Tragedy Strikes – what next?
Setting Up a Successful Patient Disclosure Program

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Implementing a "full disclosure" program

- Decide upon and adopt "full disclosure principles"
- Find your "voice" - the stories that will inspire
- Identify champions who can tell the story
- Find the stakeholders and achieve buy-in
- Map out the process including apology and remedy
- Train the trainers and train the organization
- "Just do it"
- Track your progress: celebrate success, learn from mistakes

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Full Disclosure of medical error: a definition

- "Communication of a health care provider and a patient, family members, or the patient's proxy that acknowledges the occurrence of an error, discusses what happened, and describes the link between the error and outcomes in a manner that is meaningful to the patient."
- Fein et al.: Journal of General Internal Medicine, March, 2007: 755-761

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Implementing a "full disclosure" program

- Decide upon and adopt "full disclosure" principles
  - We will provide effective communication to patients and families following adverse patient events
  - We will apologize and compensate quickly and fairly when inappropriate medical care causes injury
  - We will defend medically appropriate care vigorously
  - We will reduce patient injuries and claims by learning from the past

Credit to Rick Boothman, CRO, University of Michigan

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Implementing a full disclosure program

- Finding your voice
  - "Putting the face on patient error"
  - Tell the story in to inspire change and commitment
  - Every hospital/medical center has a story
  - Find champions who can tell the story
  - Engage patient family victims of error
  - Recall the Hippocratic Oath

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Implementing a "full disclosure" program

- Identify potential champions and possible stakeholders
  - Patients and families
  - Physicians
  - Nurses
  - Pharm Ds
  - Other Health Care Providers
  - Guest Services
  - Administrators
  - Public relations
  - Risk Management
  - Legal Counsel: "in house"; outside counsel
  - Board of Trustees

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Implementing a "full disclosure" program

- Achieve "buy in" from top, bottom & sideways
  - Identify highest barriers
  - Making the financial case
  - The link between patient safety and transparency
  - The ethical imperative

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Implementing a "full disclosure" program

- Achieving "buy-in": the biggest barriers
  - 16 Chicago medical malpractice defense law firms interviewed as part of RFP process
  - Results
  - Other big barriers: medical malpractice insurance companies
  - Must reach consensus on National Practitioner Data Bank issues

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Implementing a "full disclosure" program

- Achieving "buy-in": the link between transparency and patient safety
  - Recognizing and accepting responsibility for medical errors is the first, necessary step, toward preventing future similar errors
  - Expressing regret for the adverse outcomes caused by medical errors is the next necessary step
  - Use stories to help achieve this end

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Implementing a "full disclosure" program

- Achieving "buy-in": the ethical imperative

Five Years After *To Err is Human*
What have we learned?
JAMA May 18, 2005

" [T]he ethically embarrassing debate over disclosure of injuries to patients is, we strongly hope, drawing to a close… Few health care organizations now question the imperative to be honest and forthcoming with patients following an injury."

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Implementing a "full disclosure" program

- Map out the process
  - Adverse reporting process
  - Report screening
  - Rapid error investigation teams
  - Patient communication process: error disclosure team
  - Providing appropriate remedy
  - Accountability

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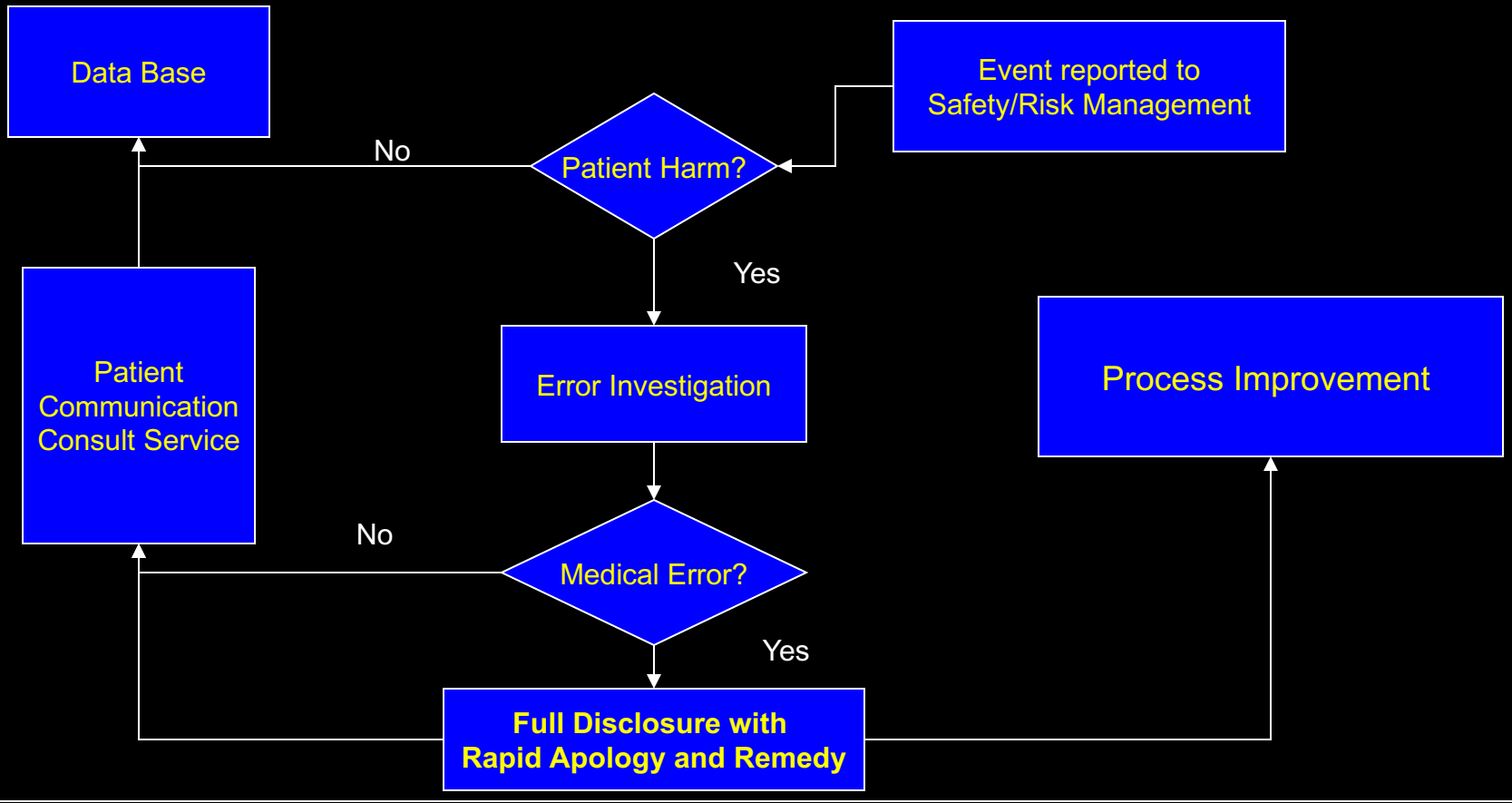
The University of Illinois Patient Communication Process



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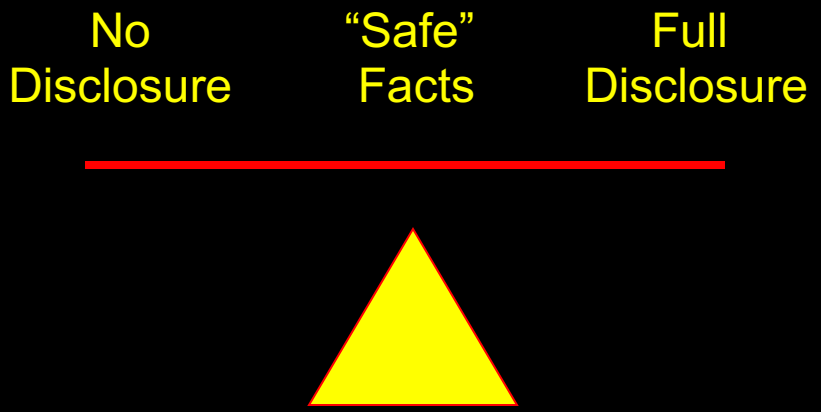
After discovery of error: what next?

- The "balance beam" approach.
- Credit to Jerry Hickson, MD and Jim Pichert, PhD
- Vanderbilt's Center for Patient and Professional Advocacy
- What is disclosed depends on what is "known".



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Implementing a "full disclosure" process

- Must create an accounting method for remedies
- Most common remedies
  - Waive hospital/professional fees for expenses caused by error
  - Provide compensation for lost wages, child care etc
  - "Pain and suffering"
  - Recommend separating clinicians and "remedy providers" [claims]

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Implementing a "full disclosure" process

- Train the trainers and train the organization
  - Teaching communication skills: SPs
    - Understanding "emotional intelligence"
  - What patients want to know
    - Explanation
    - Accountability
    - Prevention of future events
    - Non-abandonment: patient & provider
    - "Benevolent gestures"

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Implementing a "full disclosure" process

- "Just do it"
  - "Buy-in" from all stakeholders
  - Fully approved process from start to finish
  - Creation of a patient communication consult service for communicating after all adverse events
  - Leadership oversight of process
  - True test is first "big" error
  - Collect data
  - Track results

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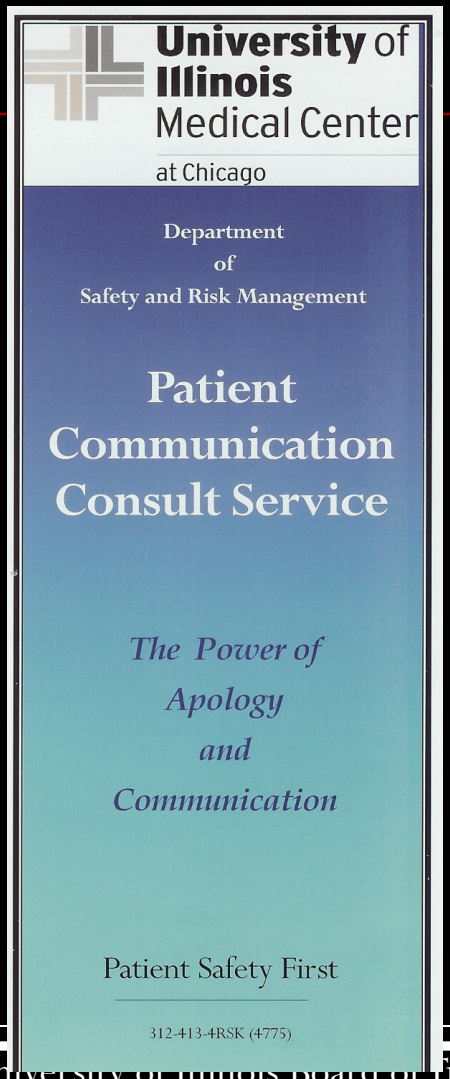
The Patient Communication Consult Service



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Implementing a “full disclosure” process

- Track your progress

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Implementing a "full disclosure" process

- Celebrate successes and learn from mistakes
  - Monthly lunchtime communication consult meetings
    - Share experiences
    - Helping to deal with "second victim", protect the messenger
    - Creating "disclosure" de-briefing tool
    - Intervening with MDs who offer remedies!
    - Discussing ways to ensure appropriate "communicators" and attendees to disclosure meetings
    - Consensus on process improvements

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Implementing “full disclosure”process

- Examples of clear errors
  - Retained object
  - Wrong-sided procedure
  - Medication overdose
  - Missed diagnosis
  - Futile procedure

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Implementing "full disclosure" process

- Learning from mistakes
  - Incomplete investigation
  - "Wrong" person communicating
  - "Right" person absent
  - Finger-pointing or "jousting"
  - Delay in disclosure
  - Failing to follow-up
  - Failing to recognize the second victim

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