



Patient Safety Action Network

Patient Driven, Patient Led

<https://www.patientsafetyaction.org/>

**Disclosure and Apology Policies following Harm Events
Patient Safety Action Network Position Paper
December 12, 2021**

This paper describes the Patient Safety Action Network's (PSAN) position on the Disclosure and Apology programs that are adopted for use by health care systems or being negotiated by state legislatures for statewide use. The goal of this paper is to educate the public, policymakers and other interested parties about what a patient-centered program should look like and why such a model is important to improve patient safety.

PSAN is a national nonprofit coalition of individuals and organizations including medically harmed patients, their loved ones, and concerned advocates. With a unified patient voice, we focus on health care accountability and transparency to end medical harm.

Disclosure and apology to patients who have been harmed while receiving medical care has become more common in recent years. This is a positive development because most harmed patients and their families want to know what happened but rarely receive such information.¹

In 2016, the Agency for Healthcare Research and Quality (AHRQ) worked with a group of experts and stakeholders to combine elements of existing programs to develop a model for disclosure and apology called the Communication and Optimal Resolution (CANDOR) process.² Currently many discussions and initiatives, including state legislation, are taking place to increase the adoption of CANDOR and similar programs as part of the delivery of health care.

Although programs vary in their intent and implementation, we believe it is essential that these programs meet the needs of patients and their families first. The primary goals of programs should be communicating honestly and transparently with patients and their families about harm, demonstrating accountability for any preventable harm, and preventing reoccurrences of the harm within the organization. In addition, programs have a responsibility to share lessons learned with other health care organizations and to be transparent with the public about how they operate.

Programs should not be used as a strategy to mitigate the risk of lawsuits or to foster secrecy about medical harm. We raise this concern because several state laws and proposals create an opportunity to hide medical harm from the public through confidentiality provisions and to shield reporting of medical harm to medical boards and the National Practitioner Data Bank. State laws and policies that sidestep these important public safeguards put more patients in danger of medical harm.

We call upon those designing and implementing these programs to uphold their responsibilities to patients, their families, and the public by adopting the following policies:

1. All harmed patients have the opportunity to participate in a Disclosure and Apology program. All patients admitted to a participating health care facility receive information about the program. Health care organizations are not allowed to select or exclude patients or families.
2. The activities of a program and the process for carrying out those activities are clearly established and communicated to all parties, including patients and their families, health care staff, and the public.
3. Patients and their families, health care staff, and any other involved parties are interviewed immediately after a harm event in order to gather accurate and timely information about what happened. They are a part of the entire investigation process from start to finish. Because patients and their families may be the best witnesses to an event, their knowledge is essential to understanding the harm event and preventing future occurrences.
4. The investigation team shares information with patients and their families as new information is learned about the harm event.
5. Programs inform patients and their families of their right to seek legal counsel.
6. Patients or their families are not prohibited from sharing information learned through the program as a condition for disclosure of information or for compensation for the harm, or for any reason.
7. Disclosures about harm and other activities carried out under these programs are shared with state licensing boards and the National Practitioner Data Bank (NPDB). Every payment made on behalf of a practitioner is considered to meet federal requirements for reporting to NPDB.
8. Programs implement metrics and conduct data analysis to regularly evaluate outcomes. Programs periodically report these outcomes to the public, including specific safety improvements made so that others can learn how to avoid similar harm events. Assertions that the program has improved safety are based on these analyses.
9. Assessments of programs include surveys of patients and families about their experiences. Assessments are conducted in a manner that allows patients and families time to reflect on their experiences with the program, for example between three and six months after disclosure.

PSAN is willing to advise organizations on designing disclosure and apology programs. For further information regarding this paper, contact info@patientsafetyaction.org.

¹ <https://www.propublica.org/article/patient-safety-voices-questionnaire-results>, accessed 8-26-21: "Only 1 in 10 people who completed the questionnaire said the hospital or other facility voluntarily acknowledged the harm. About the same proportion said the harm was acknowledged under pressure. Nearly all the rest said they were ignored, or the harm was denied."

² Agency for Health care Research and Quality Communication and Optimal Resolution (CANDOR) Toolkit. <https://www.ahrq.gov/patient-safety/capacity/candor/modules.html> accessed 7/27/21