In 2010, the Institute for Healthcare Improvement (IHI) published a white paper titled “Respectful Management of Serious Clinical Adverse Events.” Its aim is to encourage the development of clinical crisis plans and their integration into the organizational culture and provide a resource when events occur and no plan is in place to handle them. The response to the white paper has been remarkable, as detailed below. Also offered in the following discussion are a summary of the learning gained and challenges remaining for clinical crisis planning along with comments on four areas of crisis management receiving the greatest attention.

Response, Learning and Challenges
In nine months (October 2010–June 2011), more than 34,000 people visited the IHI white paper Web page, with over 12,000 downloads of the paper and more than 6,000 links to the paper from other websites. Its content is featured in educational programs and publications. New organizational crisis management plans are being reported worldwide based on the white paper’s proposals. Organizations dealing with clinical adverse events, in the absence of a plan, are using the white paper as a guide.

Valuable feedback and suggestions to strengthen the paper have focused on placing greater emphasis on the following: the need for compassion and empathy on the part of everyone involved in an adverse event; the role of compensation in any discussion of apology; the inclusion of pastoral care and ethical leaders on a crisis team; the need to engage the patient’s primary care physician; and the critical importance of providing greater detail on the elements of a true apology.

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The authors learned that many organizations have a hard time getting started without a “burning platform.” Some are still dealing with the ramifications resulting from poor discovery of earlier events: Guidance is lacking on how to disclose errors that happened in another organization; greater understanding and support are needed for “second victims” (staff involved in the event); and, not surprisingly, at many organizations there remains an overemphasis on claims management and legal protections when bad things happen, at the expense of every other variable involved.

Four Areas of Greatest Interest
An updated version of the white paper is available on the IHI website. What follows are highlights of four issues now expanded on in the updated paper that reflect the greater interest in and attention to crisis management.

Apology
Disclosure and transparency of serious clinical events are increasingly accepted and expected by caregivers, patients and others; it is the right thing to do. While apology is often appropriate, it may not be the most important immediate step. First and foremost, staff should show empathy, express sorrow, and address the patient’s and family’s most pressing needs while determining what happened.

Reimbursement and Compensation
In the initial response to an adverse event, offer service recovery in addition to empathy. For example, organizations can offer to pay out-of-pocket expenses (housing, parking, child care, transportation, meals, lost...
wages) for the patient and/or family. Service recovery, including reimbursement, should be an immediate response to all adverse events. Many patients, family members and patient safety advocates agree that an apology must also include timely, fair compensation or restitution. One example of a disclosure and reimbursement program is the COPIC 3Rs approach—recognize, respond and resolve—developed by Alan Lembirtz, MD, vice president of risk management at COPIC.

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The seminal 1991 Harvard Medical Practice Study recommended no-fault compensation for all medical injuries. Richard Boothman of the University of Michigan notes, “Not every patient wants compensation and not all compensation is financial, but the inability or unwillingness to offer it signals insincerity and suggests that apologies are really affectations or strategies, not an integrated step borne of a commitment to honesty.”

In the United States, a few early, innovative and promising developments link disclosure with early resolution, including compensation and the creation of new improvement initiatives. Often-cited work (for example, by Mello and Gallagher in “Malpractice Reform—Opportunities for Leadership by Health Care Institutions and Liability Insurers,” New England Journal of Medicine, April 2010) includes examples from the VA Medical Center in Lexington, Ky., and the University of Michigan in Ann Arbor. Anecdotal evidence suggests considerable experimentation and innovation is under way across the United States.

Some early data indicate disclosure of adverse events will not increase liability costs, and may decrease them, yet there is significant debate on the overall financial impact. Regardless of the cost incurred by disclosure, healthcare organizations are encouraged to institute a policy of disclosure, apology and compensation as a cultural norm. The first time to address this issue is not in the aftermath of an adverse event but rather right now, as a matter of ethical responsibility.

Support for Second Victims

Significant anecdotal evidence and research reports the short- and long-term impact adverse events have on the staff involved—the second victims. Organizations should answer the following key questions related to their level of support for second victims in the immediate aftermath of an event and over time:

- At a time when clinical practice is rapidly evolving, are people and resources readily available to coach staff involved in or affected by an adverse event, as
they prepare for empathetic communication and disclosure of the event, and to support them through the process?

- Is the mechanism for assigning accountability for the harm appropriate? Does leadership jump to conclusions or ask “Who did it?” or do they first ask “What happened?”

- Have frontline staff been invited to participate in the root cause analysis of the event? Does leadership recognize that inclusion promotes learning and healing, whereas exclusion promotes blame?

Organizations need to provide staff with psychological support in the aftermath of an event and be aware of long-term effects. Many employee assistance programs are not prepared and their counselors not trained to offer this level of support. Fighting off “shame and blame” is a huge challenge after serious events, as is dealing with the “complex sorrow” of healthcare professionals whose patients die.

Creating a Burning Platform

Getting organizational attention for creating a crisis management plan can be challenging. Successful strategies include the following:

- Engage the board and C-suite in confronting the realities of clinical practice. For example, one large system reviews the “harm of the week,” drawn from events across the system, on a weekly leadership call.

- Use the self-assessment tools in the IHI white paper to evaluate the comprehensiveness of your approach through your organization’s handling of the last few serious clinical events. Leaders are often startled to discover holes in their program when evaluated against best practices.

- Simulate a tragedy that occurred at another organization as a powerful way to determine “Could it happen here?” and, if it does, how you would respond.

IHI has seen extraordinary interest in the respectful management of serious clinical adverse events. Awareness exists, and beliefs and attitudes are changing. Now actions and behaviors must change and be sustained. Our ultimate goal is the elimination of harm. Until that aim is achieved, in the aftermath of adverse events the patient, family, staff and community must be able to say, “We were treated with respect.”

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Editor’s note: To learn more about IHI’s tools for helping leaders manage and reduce crisis events, visit http://tinyurl.com/IHIEffectiveCrisisMgmt.