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Insights From Patients:
The Future of Communication and Resolution

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Juliana and Amarlie's story

Key question for the future of communication and resolution

From patients' perspective, what can healthcare facilities do better to promote reconciliation after medical injury?

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Evidence from 2 studies

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THE RISK AUTHORITY
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Baystate Health

The COMMONWEALTH FUND

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Context: little systematic evidence about patients' needs

- Limited, prior studies establish:
  - Patients want to see efforts to prevent recurrences
  - Patients value disclosures that are honest and compassionate
  - Impact of medical injury can be exacerbated by poor responses from providers
- Difficult population to access for research
  - Legal concerns
  - Worry that patients will be re-traumatized

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Our studies

- Key informant interviews with patients, family members, and professionals experienced in dealing with injured patients
  - Face to face in most cases
  - In depth (usually 60-90 minutes)
  - Transcribed and analyzed using thematic content analysis
- Two countries:
  - **US**: Highly adversarial, litigation-based malpractice system with “communication-and-resolution programs” on the rise
  - **New Zealand**: No-fault, administrative compensation scheme (“ACC”)

Context: CRPs

- Timely and meaningful disclosure communications
- Rapid investigation
- Explanation and an appropriate apology always offered
- Compensation proactively offered if care was substandard
- Vigorous defense where provider's care was reasonable
- Release of claims required
- Attorney involvement welcomed

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CRPs: past, present, and future

The Journey to Date

- Establishing key elements and protocols
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CRPs are good for institutions

Univ. of Illinois Hospital & Health Sciences System (Pre/post analysis of trend, 2002-05 v. 2006-13):

Significant reductions in:

- Quarterly rate of new claims (8.8 → 5.1 per 100,000 encounters)
- Quarterly legal expenses ($554,221 → $98,017 per 100,000)
- Average settlement amount ($455,263 → $277,513)
- Average time to closure (4.0 → 2.4 years)

University of Michigan Health System (Pre/post, 1995-2000 v. 2001-07):

Significantly improved trends in:

- Average monthly rate of new claims (7.03 → 4.52 per 100,000)
- Median time from claim reporting to resolution (1.36 → 0.95 years)
- Average patient compensation costs ($405,921 → $228,208)
- Legal expenses

Sources: Lambert et al., *Health Serv Res.* 2016; Kachalia et al., Ann Intern Med 2010.

What about patients?

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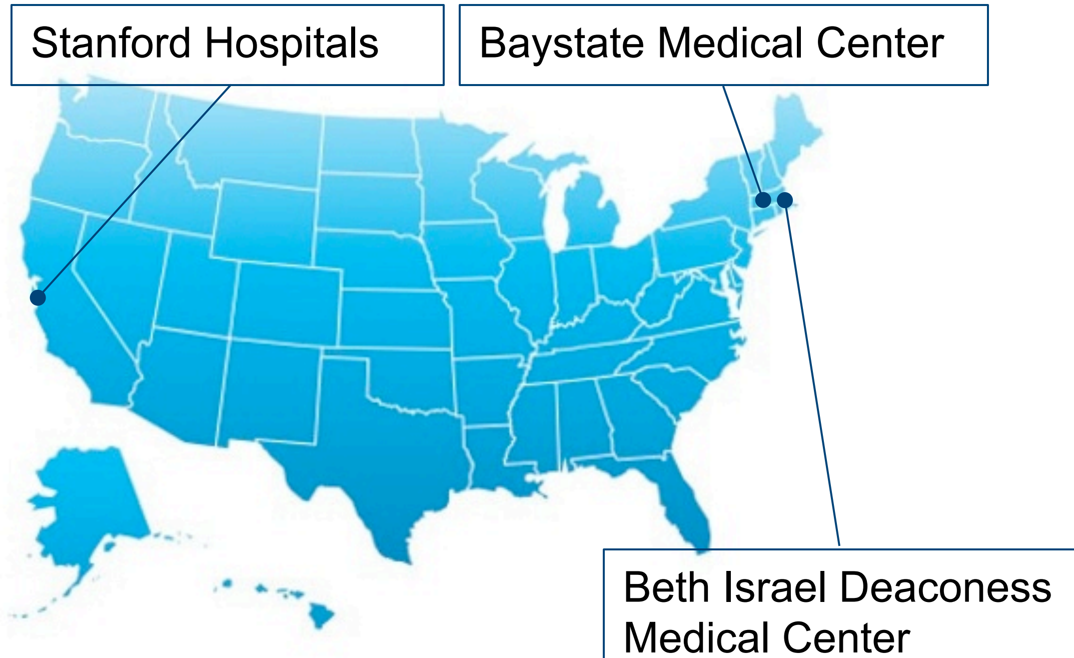
Patient sample: U.S.



40 interviews with:

- 25 patients
- 5 family members
- 10 professionals involved with CRPs (clinicians, lawyers, claims managers)

Participants recruited through CRPs

Response rate: 61%

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Patient sample: New Zealand

82 interviews with:

- 56 patients with medical injuries
- 6 family members
- 12 administrators of public hospitals
- 5 plaintiff lawyers specializing in ACC claims
- 3 ACC staff

Patients recruited through support group and snowball sampling

Response rate: 63%

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Study limitations

- Possible selection bias in identifying CRP cases (U.S. sample)
- Patients unwilling to be interviewed may have had different experiences
- Selective recall may affect participants’ reports
- Respondents were predominantly white and (in U.S.) female

What we learned

10 things hospitals can do to improve prospects for reconciliation following medical injury

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1. Ask, don't assume, what patients and families want.

- Ask open-ended questions: "How can we help?" "What do you want?"

"I loved that [the hospital] asked me 'How can we address this for you?' To be honest, I was bowled over, in a good way, that they would make such an open-ended offer ... I wanted something more than an easy 'sorry.'" (NZ patient)

- Tailor response to the patient's and family's needs

"We don't want our baby forgotten. We want our baby's life to have meaning. The plaque will serve as a reminder to staff…" (NZ family member)

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Juliana and Amarlie

“Money can’t fix what happened.”

“She wanted to apologize, and that was one thing where my mom was like, ‘No.’ I don't think my mom was ready.”

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2. Get the right people in the room

- Ask patient and family who they want included
- No excuses for clinicians

> *"A patient said to me, 'The physician has not come back and said anything to me. So this isn't ever going to end for me'." (US CRP staff member)*

- Don't involve social workers early on

> *"I would have liked to only have the surgeon come in … but no hospital administrator and definitely no social worker… I assumed my child was dead, because otherwise what do you need a social worker for?" (Family member)*

- Encourage patients to bring support persons

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Juliana and Amarlie

“The head of nursing came but it was the morning after the event and it was just too soon. She’s also a very stoic, unfeeling appearing ... I was going to say military-like.”

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3. Recognize the value of lawyers

"I saw the hospital as my enemy and the doctor as evil. My attorney asked how I'd like the outcome to look and how I saw the relationship with the hospital as part of that. It made me realize that they didn't go into work that day to hurt me and it was the mistake that needed fixing because they weren't evil people. I was able to trust them again and get more treatment there. I don't know if I'd have got to that point without my attorney, or it'd probably take a lot more time." (US patient)

- Help patients heal by listening

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Juliana and Amarlie

“The mediator said to me later, and he probably never should have said this. He was a wonderful guy. ... He said, ‘I’ve done about 5,000 of these cases and this is the worst one I’ve ever had.’ He said, ‘I don't know why they were so resistant to a decent settlement.’”

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4. Give an authentic apology

- Most patients value apologies, but not just “I’m sorry” on a checklist
- Forced quasi-apologies are especially harmful

> *“They bring the doctor along to the discussion. He says ‘sorry’ at the appropriate, predetermined time, but only when jabbed by his boss … My experience is that clients do not appreciate those types of ‘apologies’.” (NZ lawyer)*

- Apologies should not be a substitute for other forms of remediation

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Juliana and Amarlie

“I don’t want a forced apology.”

“Like the ER attending. She always has a smile on her face. She doesn’t look very sorry to me. Someone should tell her not to do that.”

“This woman [from Claims] sort of put her arm around me and she was very fake. She was saying, ‘We're going to make something good come out of this.’ … I was very straight faced and sickened by her fake, ‘Oh, everything's going to be okay’ type of thing … I just wanted to say swear words at her.”

5. Give patients a full opportunity to "be heard"

"It's absolutely, fundamentally, about being heard and being able to look the health professionals in their eyes, tell your story, and for them to look you in the eyes, and actually register." (NZ patient)

"The doctor listened and let me talk and talk and talk. I almost cried because it was the first time anyone had heard how I felt. He talked when I was done. It changed how I felt about the hospital." (US patient)

"When they didn't get the acknowledgment and admission, and being heard, my clients would go on a crusade." (NZ lawyer)

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Juliana and Amarlie

"I think this [interview] is a great opportunity, especially when I read that you'll be giving the feedback to [the hospital]. This is all I've wanted for so long."

"I'd like to have a meeting. This is a way for me to have a voice ... It might be nice for them also to see the face of what happened. ... It would definitely be the closure I need, almost, to really start to move forward from it."

"I stayed in touch with the resident ... It was definitely one of the positive things to come out of everything ... It was like we kind of helped each other through it. ... We were so separated: us and them. This was a nice way of bringing us together, like we're both still humans."

6. Always communicate patient safety efforts

"The hospital administrator risk guy … said, 'Don't worry. We're doing a full report on this. We'll give it to you before you leave the hospital.' … We never got anything. That was very disappointing because we were left thinking, 'Well, what happened? Did they change their policies and procedures? Are other people safer now at least?'" (US family member)

"I shouldn't have to keep putting my hand up to discover what patient safety policies and practices were put in place." (US patient)

"It's not resolved because I don't know if there was change." (US patient)

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Juliana and Amarlie

"They ran around and took all the vials off the carts immediately."

"I always preferred the people who would ask questions to the people who just said, "I'm sorry it happened. That's not going to happen again." That's because it could happen again and I'd rather they ask questions to learn more about how to prevent it. .... I know that I'm used as a teaching case. ... I like that."

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7. Avoid words that make patients and families bristle

- “Not severe” – patients may view the harm differently than providers
- Replace “resolution” with “reconciliation”.

“Well, I suppose from their [the hospital’s] perspective, it’s ‘resolved’ because our discussions have ended, and our ACC claim was accepted. But it’s not ‘resolved’ for us. Our baby is no longer with us and nothing will bring him back.” *(NZ patient)*

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"Yeah, 'near miss,' 'adverse events,' it's just a very unique language that they use with it, almost not owning up to it. … I just feel like they're deflecting blame. They're just reducing it to, 'An event occurred.' I'm sure they're not going to say, 'We made a huge mistake,' but at the same time it's just very interesting the way they approach it. They kind of dance around it almost, dance around what needs to be said."

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8. Offer compensation proactively

- Most families (22/30 in US) experienced financial stress
- Don’t wait for the demand

The hospital “should be reaching out and they should tell them ‘We’ll pay that bill for you now,’ because what will happen if those patients can’t pay it?” (US family member)

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Juliana and Amarlie

“They contended that Amarlie didn’t really incur any harm and that it was not that bad of an event.”

“Money isn’t everything, but my financial circumstance isn’t great. For us it would have been very helpful. My other daughter - I was just so distraught over the result of the mediation - and she said, ‘Mom, we won the prize. Amarlie.’”

9. Keep it personal and collaborative when talking money

- Communicate face to face

“The claims agent came to my house. ...She was sensitive and personally felt bad about it and that helped humanize the whole experience.” (Patient)

- Negotiations shouldn’t feel adversarial

Negotiating compensation as “completely breaking the illusion that we’re in this cooperative, collaborative process together” because “the big guns came out” and “the iron fist came out of the velvet glove.” (Patient)

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"They were very rigid. They didn't want to give us anything."

"To not even make an offer. Just for them to be so frugal and so aggressive with their mediation to somebody who has been an employee for 20 years. ... It's inconceivable to me."

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10. Ask parents whether and how to involve children

"My son is…having a hard time. He watched [his sister] go through [the operation]… He said 'Why am I not invited to talk? I was affected by all this.' I mean, he's 11." (Family member)

Juliana and Amarlie

“I was 14 at the time, so all the apologies went through my mother . ...I never got the apology. ... I’ve never seen the collection of those doctors and nurses ever again and that upsets me. ...There has just been little to no closure.”

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The Road Ahead

- Strengthening communicating guidelines by incorporating insights from patients, e.g.:
  - Asking what patients need
  - Ensuring patients feel heard
  - Relaying safety-improvement actions
- Cultivating authenticity and avoiding “the checklist”
- Thinking outside the box about remediation
- Connecting patients with attorneys
- Creating patient experience metrics
- Eliciting patients’ feedback

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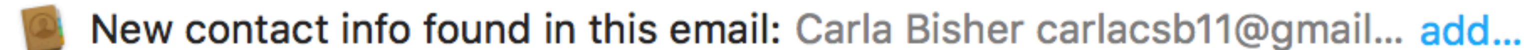
One more mom

February 6, 2018 at 5:59 PM

Medical Expert for Plaintiff

To: mmello@law.stanford.edu



Dear Ms. Michelle Mello,

I am aware of you from the movie Full Disclosure about Medical Errors and your articles. Since you are an attorney with public health interests, I wondered if you might have advice for a mom. My son, Cory Allen Bisher, died of preventable errors in a "nationally ranked" ICU, vomiting with an appearance of "coffee grounds" for 4 days, which is an obvious symptom of acute GI bleed,

services for families harmed. Wondered if you might have any advice about where I could turn as my time is running out. I feel like a bad mom, because I want Cory's life to matter and mostly, this shouldn't be happening to any parents' child ever again.