

Transparency: Patients



In last month's *CHPSO Patient Safety News*, we discussed the five targets of transparency: patients, coworkers, the organization, other organizations, and the public. A pdf version of that article is available at www.chps.org/post/transparency. For each of these targets, there are specific practices that maximize the benefit to patients, providers and other stakeholders, and we will discuss these in this and future articles. Today's focus is the patient.

It is a moral imperative to inform patients when they are harmed, even when harm is minor or accidental. However, most providers are neither inherently comfortable nor necessarily skilled at providing what the patient wants and needs most:

- Disclosure of all harmful errors
- An explanation as to why the error occurred
- How the error's effects will be minimized
- Steps the physician and organization will take to prevent recurrences

This discomfort is partly due to the intense sense of shame a provider has when an error occurs. Historically, providers have held themselves at fault for any error, even those that, on careful review, are found to be the result of normal human performance, not negligence. Widespread application of human factors-based event investigations, e.g., [the "Just Culture algorithm"](#), can help providers separate error from automatic self-blame.

A second part of this discomfort comes from the concern that transparency invites lawsuits. There is the concern that words of apology and concern will be misrepresented or misunderstood. The evidence to

date counters that concern: organizations with broad disclosure policies tend to report decreased liability expenses—and many of the liability settlements are quicker and smaller, benefitting all parties. However, poorly performed attempts at apology can cause misunderstandings or misinterpretations, pointing out a benefit of disclosure training.

Training people on how to compassionately and accurately inform patients provides needed skills and helps reduce the anxiety that is natural in such emotionally charged situations. There is a burgeoning body of literature and advice on this topic. Our partner, ECRI Institute, [provides a comprehensive summary](#) (as of 2008, but still valid) describing some of the steps to take to establish an effective disclosure program. [The AHRQ Patient Safety Network](#) provides more resources.

Not only is disclosure to patients the right thing to do, it is required in many circumstances. For example, within the [California mandatory adverse events reporting law](#), H&S 1279.1(c) states that the patient (or party responsible for the patient) shall be informed by the time the report to the state is made. Notification is required regardless of the extent of harm. CHPSO has identified, in reviewing the state's adverse event investigations, that presence or absence of patient notification is one factor differentiating events closed without findings from those that result in adverse action by the state.

Other entities also require or strongly encourage disclosure. For example, the Joint Commission standard RI.1.2.2 states that patients are to be informed about the outcomes of care, including unanticipated outcomes. The AMA code of ethics ([Opinion 8.121](#)) requires members to disclose when an unintended act or omission, or a flawed system or plan, harms the patient. Both organizations describe what should be included in the disclosure.

In summary, a well-organized and planned practice of patient disclosure benefits all involved and helps move us further on the path towards elimination of preventable patient harm.

For more information

AHRQ PSNet literature collection: <http://psnet.ahrq.gov/primer.aspx?primerID=2>

ECRI Institute Executive Summary: Disclosure of Unanticipated Outcomes:

https://www.ecri.org/Documents/Patient_Safety_Center/HRC_Disclosure_Unanticipated_Events_0108.pdf

Just Culture: <http://www.chpsso.org/just-culture>