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A Culture of Transparency

- A cultural expectation throughout our organization that we will be open with our patients whenever there are any problems with their care.

A Change in Expectations

- The common expectation has changed from “How do we keep the information protected?” to “WHEN should we share information with the patient and their family?”

The Look of the Culture

- All adverse events / RCA's are shared throughout the organization.

Stories:

- A woman in labor has a UA done. Our standard protocol includes doing a toxicology screen if an obstetric patient is new to the area. The toxicology screen was grossly positive for methamphetamines. CPS was called and a “blessed event” is turned into a nightmare.

Stories:

- In a recent event, a patient was given the wrong drug (while we do not believe the patient was injured, the risk was *very* significant). The patient's mother called our attention to the error before most of the drug was infused.

Continuing Challenges

- Who's risk manager is driving the interactions?

Tidbits We've Learned

- Don't say too much before you have had time to investigate. It's OK to say you will get back to them.

- It's a process. Disclosure may involved a number of contacts, letters, and meetings over a period of months.

Tidbits We've Learned

- The patient and family may be in the anger stage of grieving – wear your asbestos suit just in case.

- It should be assumed that the patient and family will be in crisis and can only handle small bits of data.

Tidbits We've Learned

- You *will* make mistakes.

  We are still learning.

Don’t Forget Your Staff

- Assume this is painful for the staff members involved.
- Assume that physicians are also in crisis.
- http://www.physicianlitigationstress.com

Questions?