Transparency Programs in Light of Medical Errors

Exploratory Paper

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Introduction

The study of medicine is not exact. Although the intent and pledge of medical professionals is to do no harm, on occasion errors do occur. Sometimes these errors can be the cause of permanent injury to or even death of a patient. In these instances, most patients (or their families) will seek litigation as a means to be compensated for the injury. These suits impact the medical professional's malpractice rate, their reputation, and the overall cost of healthcare. Typically, when such an adverse event occurs, a health care organization (HCO) will shut down any communications regarding the incident and refer all conversation through a corporate attorney. (Fein, et. al, n.d.) Despite the lack of tort reform requiring transparency programs, the tide is turning on this approach and an increasing number of HCOs are implementing their own internal programs. In many transparency programs, it is not uncommon for medical professionals to not only apologize for the error, but also to publicize the adverse event. The predominant question posed is: Should healthcare organizations implement internal transparency programs?

Purpose

This paper will serve as exploratory research in order to gain a better understanding of the transparency issue by utilizing available secondary sources (books, articles and publications) and programs implemented by other health care organizations. It will evaluate some of the historical trends on medical error transparency, and propose sample program infrastructure to be implemented within health care organizations wishing to adopt such a program. The adoption of transparency programs within HCOs can serve several functions: promote accountability; actuate improved quality and safety; encourage ethical behavior and trust; and promote patient choice. Implementation of a transparency program will necessitate a change in organizational culture, and it will improve final outcomes by assuring physician protection, demonstrating consistent

commitment towards program improvement, and encourage teamwork towards the final goal – optimal patient outcomes.

Background

The issue of medical malpractice and the resulting financial implication is at the heart of the issue surrounding medical error transparency. Medical malpractice is defined as the "improper, unskilled, or negligent treatment of a patient by a physician, dentist, nurse, pharmacist, or other healthcare professional" (Medical Malpractice, n.d.). It includes not only the acts, but also the omission of care provided by a physician that fails to follow the accepted norms of treatment, that result in patient injury. (Bal, 2009)

Medical malpractice law has roots originating from English common law, and cases weren't commonly seen in the United States until the 1800's, when malpractice suits were filed with increasing regularity. Historically, physicians would not testify against one another or would not even publicize the fact that a medical error occurred. Jumping forward to the 1960's the frequency of suits increased, and have become a relatively common occurrence today. (Bal, 2009) It is also during this time of increased suits (1960's) that physicians began to testify regarding the standard of care in malpractice cases (Medical Malpractice, n.d.). While it may have been disadvantageous for the defendant practitioner, this served to alter the mindset of 'damage control' to one of sharing outcomes even when it was an adverse outcome. This marked the beginning of transparency in revealing medical errors.

Most healthcare organizations have experienced some sort of malpractice claims and most have implemented internal protocols on how to handle such suits. Despite this, in response to fear of being sued staff are most often advised to keep silent and refer inquiries to the legal department in any case of error or possible malpractice. An atmosphere of staff frustration and fear surrounding these incidents results. Staff usually understand what went wrong in the cases, but are not free to

openly discuss them. Clinicians also understand the errors and desire to alter procedure to ensure no further errors occur. However, fear of retribution and being deemed an outsider are prevalent themes with clinical staff. Unfortunately, this is not an uncommon occurrence (Griner, 2017). According to Wolf's book*, Patient Safety and Quality: An Evidence-Based Handbook for Nurses*, hospital leadership in six states expressed opinions about different state reporting systems: mandatory (confidential and non-confidential), and voluntary. The respondents suggest a prevalence of fear of non-confidential mandatory reporting contributing to likelihood of malpractice cases. (Wolf, 2008)

However, remaining quiet can actually escalate the issue. As a result of not receiving relevant information pertaining to an adverse event, the patient will often seek legal remedies to understand what went wrong and how it came to be that they suffered. An article authored by Rothstein evaluated patient motivators towards litigation - 44% of respondents indicated that they sued in order to get more information about what happened, or reported that the physician was not honest or intentionally misled the patient. (Rothstein, 2010) The author believes this ultimately creates a barrier towards quality care and effective interdepartmental communications.

Best Practice Identified

'Best practice' is a term used to describe the treatment methodology that has been tested and has proven itself as a reliable course of action (Kusserow, 2012). It is a term for the process of incorporating medical practice with research based knowledge. Healthcare organizations and clinicians that are committed to excellence will closely follow the best practice standard of care and this measure is frequently at the core of malpractice claims – as oftentimes injury occurs from practicing outside of 'best practice standard of care'. Best practice, similar to evidenced based medicine, integrates clinical expertise with the best clinical evidence obtained from standardized research. "The goal of 'best practices' is to apply the most recent, relevant, and helpful nursing interventions, based on research, in real-life practice" (University of Iowa, n.d.).

Barriers to Error Reporting

According to Moskop, "US health systems are not generally designed to encourage error recognition, reporting, and remediation" (Moskop, et. al, 2006). These mindsets include fear of conflict and the possible damage to reputation. Medical errors can occur for a variety of reasons, but incidents due to the malicious or egregious negligence of a healthcare professional are infrequent. The root cause of the majority of medical errors can be traced to a result of a systems error. For example, in 2004 a patient suffered death due to injection of the incorrect medication. The error was quickly discovered, but even life-saving efforts to reverse the damage proved unsuccessful. This tragic error was not hidden, but rather it was thoroughly investigated and once the systems error was identified, the remedy was openly shared with other HCOs. The result allowed other HCOs to revise their systems to prevent such an error from occurring (Wachter, et. al, 2015).

Disclosure of errors and near misses (incidents where protocol/best practice wasn't followed but no injury occurred) result in improved patient safety, as identified in the previous example. Dissection of the disclosure focuses more on the 'what and why,' rather than the 'who.' Additionally, it details the after effects of errors, and provides for process improvement to prevent repeat errors. Ideally, this information is shared interdepartmentally within the HCO and others within the field, for this is how true patient safety can be impacted.

A parallel can be drawn from the healthcare industry to the airline industry and the Aviation Safety Reporting System. This confidential, voluntary reporting system has focused on collecting data reported on near misses. The information is taken, analyzed to determine root causes, and recommendations for enhancements are provided. From there, the findings and recommendations are shared not just with the effected party, but with the entire aviation industry. The primary tenet of the program being non-punitive is what ultimately contributes to the success

of this reporting system. Other industries have implemented similar reporting mechanisms and have experienced improved safety and better outcomes as a result. (Journal of Oncology, 2007)

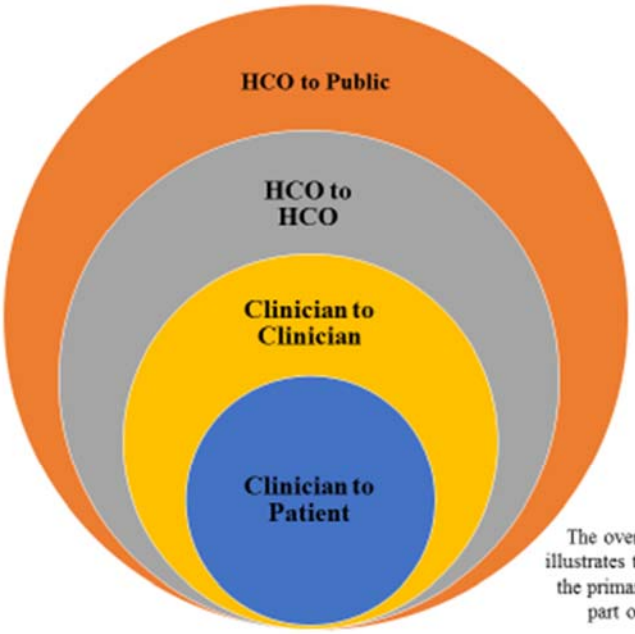
Sample Program Infrastructure

As identified, error reporting can affect improvement in the quality and safety of patient care. According to the National Patient Safety Foundation, a transparency program requires infrastructure focusing on four key domains of communication: clinician to patient: clinician to clinician; organization to organization; and to the public. (National Patient Safety Foundation, 2015)

- *Clinician to patient* transparency focuses on the engagement between these two parties. As the clinician is free to openly communicate his/her opinions with the patient, the relationship will be based on honesty and transparency. Further, it will serve to support non-adversarial interactions, encourage shared decision making, reduce litigation (and the disruption caused by it), and most importantly support an improved experience for the patient.
- *Clinician to clinician* transparency focuses on the engagement between clinicians and improves communications between those involved in direct patient care. This type of transparency will serve to encourage sharing of best practices as the normal course of treatment, decrease orders for duplicate diagnostic testing, and will serve to support accurate patient records.
- *Organization to organization* transparency focuses on the engagement between health care organizations (HCOs) and improves communications at the level of organizational structure and policy. It will serve to share best practices observed in the organization, provide benchmarking data, share patient data that serves to reduce redundant testing, and will aid in education towards preventing similar errors from occurring in other organizations.

- *Organization to Public* transparency focuses on the engagement between health care organizations and the general public. This transparency will provide the public with the ability to critically compare organizations that support informed decision making, motivate physicians towards improved quality, and provide an opportunity for increased patient trust.

Patient autonomy is a critical aspect of the ethical consideration to a transparency program. The implication of beneficence and non-maleficence are addressed in a transparency program. Physicians are encouraged and supported to report errors or near-misses without fear of punishment or malpractice. Organizations' core mission is to provide safe, quality care and they have an ethical obligation to expose errors. (Wolf, 2008) This contributes to the patient relationship built on trust and supports collaborative relationships. The primary transparency domain of clinician to patient acts as the foundation for the remainder of the domains, for transparency can go no further if it is not initiated at this primary level.



The overlapping Venn diagram illustrates the relationships and how the primary domain is an integral part of the other domains.

In addition to these key domains, a transparency program requires infrastructure focusing on targeting strategic priorities within the healthcare organization. The elementary focus must be a change in the internal culture to promote acceptance vs. penalty and being proactive rather than reactive. This will enhance the ability to sustain a culture of safety and accountability. The executive team for the transparency program, typically compromised of Compliance, Legal, Chief Medical Officer, and Quality and Safety (but can include additional departments), will need to serve as ambassadors of change. It is important for these ambassadors to support the culture change in order to overcome the fear of disclosure and potential negative impact on reputation and effectiveness. Implementation of a transparency program will require cooperation from all departments – the program's executive team to create organizational culture that supports the campaign, clinicians to collaboratively involve patients before, during and after care, and leadership to thoroughly report on quality measures.

Diagram demonstrates the sequential process that contributes to transparency

Understandably, implementing such a program requires a buy-in from the HCO leadership/major stakeholders and preparation for dealing with those who prefer to maintain current programs unchanged. Transparency will involve educating/training staff and providing

support at all levels. Fears about admission of error and the perceived harm to reputations must be acknowledged and addressed. The key issues are that the program will effect change, will ultimately improve the quality of care, and improve relationships with the public.

Summary of Findings

Despite the initial fear of worsening malpractice claims due to admitting errors, historical trends suggest that implementing a transparency program will not significantly increase total malpractice claims and liability costs. (Kachalia, et al, 2010) Through research and analysis of transparency programs implemented in other health care organizations, one particular organization comes to light as successful in their incorporation of such a program. An academic HCO located in the Midwest has effectively demonstrated this – since 2001, the HCO has successfully managed a transparency program that offers full disclosure and a settlement offer after an adverse event. Since inception, the HCO has experienced a reduction in the average rate of new claims (7.03 to 4.52 per 100,000 patient encounters), a reduction in the average monthly rate of lawsuits (2.13 to 0.75 per 100,000 patient encounters), and a reduction in the median time until settlement (1.36 years to 0.95 years) (Kachalia, et. al, 2010).

Another HCO has successfully implemented an organization to organization transparency program. This healthcare system, also located in the Midwest, has affected a 40 percent decrease in the rate of serious harm over a 20 month period of time, simply by encouraging and supporting transparency within its member organizations. (Wachter, et. al, 2015).This is promising data that supports the effectiveness of transparency programs.

Due to the adoption of the Affordable Care Act, price transparency is at the forefront of many healthcare initiatives. While price is certainly an appreciable component, the issue of care outcomes and error reporting transparency will be key for effective healthcare management in the future. Legislative efforts that have encouraged/financially rewarded adoption of an electronic

health record (EHR) system are a start towards system wide transparency. When EHRs are able to communicate inter-organizationally, the interchange of relevant health data will support transparency. If HCOs can communicate effectively and collaboratively, patient care becomes more efficient and therefore less costly. Improved communication begins at the core of the healthcare relationship: between clinician and patient.

Despite the potential benefits of improved communication, accountability, and reduced malpractice exposure, there are definite hurdles that must be overcome by implementing a transparency program. HCOs will need a strong alliance with providers to assure them of non-punitive discipline when human or systems errors occur. HCOs will need to accept the responsibility for errors on an organizational level to protect the provider's reputation. Organizational culture must embrace accountability while remaining open and receptive towards errors. This is a change from the current practice in the majority of HCOs and will take effort to realize. (Kachalia, 2013) Leadership must remain cohesive and committed to change in order to convince all stakeholders of the benefits of program implementation.

As identified, our healthcare culture is reluctant to share errors and this ultimately serves to harm patients by withholding important information. Transformation to a culture of transparency will be slow and will not happen overnight, but continuous commitment through incremental steps will eventually improve final outcomes. Organizational leadership must demonstrate commitment towards improvement, assure physician protection, and encourage teamwork. HCOs will need to actively review performance data, incorporate best practices, and share lessons learned with others

Conclusion

It is important to remember that the cornerstone of error prevention is that of error acknowledgement and reporting. This includes a system that supports identification and reporting

of near-miss errors – errors that had potential to cause harm, but were realized before an adverse event occurred. Success of any transparency program will require a shift in the organization's culture from that of blame to a proactive one of patient safety. The Joint Commission, the accreditation organization that promotes patient safety standards for health care organizations, supports the ideal that once errors are dissected and root causes are identified, it can benefit future outcomes by preventing a reoccurrence. (Wolf, 2008)

Healthcare has seen many changes over the years, and healthcare management has seen even more. As administrators evaluate the past failures and successes in the industry, they are wise to broaden their vision to focus on nationwide healthcare as a whole. Transparency programs appear to hold the future of healthcare and will aide towards promoting accountability from all stakeholders – ranging from patient to hospital system CEO. Implementing treatment transparency actuates improved quality and patient safety, and ultimately provides a more stable healthcare environment. Transparency removes the punitive blame that often is found with a treatment error, allows for open communication between clinicians, and will encourage ethical behavior and trust among healthcare professionals.

Patient safety is the overarching theme in the vast majority of healthcare organizations. Patients are a HCO's greatest resource and without them, the organization's existence in healthcare is limited. Healthcare managers must strive towards constant program improvement to meet the goal of providing quality care to all patients. Implementing a transparency program at an organization will demonstrate commitment to this goal.

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Key Words

- Medical errors
- Transparency program
- Quality and safety
- Organizational culture
- Patient safety
- Improved outcomes
- Malpractice
- Ethical

Abstract

This exploratory paper will focus on the issue surrounding transparency programs and the admission of medical errors realized during the course of patient treatment. It will provide a brief overview of historical trends, highlight results of successful programs, and propose sample transparency program infrastructure guidelines. Through referencing other healthcare organizational programs, the reader will gain a deeper understanding of the impact a transparency program has on malpractice rates and liability exposure. The reader will clearly recognize challenges inherent to transforming organizational culture and identify the benefits of a transparency program. Ultimately, the paper will guide the reader towards answering the predominant question: *Should healthcare organizations implement internal transparency programs?*