

## What Makes Open Disclosure Effective?

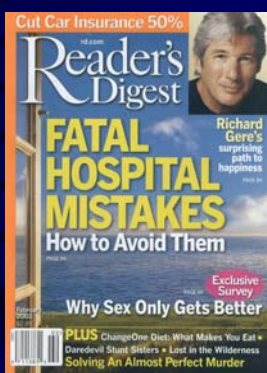
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## Agenda

Topic	Time
Introductions	9:00-9:05
The Disclosure Gap	9:05-9:45
Patient Perspective	9:45-10:05
Policy Issues	10:05-10:20
Disclosure in Action	10:20-10:50
Coaching	10:50-11:05
Team Disclosure	11:05-11:25
Wrap-Up	11:25-11:45

## Accelerating Interest in Disclosure

- Growing experimentation with disclosure approaches
  - Healthcare organizations
  - Malpractice insurers
- New standards-NQF and others
- State laws re disclosure, apology
- Increased emphasis on transparency in healthcare generally



## Disclosure Performance Gap Also Increasingly Evident

- Harmful errors often not disclosed
- When disclosure does take place, often falls short of meeting patient expectations
  - Failed disclosures have substantial impact for patient, healthcare workers, institution
- Little prospective evidence exists regarding what disclosure strategies are effective
- Impact of disclosure on outcomes unclear



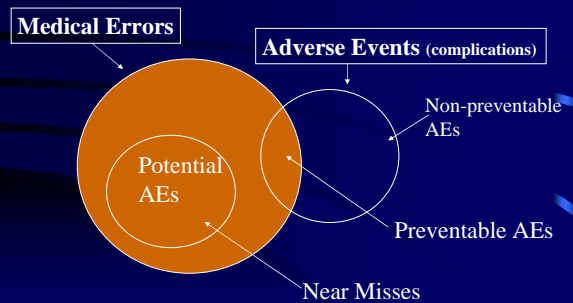
## Session Goals

- To enhance your knowledge and skills regarding disclosing adverse events and errors to patients.
- To consider the implications of disclosure as an institutional responsibility
- To learn basic skills for coaching healthcare workers in disclosure
- To consider next steps for enhancing disclosure in Western Australia

## Emerging Disclosure Trends

- Research data on disclosure gap
- Disclosure as institutional responsibility
  - Applying QI principles to disclosure
  - Disclosure as team sport
  - Key role of disclosure coaches
  - Disclosure and compensation
- Emerging training paradigms

## Relationship of Errors and Adverse Events



## Elements of Open Disclosure

- Open Disclosure offered to all patients who experience harm while receiving health care
  - An expression of regret
  - A factual explanation of what happened
  - The potential consequences, and
  - Steps being taken to manage the event and prevent recurrences

## Rationale for Disclosing Errors to Patients

- Error disclosure as informed consent
  - Positive obligation to inform patients of errors
- Error disclosure as truth-telling
- Regulatory requirements
- Disclosure gap
  - Blendon study: 30% disclosure rate

## Ethical Complexities in Error Disclosure

- Should I disclose:
  - Errors with minor/transient harm?
  - Fatal errors?
  - Harmful errors in patients who are hopelessly ill?
  - Other doctors' errors?

## USA Disclosure Barriers

BARRIER	POTENTIAL SOLUTIONS
<u>Clinician Barriers</u>	
Fear that disclosure will prompt litigation	<ul style="list-style-type: none"> <li>• Learn about relationship between disclosure and litigation</li> </ul>
Concern that disclosure will not benefit patient	<ul style="list-style-type: none"> <li>• Understand patients' preferences for disclosure, consequences of failed disclosure on patient-provider relationship</li> </ul>
Lack of confidence in communication skills	<ul style="list-style-type: none"> <li>• Seek disclosure skills training</li> <li>• Use disclosure coaches</li> </ul>
Shame, embarrassment around error	<ul style="list-style-type: none"> <li>• Utilize institutional support resources</li> </ul>
<u>Additional Institutional Barriers</u>	
Concern that clinicians are not skilled in disclosure	<ul style="list-style-type: none"> <li>• Institute a disclosure support system, including training, coaching, emotional support</li> </ul>
Lack of awareness about deficiencies in current disclosure practices	<ul style="list-style-type: none"> <li>• Measure quality of actual disclosures</li> </ul>
Perception that disclosure is a risk management rather than patient safety activity	<ul style="list-style-type: none"> <li>• Engage patients in safety and quality activities, including event analysis</li> </ul>

## Disclosure Barriers

## Patients' Attitudes about Errors

- Patients conceive of errors broadly
- Desire full disclosure of harmful errors
  - Worry that health care workers might hide errors

## Patients' Preferences for Error Disclosure

- Information patients want disclosed
  - Explicit statement that error occurred
  - What happened, implications for their health
  - Why it happened
  - How will recurrences be prevented
- Importance of an apology

## Physicians' Attitudes about Errors

- Define errors more narrowly than patients
- Agree in principle with full disclosure
- Want to be truthful, but experience barriers to disclosure

## Choosing Your Words Carefully

- Physicians “choose their words carefully” when disclosing errors to patients
  - Avoid explicit identification of error, discussion of prevention
  - Assume interested patients will ask clarifying questions
  - Concern re: legal liability makes apologizing hard

## Physician Surveys

- Survey of:
  - 2,000 physicians at Washington University/BJC HealthCare, University of Washington, Group Health Cooperative
  - 2000 Canadian physicians
- Topics: Communicating about medical errors with patients, colleagues, and health care institutions
- Response rate: 63%
- Local data helpful in driving disclosure improvement

## Physicians' Disclosure Attitudes

	Insulin Case	Hyperkalemia Case	Sponge Case
“Definitely disclose”	65%	34%	96%
Say “error”	71%	40%	14%
Full apology	43%	35%	9%

## Additional Survey Findings

- 64% unaware of hospital error reporting system
- 19% agreed that systems to disseminate error information to physicians are adequate
- 10% agreed that hospitals adequately support them after errors

## Survey Conclusions

- Physicians support concept of disclosure
- Little agreement exists regarding the core content of disclosure
- Less information disclosed for errors that would not be apparent to patient
- Medical and surgical physicians may approach disclosure differently
- Unmet needs for emotional support after errors
- Disclosure training needed

## Quality of Actual Disclosures

- COPIC-large malpractice insurer
- 3Rs program for disclosure and compensation
  - 140 events
  - 87 patient surveys
  - 112 physician surveys

### Event Severity

	Patient Assessment	Physician Assessment
Extremely serious (I might have died)	31%	7%
Very Serious (permanent injury)	25%	25%
Somewhat serious (injury that resolved)	28%	61%
Not at all serious	3%	6%

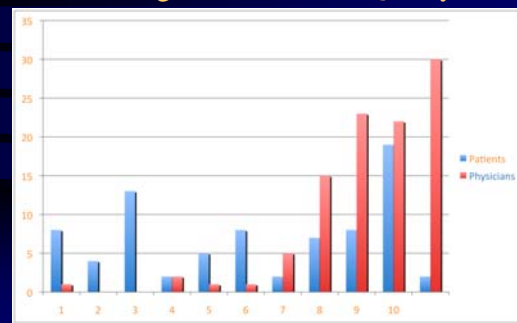
### Patient Satisfaction with Disclosure

- 10-point scale
- Mean: 6.4
- Rating of 4 or less: 32%
- Rating of 9 or higher: 43%

### Physician Rating of Disclosure Conversation

- Mean 8.3
- Rating of 4 or less: 5%
- Rating of 9 or 10: 51%

### Comparing Patient and Physician Ratings of Disclosure Quality



### Scenario 1: Insulin Overdose

*You have admitted a diabetic patient to the hospital for a COPD exacerbation. You handwrite an order for the patient to receive "10 U" of insulin. The "U" in your order looks like a zero. The following morning the patient is given 100 units of insulin, ten times the patient's normal dose, and is later found unresponsive with a blood sugar level of 35. The patient is resuscitated and transferred to the intensive care unit. You expect the patient to make a full recovery.*



## The Patient Perspective



## Disclosure 101

- Patients need
  - Truthful, accurate information
  - Emotional support, including apology
  - Follow-up, potentially compensation
- Healthcare workers need
  - Disclosure coaching
  - Emotional support
- Process, not an event
  - Initial conversation
  - Event analysis
  - Follow-up conversation

## Key Disclosure Content

- What happened, implications
- Was event preventable (due to error)
- Why event happened
- How recurrences will be prevented
- Apology
  - Expression of sympathy for all adverse events
  - Full apology when adverse event due to error
- Plans for follow-up

## What We Know about Relationship Between Disclosure and Litigation

- Patients who have sued often cite perception that truth was hidden from them, deficient MD-pt, communication as important motivators
- Disclosure reduces intention to sue, promotes more favorable settlements (in vitro)
- Disclosure reduces size of jury awards, may make case less attractive to plaintiff attorney
- Some institutions have adopted open disclosure policy without deterioration in legal expenses

## Important caveats

- Vast majority of patients injured by negligent care never sue
  - Lack of awareness of error may contribute to this low rate
  - Some recent analysis suggests disclosure may increase litigation
- No RCT data exists (or is likely to exist in near future) about impact of disclosure on litigation

# Disclosing medical errors to patients: Recent developments and future directions

## University of Michigan

- Full disclosure program:
  - Disclose cases of harmful error
  - Compensate patients quickly and fairly
- In five years since implementing full disclosure program:
  - Annual litigation costs:
    - \$3 million ⇒ \$1 million
  - Average time to resolution of claims:
    - 20.7 months ⇒ 9.5 months
  - Number of claims and lawsuits
    - 262 ⇒ 114
- Stanford, UIC launched similar programs

## COPIC

- Large Colorado malpractice insurer
- Developed “3Rs” Program in 1998
- Program seeks to promote disclosure, early offer following unanticipated outcomes
- Program is “no-fault”
- Exclusions-patient death, attorney involvement, complaint to BME
- Patient not asked to sign waiver
- Payments not reportable to NPBD

## 3Rs Processes

- Event reported
- Physician and COPIC in accord as to intervention
- Doctor engages in disclosure process, tells patient about program, and puts patient in touch with 3Rs administrator
- 3Rs Administrator reimburses patient upon obtaining receipts for out of pocket expenses and lost time up to \$30,000

### 3Rs Program Highlights – 50 Month Financial Results (10/1/00-12/31/05)

Participants	2532	310 for all 50 months; 1713 for 38/50 months
Reported Incidents	4674	Cornerstone – Early Incident / Event Reporting
3Rs Criteria Met	2174	No incident with 3R criteria met has proceeded to full litigation
Closed with no \$ Paid	1622	1235 of 2174 closed and 387 about to close with no \$ paid, simply satisfactory communication
Closed with payment	500	259 closed and 241 about to be closed with payment
Sent to Claims	52	4 of 52 settled w/o lawyers, indemnity paid, & docs reported; 12 also with 3R payments (no offset, not reported)
Spent so far	\$2,908,137	About 50/50 spent so far for reimbursable expenses and loss of time
Average paid per incident	\$5,680	Compared to avg. severity in 2003 of \$88,056, and in 2004 of \$74,643, and in 2005 of \$77,936
Dollar range per incident	\$95 - \$30,000	\$30,000 maximum allowed
Operational Costs	\$975,899	Two FTE administrators; 1 P/T physician, 1 secretary, managerial consulting
Total Program Cost	\$3,884,036	All costs (reimbursement \$, time loss \$, & Administrative \$) over 63 months

## Role of Compensation in Disclosure Process



## Disclosure Training Paradigms

- Background training for all clinicians
  - Often web based
- More in-depth training for clinicians likely to participate in disclosures
  - Simulation-based
- Trained cadre of coaches provides just-in-time training

# Disclosing medical errors to patients: Recent developments and future directions


## Web-based Disclosure Assessment Tool



## Sample closed ended question


Error Disclosure TAC1  
CLICK FOR CASE SUMMARY

Please respond to the following questions using the rating scale provided below. When finished, click the Submit button.

Click here to review video 

**How effective was the team in the following aspects of disclosure?**

	Not at all effective	1	2	3	4	5	Extremely effective
Explicit statement that an error occurred	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Explanation of how the error occurred	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Truthful communication	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Presenting a plan to prevent future errors	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>


 Submit Clear

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## Sample open-ended question

Error Disclosure TAC1  
CLICK FOR CASE SUMMARY

Please respond to the following question. When finished, click the Submit button.

Click here to review video 

**Which team behaviors were most effective and should be continued in future disclosures? Please explain briefly.**

 Submit Clear

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## Scenario 1: Insulin Overdose

*You have admitted a diabetic patient to the hospital for a COPD exacerbation. You handwrite an order for the patient to receive "10 U" of insulin. The "U" in your order looks like a zero. The following morning the patient is given 100 units of insulin, ten times the patient's normal dose, and is later found unresponsive with a blood sugar level of 35. The patient is resuscitated and transferred to the intensive care unit. You expect the patient to make a full recovery.*

## Interprofessional Issues in Disclosure

- Disclosure conceptualized as doctor-patient conversation
- We make errors as teams--should we disclose them as teams?
- Team disclosure complicated by power dynamics

## Nurses' Disclosure Attitudes

- ▶ 9 focus groups at 4 institutions
- ▶ Support disclosing errors that cause serious harm or require further intervention
- ▶ Routinely disclose "nursing errors" independently
- ▶ Worry that disclosing minor errors would scare patients and family
- ▶ Eager to participate with MD in disclosure conversations, in part so they won't be blamed

### Nurses' Disclosure Attitudes (cont.)

- Often left out of disclosure planning process
- “Walking on eggshells”
  - Unsure what to say to patient when error occurred that had not yet been disclosed
  - Sometimes led nurses to adopt evasive communication strategies with patients
  - Period of high moral distress

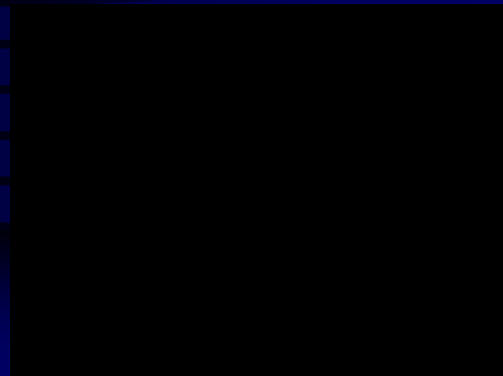
### Stages in Team Disclosure

- Team discussion of error
- Disclosure planning
- Disclosure to patient

### Case: Dilantin Overdose

- Patient admitted to ICU with recurrent seizures
- Given loading dose of Dilantin (300 TID), then switched to 300 QD
- Physician writing transfer orders to floor mistakenly writes for larger loading dose
- Error not noticed by nursing, pharmacy
- Patient falls, hits head; Dilantin level 29. Head CT normal
- Patient thinks another seizure caused her fall

### Error Discussion & Disclosure Planning



### Rationale for Disclosure Coaches

- Disclosure – uncommon event for clinicians; few have had disclosure training
  - Want to “tell the truth” but unsure how
  - Unaccustomed to planning for disclosure
  - Most patients want disclosure to come from their providers, not a “disclosure expert”
- Emotional needs of healthcare workers following errors often unmet

### Disclosure Coaching Skills

- Expertise in disclosure content & process
- Can teach clinicians under stress
- Comfortable working with different healthcare professions
  - Conflict resolution skills important
- Able to respond rapidly to requests
- Can provide emotional support
- Individuals from diverse background can be successful disclosure coaches



## Other Disclosure Projects

- Randomized trial of impact of disclosure training on patient satisfaction with disclosure
- Study of breast and colorectal cancer patients' experiences of problems with their care
- Other healthcare workers' errors

## Future Directions

- Ongoing experimentation with disclosure by healthcare organizations, insurers will continue
  - Will yield useful information on impact of disclosure on outcomes
  - Additional research sorely needed
- Challenges of effective disclosure will become increasingly evident
- Additional disclosure standards will be released
  - Likely to remain voluntary
- Important work yet to be done in preparing clinicians for disclosure