Disclosure, Resolution, and Accountability Following Medical Error
Taking the Next Steps

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Disclosure and Accountability

- A decade’s emphasis on disclosing unanticipated outcomes to patients has brought limited change
- This may reflect a failure to situate disclosure within the broader context of accountability
- Increasingly punitive external regulatory regimes reflect failures of professional self-regulation

What is accountability after medical injury?

- Healthcare institutions and providers:
  - Recognize that event has occurred
  - Disclose it effectively to the patient
  - Proactively make the patient whole
  - Learn from what happened
  - Discuss the event across colleagues, institutions
- in a healthcare delivery environment that:
  - Prospectively monitors quality of care
  - Identifies unsafe providers and employs effective remediation
  - Spreads learning across institutions

Recent Developments

- Measuring quality of actual disclosures
- Communicating about other healthcare workers’ errors
- “More than just words”: Disclosure and Resolution Programs
- The next frontiers
  - Learning from error
    - Peer review, QI, cross-institution collaboration
  - Just Culture
Quality of Actual Disclosures

- COPIC
- 3Rs program for disclosure and compensation, 2007-2009
  - 837 Events
  - 445 patient surveys (55% response rate)
  - 705 physician surveys (84% response rate)

Event Severity

<table>
<thead>
<tr>
<th>Event Severity</th>
<th>Patient Assessment</th>
<th>Physician Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely serious (I might have died)</td>
<td>31%</td>
<td>7%</td>
</tr>
<tr>
<td>Very Serious (permanent injury)</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Somewhat serious (injury that resolved)</td>
<td>28%</td>
<td>61%</td>
</tr>
<tr>
<td>Not at all serious</td>
<td>3%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Quality of Disclosure

Patient Rating of Disclosure Skills

<table>
<thead>
<tr>
<th>Skill</th>
<th>Agree</th>
</tr>
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<tbody>
<tr>
<td>The physician provided a sincere apology to me for this event</td>
<td>66%</td>
</tr>
<tr>
<td>The physician had good listening skills</td>
<td>64%</td>
</tr>
<tr>
<td>The physician was truthful when explaining the event to me</td>
<td>63%</td>
</tr>
<tr>
<td>The physician explained the event using terms I could understand</td>
<td>62%</td>
</tr>
<tr>
<td>I trust this physician’s clinical competence</td>
<td>59%</td>
</tr>
<tr>
<td>The physician told me as much information as I wanted to know about the event</td>
<td>54%</td>
</tr>
<tr>
<td>The physician told me why the event happened</td>
<td>50%</td>
</tr>
<tr>
<td>The physician told me whether or not the event was preventable, i.e., known complication</td>
<td>44%</td>
</tr>
<tr>
<td>The physician assured me that steps would be taken to prevent similar events from happening again</td>
<td>37%</td>
</tr>
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Real and Imagined Barriers to Disclosure

- Imagined
  - Fear of litigation
  - Misunderstanding of patient preferences
    - Does not know/Would not want to know
    - It would harm patient to know
- Real
  - Shame/embarrassment/rationalizations
  - Low confidence in communication skills
  - Mixed messages from institution
  - Specialty-specific challenges
    - Radiology, pathology, birth injury, delayed dx

Cancer patients’ experiences of problems in care

- Screened 416 cancer patients for perceived problems in care
  - Something went wrong, what went wrong was preventable, caused harm
  - 93 of 416 (22%) screened positive. In-depth interviews with 78 patients
  - 28% described problem with medical care; 47% described problem with communication; 24% reported both
Suffering in silence
- Only once did patient perceived that person responsible had assumed responsibility
- 6% of patients reported receiving a clear explanation of the event
- 13% of patients formally reported the problematic event to the organization
  - Reasons for not reporting
    - Need to focus on own health, put event behind them
    - Belief that reporting would not do any good
    - Concern about impact on relationship with clinicians

Accountability: More Than Words
- Action that follow the disclosure need to be congruent with the words
  - “If you’re just going to apologize and you’re not going to fix anything, that’s insulting to my intelligence”
  - “There’s got to be accountability. I don’t want to hear ‘I’m sorry.’ I’m sorry is nothing. I want to hear what steps have been taken to correct the problem.”
  - “Don’t tell me you were sorry that the problem occurred. That just puts a band aid on something… I want to see results.”

Patient-Centered Disclosure

Context
- Disclosure to date has focused on a doctor talking with patient about “my” error
- Yet most errors involve multiple providers, institutions
- Therefore, most disclosure dilemmas will not fit the “my error” paradigm
- No guidance regarding disclosure when other provider(s) primarily responsible for error

Practical implications
- What, if anything, should I say to the involved provider?
- What, if anything should I say to the institution?
- What, if anything, should I say to the patient?
- Is there anyone else I should talk to?
- How do I do this?

Greenwall project overview
- Empiric research
  - ACP survey
  - Key informant interviews
  - Focus groups
- Related research
  - Focus groups with OB, peds, pathology, cancer providers; survey of radiologists, ABIM/ACP survey
What’s different when it’s someone else’s error?
- Uncertainty about what happened
- Strong beliefs about “tattling”, norms around “collegial” behavior, power issues
- Two awkward conversations
  - Talk about event with responsible colleague?
  - Talk about event with patient?
- Lack of clarity about accountability for disclosure
- Limited institutional support

Is this a common problem?
- ACP membership survey, fall 2007
  - Responses received from 900 practicing internists
  - 46% reported talking with a patient about another healthcare workers’ error in the last year
  - 57% did not know what to say when telling patients about another healthcare workers’ error

What happens currently?
- When faced with another healthcare workers’ error, most providers
  - Envision the “shoe being on the other foot”
  - Hesitate to discuss event with the involved provider, especially when at outside institution
  - Worry that reporting event to institution could trigger punitive, unpredictable cascade
  - Are reluctant to tell the patient
    - If event mentioned at all, vague language used and patient left to “connect the dots”

I wasn’t there
- Medical record, perceptions of what happened often incomplete, sometimes misleading or totally wrong
- Retrospectoscope
- Epistemic bias in medicine—don’t believe things we did not do or see first hand
- Recognition that disclosure of incorrect information can do more harm than no disclosure at all

Step forward or stay on sidelines?
- What are my responsibilities for
  - Figuring out what happened?
  - Sharing my concerns with the involved provider?
  - Sharing my concerns with the institution, outside regulatory bodies?
  - Ensuring patient is informed about what happened
  - Make sure they understand that event in question was due to error?

The feedback paradox
- Providers recognize the implications of these events for quality, safety
- Providers report receiving little feedback on quality of care and are eager for more
- Providers hope a colleague would let them know if they have made an error
- Yet the prospect of suggesting a colleague has made a mistake is so intimidating that few actually initiate these discussions
Talking with colleague about potential error they have made
- Event placed in context of our beliefs about colleague’s general competence
- Lack of confidence in communication skill for raising error concern with colleague
  - Fear that conversation will be taken personally
  - Especially with colleagues we don’t know
- Chart is used to avoid talking

Disclosure to the patient: What are we trying to accomplish?
- Help patients make informed decisions?
  - Allow patient to avoid future harm
    - Prevent harmful misconceptions
    - Stop inappropriate therapy
    - Switch to more competent provider
  - Facilitate compensation?
- Truth-telling for its own sake
  - Maintaining trusting patient-provider relationship

Water under the bridge
- Provider assuming care should “pick up the ball and move it forward,” not focus with patient on quality of preceding care
  - Belief is especially prevalent around errors involving delayed diagnosis of cancer
  - Benevolent deception
    - Yet providers all report they would want to be told about delayed diagnosis if they were patient

Key Principles
- Patients and families come first
- Explore, don’t ignore
- Importance of institutional support
- Focus on learning for the future

Role of Compensation in Disclosure Process

The Disclosure-and-Offer Approach
- Be candid and transparent about adverse events
- Conduct a rapid investigation, offer a full explanation, and apologize when appropriate
- Provide for the family’s financial needs (in at least a limited way) through a quick, accessible process
- Build systematic patient safety analysis and improvement into risk management
Disclosure-and-Offer Program Models

- **Reimbursement model**
  - Goal: Reimburse out-of-pocket expenses for non-fatal adverse outcomes due to medical care without determination of negligence
  - Examples: CIGNA Insurance, Maryland Mutual Insurance Co., ProMutual Group

- **Early settlement model**
  - Goal: Expedite settlement of incidents involving substandard care
  - Examples: University of Michigan Health System, University of Illinois at Chicago, Stanford University Medical Indemnity Trust

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

AHRQ Grants with DRP Component

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Planning Grants

- MA: Sands
  - Create MA collaborative for DRP implementation
  - Implementation underway using alternate funding

- UT: Guenther
  - Exploring DRP options in Utah
  - Collaborative with Utah stakeholders

- WA: Garcia
  - Accelerated Compensation Events

DRP Goals

- Facilitate communication about unanticipated care outcomes (disclosure and reporting)
- Attend to the emotional needs of patients, families, and providers
- Create mechanisms for providers, insurers, and others to collaborate around communication, event analysis, and resolution

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The DRP is not:

- A rush to judgment
- A rush to settlement
- Mandatory
- Telling the patient absolutely everything known about an adverse event
- Paying patients when care was reasonable
- Business as usual

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Potential DRP metrics

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<td>• Pre/post comparison of summary-level data</td>
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Exciting Developments

- IRB approvals secured
- Successful collaborations among diverse stakeholders
  - DRP as mechanism to improve response to injury that triggers less concern about "tort reform"
- Growing interest in expanding DRP model at state, institutional level
- Recognition of DRPs potential for significant cost savings for payers
- Rising awareness of need for reform at NPDB, state medical board level
  - Broader implementation of Just Culture concepts

DRP: Policy/Legal Barriers

- NPDB
- State medical boards
- QI protection

DRP: Implementation Barriers

- Reaching consensus on what events qualify for DRP
- Overcoming mistrust
  - Within healthcare stakeholders
    - MD: Is DRP in my best interest? Why be proactive if claim may never materialize?
    - Malpractice insurers: What cases benefit most from DRP?
    - Healthcare institutions: Is DRP "inviting claims"?
  - Outside healthcare: "fox guarding the hen house"
- Bandwidth challenges for front-line personnel tasked with DRP implementation

DRP: Scientific Barriers

- Time horizon problems
- Small numbers problem
- Uneven implementation across sites

There’s no easy way I can tell you this —
so I’m sending you to somebody who can...
Institutions have robust mechanisms for:
- Adverse event reporting
- Analysis
- Discussion with patient
- Peer review

Adverse event analysis, shared learning occurs across institutional boundaries
Regulatory environment supports disclosure, resolution, quality of care

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Regulatory environment supports disclosure, resolution, quality of care

Major gaps persist in event reporting, analysis, peer review
Institutions hesitate to collaborate around shared learning
- Often view one another as competitors
- In aftermath of serious adverse event, involved institution tend to focus blame on one another
- Healthcare workers lack confidence that institution, regulators can distinguish system from individual error

Errors are inevitable
Errors are opportunities for learning and system improvement
Non-punitive reporting of errors is essential for learning
All staff are accountable for their behaviors
Most errors are caused by system problems.
Organizational leadership is accountable for developing systems that reduce risk
We are all accountable for correcting system flaws that raise the probability that error will occur

Easier to describe than implement
- 2012 AHRQ Patient Safety Culture Survey, 650 hospitals
  - Half feel like their mistakes are held against them
  - 65% worry that mistakes they make are kept in their personnel file.

No good measures re whether institutional response to event is consistent with Just Culture concepts
Lots of grey area cases
Microcultures
Key next steps

- Start measuring occurrence, quality of disclosure
- Provide institutional supports for colleagues to discuss errors with one another, with patients
- Disseminate disclosure and resolution models
- Refine Just Culture concepts
- Promote regulatory environment that supports accountability after medical injury
  - Balancing QI protection with transparency
  - Encourage cross-institution collaboration around adverse event analysis and shared learning