Associations between organizational communication & patients' experience of prolonged emotional impact following medical errors

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Disclosures

- No financial relationships with ineligible companies

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- Institute for Healthcare Improvement, Lucian Leape Institute
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- Beth Israel Deaconess Medical Center (BIDMC) Center for Healthcare Delivery Science

Objectives

- Recognize the types, severity, and duration of harm patients can suffer as a result of their healthcare.
- Analyze the impact communication and resolution programs (CRPs) can have on these harms.
- Propose next steps for CRPs, their implementation, and the field.

CRPs are best practice

- Joint Commission, National Quality Forum, Leapfrog, U.S. National Steering Committee for Patient Safety, World Health Organization
- 2023 President's Council of Advisors on Science & Technology (PCAST)
- CMS Patient Safety Structural Measure
- Agency for Healthcare Research and Quality (AHRQ)

Yet implementation is inconsistent

?

AHRQ-funded Literature Review about CRPs

Contributor Strong evidence of effectiveness – especially for patient, family, and many clinician-centered outcomes – has been lacking

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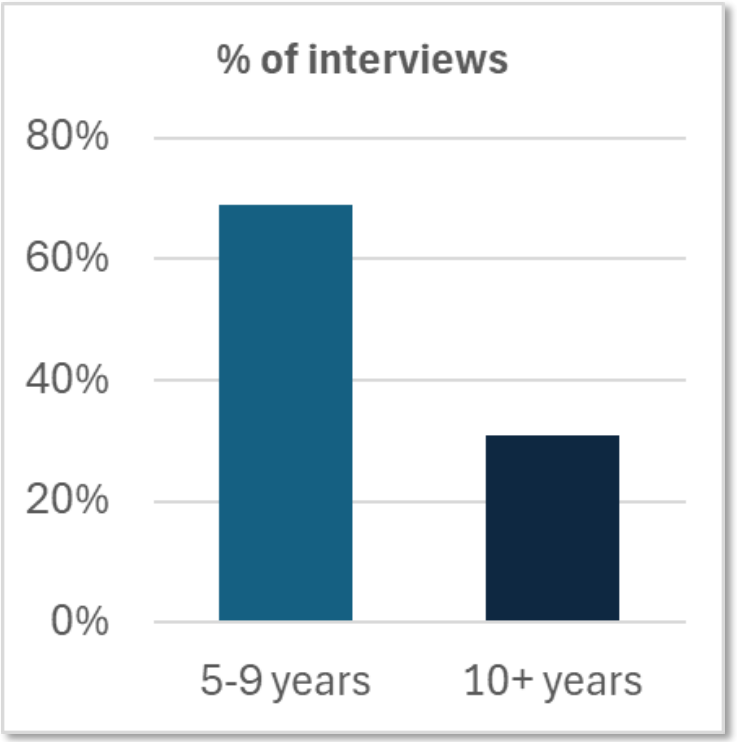
The tale & tail of harm from healthcare

Interviews with patients & family members 5+ yrs after events



66% lasting physical impacts

"non-physical"

- 59% altered life/view of self
- 53% vivid memories
- 50% loss of trust in healthcare
- 50% anger
- 34% grief
- 34% "psychological scars" (depression, suicidality, paranoia, PTSD)
- 31% financial impacts
- 31% altered healthcare seeking behaviors
- 28% self-blame

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Ottosen et al. "Long-Term Impacts Faced by Patients and Families After Harmful Healthcare Events." *Journal of Patient Safety* 2018. https://doi.org/10.1097/PTS.0000000000000451

Physical

Debilitation, organ injury, loss of function, disfigurement, death

Emotional / Psychological

Anger, grief, self-blame, depression, PTSD, suicidality

Socio-behavioral

Changed relationships with others, decreased trust, fractured therapeutic relationships, less willing to return or recommend

Financial

Direct costs: additional care, associated logistics, legal costs; Indirect costs: lost income, caregiver burden

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"The Financial and Human Cost of Medical Error... and How Massachusetts Can Lead the Way on Patient Safety." Betsy Lehman Center for Patient Safety, June 2019. https://www.betsylehmancenterma.gov/assets/uploads/Cost-of-Medical-Error-Report-2019.pdf.

Physical

12% died

19% have a “strong impact” for 1+ years

Emotional / Psychological

Anger, grief, self-blame, depression, PTSD, suicidality

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Of those whose errors were 3-6 years ago, 21% still depressed, 26% still feel abandoned/betrayed, 27% still angry

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Of those whose errors were 3-6 years ago, 21% still depressed, 26% still feel abandoned/betrayed, 27% still angry

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Of those whose errors were 3-6 years ago, 57% avoid the doctor & facility, 67% remain less trusting of healthcare, 37% avoid medical care overall

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Direct costs: additional care, associated logistics, legal costs; Indirect costs: lost income, caregiver burden

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Financial

50% have increased medical expenses, 33% have increased household expenses (childcare, transportation, etc.), 33% have a decrease in income

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“The Financial and Human Cost of Medical Error... and How Massachusetts Can Lead the Way on Patient Safety.” Betsy Lehman Center for Patient Safety, June 2019. https://www.betsylehmancenterma.gov/assets/uploads/Cost-of-Medical-Error-Report-2019.pdf.

What is the most striking part of these data for you?

Harms to patients

- Physical
- Emotional, Psychological
- Socio-behavioral
- Financial

Harms to families

Harms to clinicians

Harms to organizations

\+

Healthcare organization responses (e.g. CRPs)

Outcomes

Better?

Unchanged?

Worse?

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How much do you think CRPs affect patients' emotional outcomes?

Australia

Feeling	No Open Disclosure	With Open Disclosure	Statistically significant
Angry	56%	33%	Yes
Depressed	45%	41%	No
Relieved to know	53%	61%	No
Confident in good hands	48%	68%	Yes
Satisfied with treatment	47%	63%	Yes

Box 1. NSW Health Open Disclosure Policy[7]

NSW Health Open Disclosure Policy states that hospitals must provide:

- acknowledgement of a patient safety incident to the patient and/or their support person(s), as soon as possible, generally within 24 h of the incident. This includes recognising the significance of the incident to the patient
- truthful, clear and timely communication on an ongoing basis as required
- an apology to the patient and/or their support person(s) as early as possible, including the words 'I am sorry' or 'we are sorry'
- care and support to patients and/or their support person(s) which is responsive to their needs and expectations, for as long as is required
- support to those providing health care which is responsive to their needs and expectations
- an integrated approach to improving patient safety, in which open disclosure is linked with clinical and corporate governance, incident reporting, risk management, complaints management and quality improvement policies and processes. This includes evaluation of the process by patients and their support person(s) and staff, accountability for learning from patient safety incidents and evidence of systems improvement
- multidisciplinary involvement in the open disclosure process.
- compliance with legal requirements for privacy and confidentiality for the patient and/or their support person(s), and staff delivering health care.[3]

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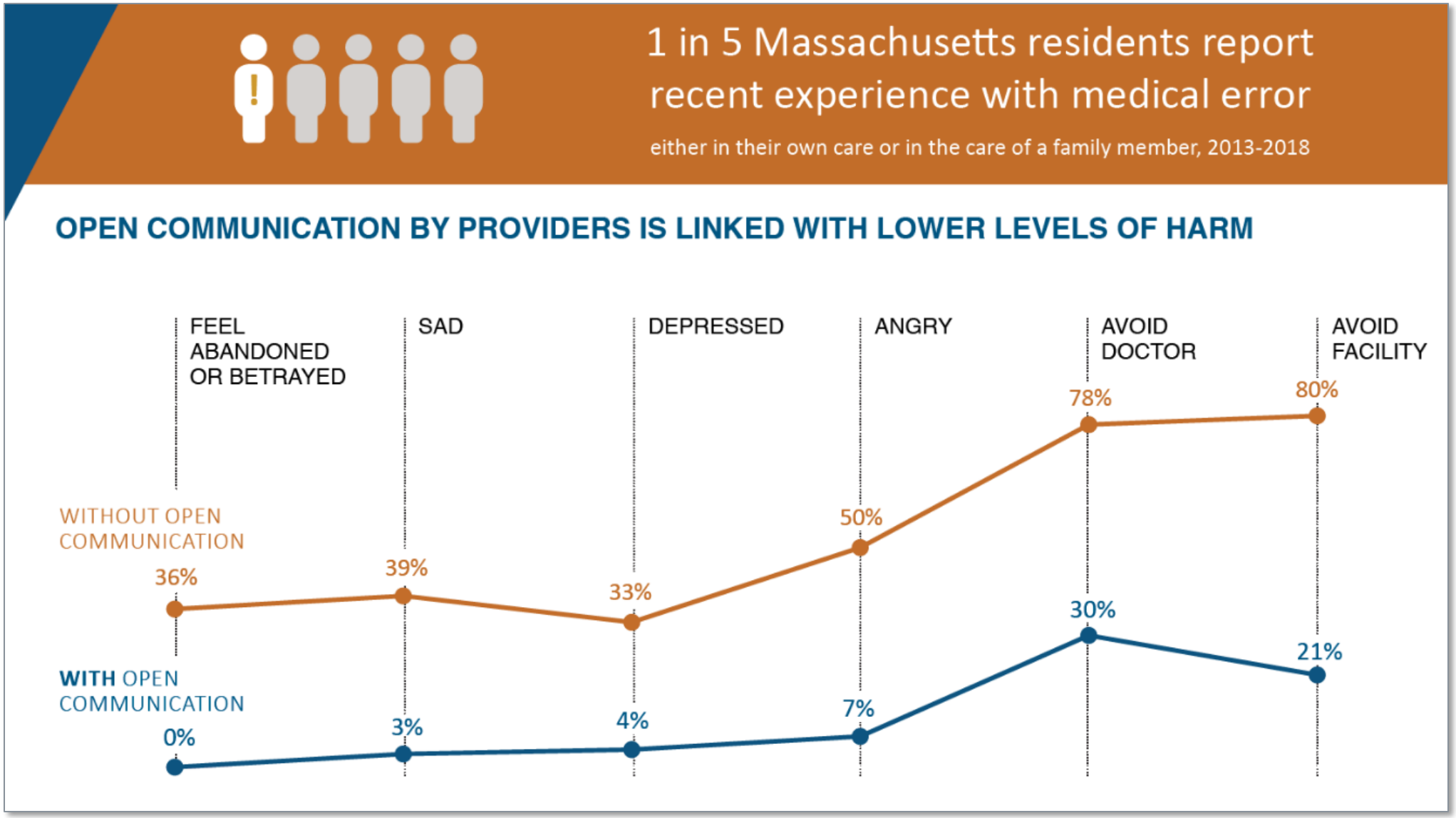
Walton et al. "Disclosure of Adverse Events: A Data Linkage Study Reporting Patient Experiences among Australian Adults Aged ≥45 Years." *Australian Health Review* 2019. https://doi.org/10.1071/AH17179.



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Prentice et al. "Association of Open Communication and the Emotional and Behavioural Impact of Medical Error on Patients and Families: State-Wide Cross-Sectional Survey." *BMJ Quality & Safety* 2020. https://doi.org/10.1136/bmjqs-2019-010367.

National data

Institute for Healthcare Improvement
NPSF
TOGETHER FOR SAFER CARE

NORC at the UNIVERSITY of CHICAGO

Americans' Experiences with Medical Errors and Views on Patient Safety

FINAL REPORT

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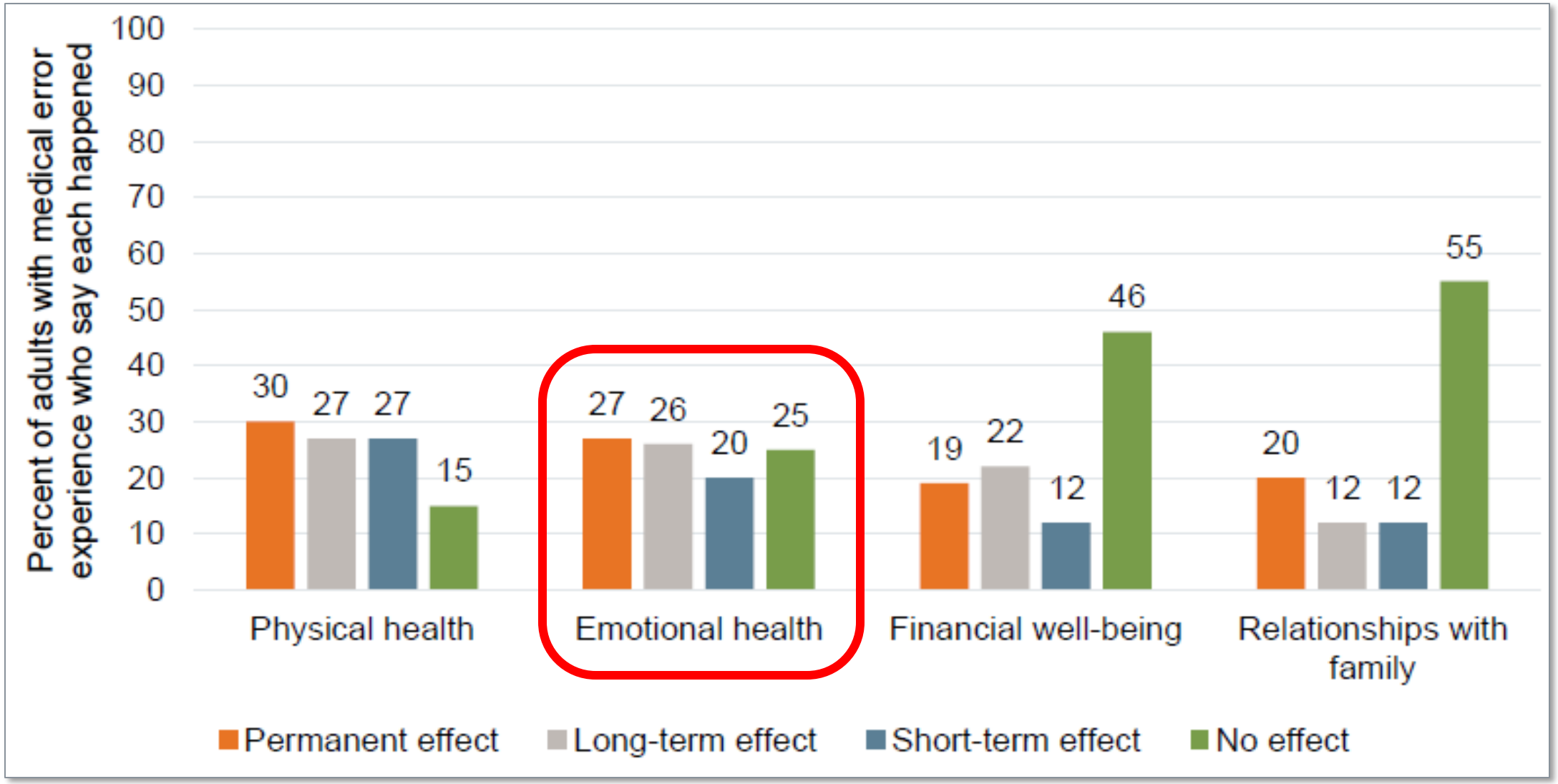
NORC at the University of Chicago and IHI/NPSF Lucian Leape Institute. (2017). Americans' Experiences with Medical Errors and Views on Patient Safety. CHICAGO, IL.



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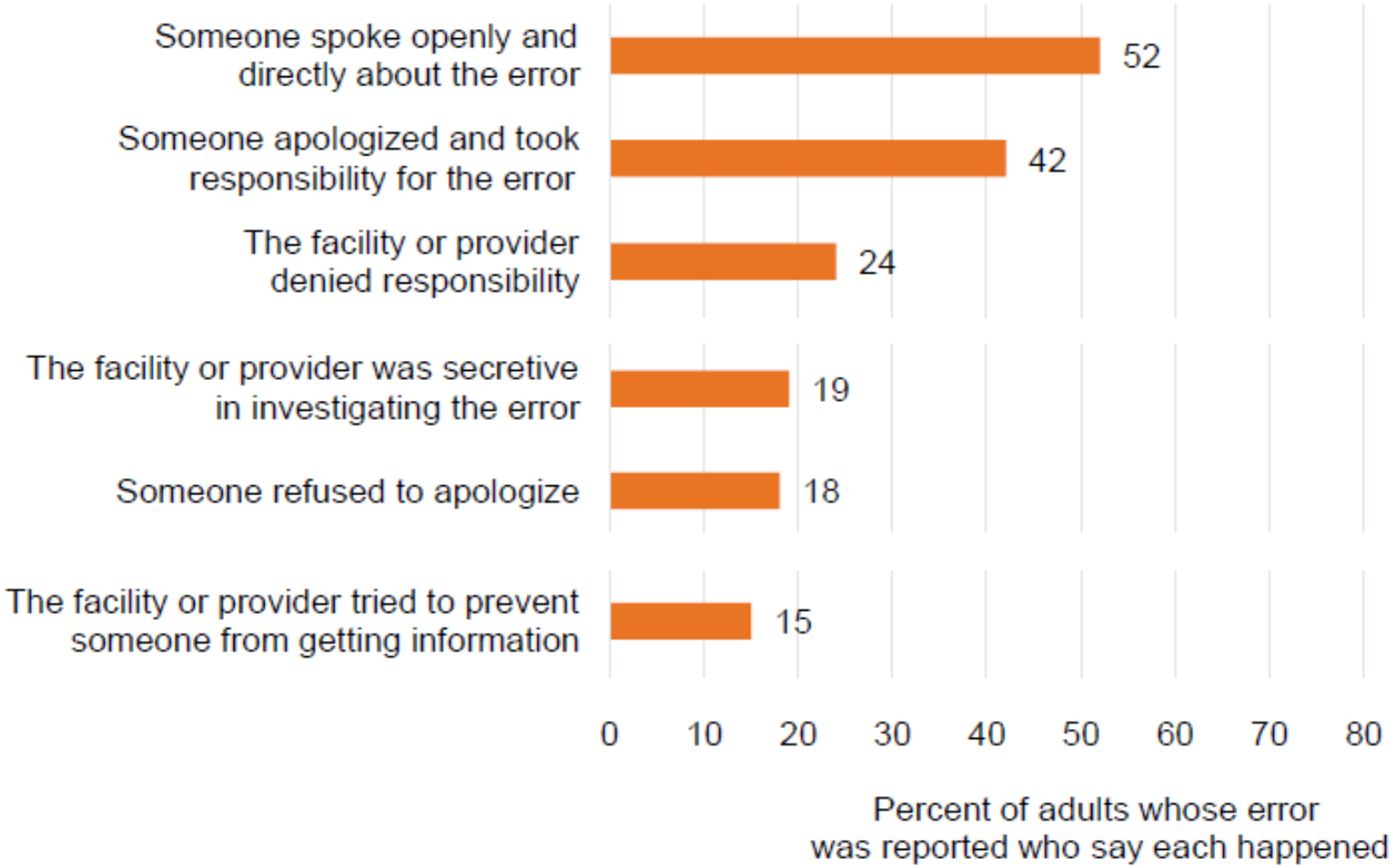
When errors were disclosed or reported, then these yes/no questions were asked →



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Sub-analysis

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The Joint Commission Journal on Quality and Patient Safety 2024; 000:1–10

Associations Between Organizational Communication and Patients' Experience of Prolonged Emotional Impact Following Medical Errors

Lauge Sokol-Hessner, MD; Tenzin Dechen, MPH; Patricia Folcarelli, RN, PhD; Patricia McGaffigan, RN, MS; Jennifer P. Stevens, MD, MS; Eric J. Thomas, MD, MPH; Sigall Bell, MD

Background: The emotional impact of medical errors on patients may be long-lasting. Factors associated with prolonged emotional impacts are poorly understood.

Methods: The authors conducted a subanalysis of a 2017 survey (response rate 36.8% [2,536/6,891]) of US adults to assess emotional impact of medical error. Patients reporting a medical error were included if the error occurred ≥ 1 year prior. Duration of emotional impact was categorized into no/short-term impact (impact lasting < 1 month), prolonged impact (> 1 month), and especially prolonged impact (> 1 year). Based on their reported experience with communication about the error, patients' experience was categorized as consistent with national disclosure guidelines, contrary to guidelines, mixed, or neither. Multinomial regression was used to examine associations between patient factors, event characteristics, and organizational communication with prolonged emotional impact (> 1 month, > 1 year).

Results: Of all survey respondents, 17.8% (451/2,536) reported an error occurring ≥ 1 year prior. Of these, 51.2% (231/451) reported prolonged/especially prolonged emotional impact (30.8% prolonged, 20.4% especially prolonged). Factors associated with prolonged emotional impact included female gender (adjusted odds ratio 2.1 [95% confidence interval 1.5–2.9]); low socioeconomic status (SES; 1.7 [1.1–2.7]); physical impact (7.3 [4.3–12.3]); no organizational disclosure and no patient/family error reporting (1.5 [1.03–2.3]); communication contrary to guidelines (4.0 [2.1–7.5]); and mixed communication (2.2 [1.3–3.7]). The same factors were significantly associated with especially prolonged emotional impact (female, 1.7 [1.2–2.5]; low SES, 2.2 [1.3–3.6]; physical impact, 6.8 [3.8–12.5]; no disclosure/reporting, 1.9 [1.2–3.2]; communication contrary to guidelines, 4.6 [2.2–9.4]; mixed communication, 2.1 [1.1–3.9]).

Conclusion: Prolonged emotional impact affected more than half of Americans self-reporting a medical error. Organizational failure to communicate according to disclosure guidelines after patient-perceived errors may exacerbate harm, particularly for patients at risk of health care disparities.

Study population

Respondents who…

- Had personal experience with an error in their own care
- More than one year ago
- Reported the duration of emotional impact

451 people

(out of the 2,536 that completed the original survey)

Results

Study population characteristics

60.8% Female, Mean age 51.5

70.7% White non-Hispanic
12.6% Hispanic
9.3% Black non-Hispanic
7.3% Other

12.9% Speak a language other than English at home

15.5% low socio-economic status

- Household income <$50,000/yr, AND
- Less than a high school education

29.0% fair or poor physical health

Emotional impact

30.8% lasting > 1 month

20.4% lasting > 1 year

Types of perceived errors

among those reporting >1 year emotional harm

77.2% diagnosis-related

66.2% treatment-related

56.5% disrespect-related

Other harm

52.5% physical impact (more than minimal)

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Categorizing organizational communication with patients

(1) "Did the healthcare provider or anyone else at the facility where the error happened inform you that a medical error had been made in your treatment, or didn't anyone tell you?"

(2) "Did you report the medical error, did someone else report it on your behalf, or did no one report it?"

No → **None:** Organization did not disclose the perceived error & no one reported it

Yes →

Question	Alignment with guidelines
Someone spoke openly and directly about the error.	Consistent
Someone apologized and took responsibility for the error.	Consistent
Someone refused to apologize.	Contrary
The facility or provider was secretive or unwilling to include me in investigating the error.	Contrary
The facility or provider denied responsibility.	Contrary
The facility or provider tried to prevent me from getting crucial information.	Contrary

Good: only consistent with guidelines

Mixed: both consistent with & contrary to guidelines

Bad: only contrary to guidelines

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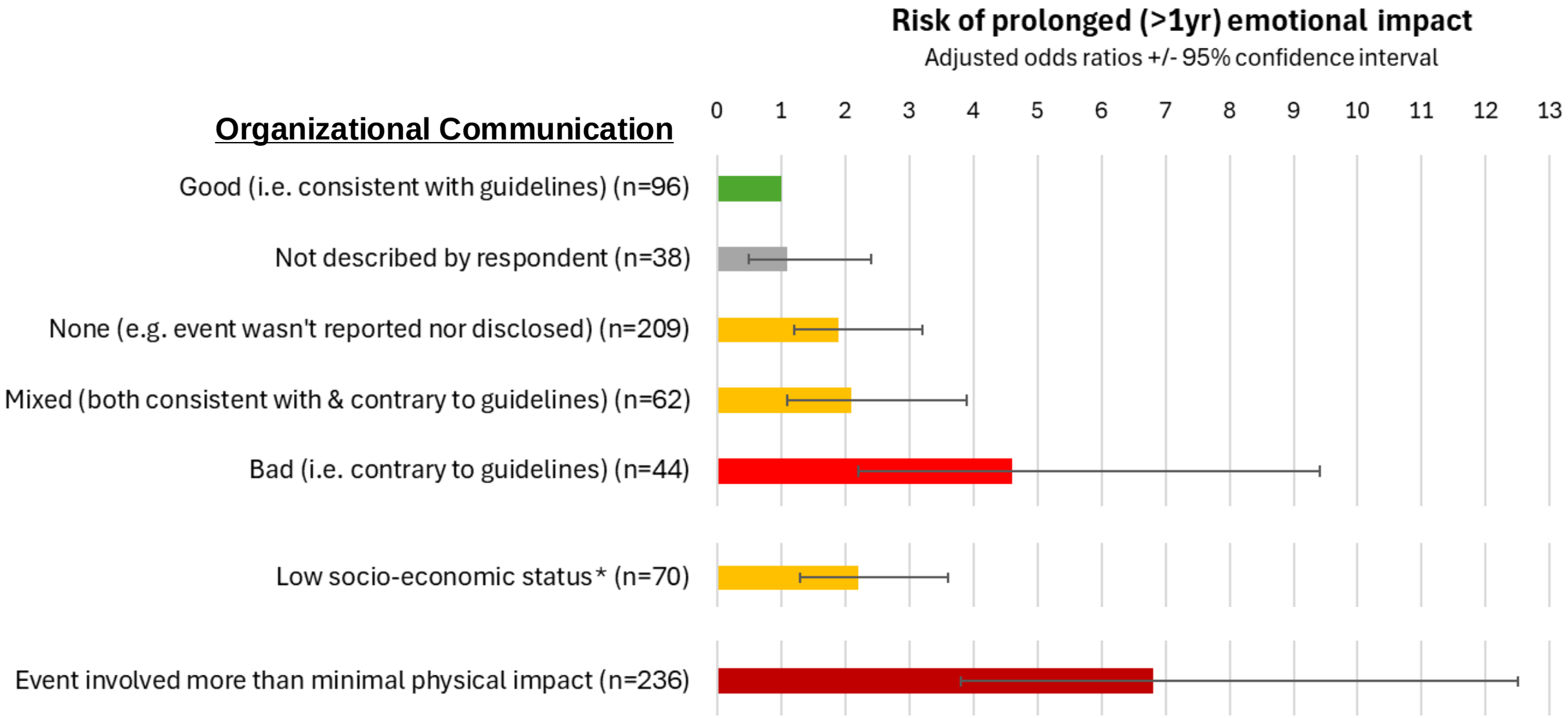
Organizational Communication



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* household income <$50,000/yr & < high school education

Factors **not** associated with the risk of prolonged emotional impact in adjusted analyses included age, race/ethnicity, and speaking a language other than English at home

Sokol-Hessner et al. *JCJQPS 2024*. https://doi.org/10.1016/j.jcjq.2024.03.002.

Limitations

- Data from 2017
- Modest original survey response rate (37%)
- Small sample size, especially for certain sub-groups
- Content & format of original survey items
- Data relied on patient recall, sometimes about events many years prior
- Patient-reported errors were not verified

What from this study stands out most for you?

Implications

Implementation

- CRPs occur *after* patients experience harm, but they seem to prevent additional or secondary harm: *CRPs themselves should be viewed as patient safety interventions*
- Although only some patient-reported errors will be confirmed as errors, it's best practice to respond to *all* serious harm events with a CRP-type of approach
- Extra attention to vulnerable patients/families (e.g. low socioeconomic status)

Implications

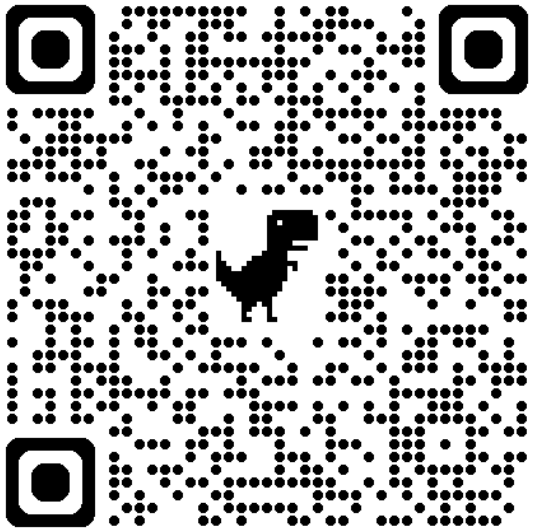
Future research

- Larger sample sizes, more diverse populations
- Verification of errors
- Assessments of other aspects of the response (not just initial communication)
- Additional innovations & interventions to reduce emotional harm
- Understanding predictors of other non-physical harms (socio-behavioral, financial)

Implications

Measurement

For research & operations



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Measuring how healthcare organizations respond after patients experience harm: perspectives and next steps

Lauge Sokol-Hessner[1,2*], John Adams[3†], Carole Hemmelgarn[4], Beth Miller[5], Diane O'Connor[6], Melissa Parkerton[2], Leilani Schweitzer[7] and J. Matthew Austin[6,8]

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Patients can experience serious harm from healthcare, the impacts can be prolonged, and events may also affect families and clinicians. Communication and Resolution Programs (CRPs) are designed to reduce these negative impacts, rebuild trust, and improve patient safety, but are not consistently implemented. To inform implementation efforts, enable accountability, and promote innovation, it is critical to develop standardized performance measures assessing CRPs' structure, process, and outcomes. To advance CRP measurement, an interdisciplinary workgroup from the Pathway to Accountability, Compassion, and Transparency (PACT) Leadership and Innovation Network—a group of leading healthcare organizations with CRPs—explores meaningful approaches to measurement and proposes a set of next steps. Interested parties in CRP

What do you feel are the most important implications of this study?

Thank you for your attention!

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Resources

- University of Washington Collaborative for Accountability and Improvement (CAI): https://communicationandresolution.org/
- Pathway to Accountability, Compassion, and Transparency (PACT): https://www.ariadnelabs.org/pact/

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