four explanatory metaphors (*Circuit Breaker, Fail-Safe, Aviation Industry, and Food Safety*).

In the second experiment, we tested 10 message treatments: three guiding principles (*Information Provision, Standardized Procedures, and Patient Empowerment*); two issue frames (*Health and Economic*), both of which were presented with one of two possible valences (*Loss or Gain*); and three tone variations (*Efficacious, Crisis, and a Tone Control, which included the same information as the two tone conditions without their unique tone elements*).

### Demographic Breakdown

Sample Demographics: Wave 1 Survey Experiment (Total n=2,866)	
Age	
18–29	19.2%
30–44	30.5%
45–59	25.1%
60 and older	25.2%
Gender	
Male	39.4%
Female	60.6%

<b>Race/Ethnicity</b>	
White	67.0%
Asian	14.4%
Black/African American	10.6%
Hispanic/Latino	4.0%
American Indian/Alaskan Native	0.8%
Hawaiian/Pacific Islander	0.2%
Other/Bi- or Multi-Racial/Ethnic	3.0%
<b>Income</b>	
Less than \$24,999	24.7%
\$25,000-\$49,999	24.5%
\$50,000-\$99,999	30.1%
\$100,000-\$149,999	10.1%
\$150,000 or more	10.5%
<b>Political Party</b>	
Democrat	38.6%
Republican	29.4%
Independent/Other	32.1%

<b>Sample Demographics: Wave 2 Survey Experiment</b> (Total n=3,322)	
<b>Age</b>	
18-29	15.4%
30-44	28.8%
45-59	28.9%
60 and older	26.9%
<b>Gender</b>	
Male	45.6%
Female	54.4%
<b>Race/Ethnicity</b>	
White	61.0%
Asian	16.1%
Black/African American	12.6%
Hispanic/Latino	6.0%
American Indian/Alaskan Native	0.8%
Hawaiian/Pacific Islander	0.1%
Other/Bi- or Multi-Racial/Ethnic	3.6%
<b>Income</b>	
Less than \$24,999	23.0%

\$25,000-\$49,999	23.8%
\$50,000-\$99,999	32.1%
\$100,000-\$149,999	14.0%
\$150,000 or more	7.1%
<b>Political Party</b>	
Democrat	38.4%
Republican	30.3%
Independent	27.4%
Other	3.8%

Multiple regression analysis was used to determine whether there were significant differences in responses to questions between the treatment groups and the control group. To help ensure that any observed effects were driven by the frames rather than demographic variations in the sample, all regressions controlled for the demographics mentioned above. A threshold of  $p < 0.05$  was used to determine whether treatments had any significant effects.



## About the FrameWorks Institute

The FrameWorks Institute is a nonprofit think tank that advances the nonprofit sector’s communications capacity by framing the public discourse about social problems. Its work is based on Strategic Frame Analysis®, a multi-method, multidisciplinary approach to empirical research. FrameWorks designs, conducts, publishes, explains, and applies communications research to prepare nonprofit organizations to expand their constituency base, to build public will, and to further public understanding of specific social issues—the environment, government, race, children’s issues, and health care, among others. Its work is unique in its breadth—ranging from qualitative, quantitative, and experimental research to applied communications toolkits, eWorkshops, advertising campaigns, FrameChecks®, and in-depth FrameLab study engagements. In 2015, it was named one of nine organizations worldwide to receive the MacArthur Foundation’s Award for Creative and Effective Institutions. Learn more at [www.frameworksinstitute.org](http://www.frameworksinstitute.org).

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<sup>1</sup> The FrameWorks Institute. (2018). *Telling a story of safety: Media and organizational discourse on patient safety*. Washington, DC: FrameWorks Institute.

<sup>2</sup> Ibid.