

By William McDonough

Healthcare moves toward greater transparency and closure

Serious medical errors occur in our healthcare system every day. Known as “adverse events,” these errors not only cause serious physical harm to patients, but also psychological, financial, and operational harm to all involved. Patients and their families bear much of this burden. But there are other parties who suffer when serious medical errors occur. These include physicians and other clinicians (often referred to as the second victim of error), other staff within the healthcare organization, and the community in general.

Despite comprehensive efforts to enhance patient safety, have adverse events gone down over the past decade? In 2002, North Carolina hospitals adopted what they believed to be a highly effective patient safety tool known as the *Global Trigger Tool*. However, a recent study conducted randomly at ten of the participating hospitals indicates that patients are still being harmed at the same alarming rate. These findings surprised many, including the providers themselves, as the U.S. healthcare system has been focused on reducing risk to patients and improving safety for more than fifteen years.

Providers have made major investments in safety initiatives since the 1999 groundbreaking IOM report, *“To Err is Human.”* They’ve committed themselves to improving healthcare quality including training, technology (e.g., CPOE, ERH/EMR, bar coding, E-ICU), simulation, rapid response teams, and other techniques including “trigger tools” to identify and minimize injury to patients.¹ These efforts are intended to move organizations to what is referred to as “high reliability”—organizations which strive to simplify processes, support failure mode analysis and listen to those on the front line as process experts.

Another major development in the U.S. healthcare system is the promotion of provider accountability, transparency, and a culture of linking pay to performance. This focus makes perfect sense as the general public learns more and more about the incident rate of error in hospitals—often as a result of the lack of industry-wide systems, guidelines, and technology to prevent risk and injury.

The Right Culture

Responding to adverse events in a healthcare organization is challenging and often requires investing in organizational culture to be successful. These organizations have learned that the risks of not responding to adverse events in a timely and effective manner are significant. This may involve:

- 1) loss of trust by a patient or family
- 2) inability to heal by many parties
- 3) lost opportunities for learning
- 4) lost opportunities to improve and prevent future loss
- 5) regulatory and accrediting body actions
- 6) staff demoralization
- 7) liability via medical malpractice claims.

Responding, the Risk Management Framework

Providers have made considerable progress in embracing disclosure and apology after an adverse clinical event. The Joint Commission, American Medical Association, American College of Healthcare Executives, American Society for Healthcare Risk Management, and other patient safety experts agree that disclosing errors to patients and apologizing for adverse outcomes is the right thing to do. However, many healthcare organizations still struggle to answer these very basic questions at the core of any “disclosure, apology, and early offer” program:

- How should we respond when there is a medical error/adverse event?
- Who should disclose an error to a patient or family and when?
- Who should apologize for an adverse outcome and when?
- What should we say? How do we do it?
- Who should be held accountable?
- What can we offer to the injured party, if anything?

Early Offer Results

Many hospitals and other health care organizations are reluctant to share their “disclosure, apology and early offer” program experiences publicly for fear of alerting the plaintiffs’ bar or drawing media scrutiny. Also, many organizations are using the disclosure, apology, and compensation approach on a case-by-case basis and may not have formalized programs according to a white paper released by The Institute for Healthcare Improvement (IHI) in November 2011.

The paper, *Respectful Management of Serious Clinical Adverse Events*², suggests how to support affected patients, families, physicians, and other health professionals; investigate adverse events; communicate internally and with the media; and offer apologies and compensation when appropriate. According to the IHI white paper, Stanford University’s hospitals and clinics have saved \$3.2 million in annual premiums since establishing a program to disclose and investigate adverse events as well as offer an apology and compensation to patients when the bad outcome has been deemed preventable.

The results come on the heels of other successful experiments with “disclosure, apology, and early offer” programs. The University of Michigan Health System, for example, has cut litigation costs by \$2 million a year and seen new claims fall by 40% with a similar well-publicized initiative. *Detractors had originally predicted a 40% jump in medical liability claims for healthcare organizations that adopted programs.*

These two healthcare systems and other early program adopters report that their programs have been very successful in meeting three key goals:

- Reducing the overall costs of professional liability (medical malpractice) claims
- Reducing the time to bring adverse events to closure for all parties, and
- Reducing the burden of malpractice claims on patients, providers and the legal system

Program sponsors at early adopter organizations all agree that it is important to keep in mind the following tenets:

- Compensate quickly and fairly when *unreasonable* care causes injury
- Defend *reasonable* and appropriate care vigorously, and
- Develop a “lessons learned” platform to learn from adverse events and outcomes

These principles serve as the platform for an effective “disclosure, apology, and early offer” program. As successful program sponsors suggest, the tenets provide consistency and predictability for patients, clinicians, and the organization’s risk management program.

What do we need to do as an organization? What are the next steps?

Implementing a formal “disclosure, apology, and early offer” program requires staff commitment. Education is key with both risk management staff and clinicians. Some staff may challenge the “early offer” approach because they believe this form of resolution is selling out the providers involved. Careful planning is essential:

- Set up a task force to guide the organization
- Secure commitment from senior leadership and clinicians that this is the “right thing to do”
- Develop an organizational baseline as to “where we are” across the system
- Produce policies, procedures, and protocols to address all three program components
- Agree on criteria for which cases are appropriate for early offer
- Develop education, training, and development for disclosure and apology
- Build a strong business case and budget
- Produce a mechanism for reinforcing success stories (lessons learned) which are shared with the organization

Conclusion

As long as serious medical errors are part of the healthcare landscape, acknowledging errors and apologizing to patients constitutes a positive first step toward improving patient safety. It can also impact a healthcare provider’s total cost of risk. “Disclosure, apology, and early offer” programs represent a proven path to increase transparency and closure for healthcare organizations and their constituents.

Author William McDonough and contributor Ruth Kilduff are managing principals with Integro’s Healthcare Practice based in Boston. McDonough has more than 20 years of experience in risk management and risk financing for healthcare clients, including integrated delivery systems, physician groups, managed care organizations, and clinics. Kilduff has more than 30 years of expertise in senior care professional liability, healthcare professional liability, alternative risk financing, and risk consulting.

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¹ Kohn LT, Corrigan J, Donaldson MS. To err is human: building a safer health system. Institute of Medicine. Washington, DC: National Academies Press; 2000. Available at: http://books.nap.edu/openbook.php?record_id=9728

² Conway J, Federico F, Stewart K, Campbell MJ. *Respectful Management of Serious Clinical Adverse Events (Second Edition)*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011. (Available on www.IHI.org)