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# Transparency Between Patients and Providers

## A Necessary Step to Safer Care

Earlier this year, as part of the National Patient Safety Foundation's annual Patient Safety Congress, senior healthcare executives from across the country took part in a one-day educational program focused on the issue of how to increase transparency in healthcare. An informal poll conducted during the session found that:

- Most attendees (93%) agreed that a healthcare system that embraces transparency will produce safer care and better outcomes.
- Yet only 22% said they were satisfied with the degree of transparency in their organizations.

While not rigorous science, our poll reveals the conundrum of transparency. That is, many people believe transparency has benefits beyond the ethical pull of “doing the right thing,” yet these same people work within cultures and systems that create barriers to full and complete openness with patients and families, and within and across the healthcare system.

So, how do we transform transparency from a worthy ideal to a

routine practice? This article makes the case that the initial focus should be the relationship between clinicians and patients, and it offers practical steps for getting started.

### Leadership and culture: at the core of transparency

First, some background. A recent report from the Lucian Leape Institute<sup>1</sup> defines transparency in healthcare as the “free flow of information that is available to the scrutiny of others.” It frames transparency in two ways: as ethically correct, and also as a pathway to achieving improved outcomes, greater patient satisfaction, safer care, and lower costs. The report outlines a broad range of recommendations for actions by all stakeholders, including policy and regulatory changes.

If transparency is to be truly successful and sustainable, it must be routine practice in multiple domains of healthcare that overlap and intersect:

- Between clinicians and patients, so that patients are fully informed of all aspects of their care
- Among clinicians, to improve coordination of care and to share best practices

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- Among organizations, so shared experiences can benefit others through lessons learned
- With the public, through metrics that are understandable, timely, and useful for guiding patients' decisions on care and for building trust.

Many organizations have, independently, made the decision to pursue greater transparency in one or all domains. Those that have successfully increased transparency between clinicians and patients have done so through the efforts of strong leaders who are committed to transparency and to a culture of safety. Leadership must drive the push for transparency. Ideally, an organization's chief executive officer, with the backing of the board of directors, will lead the way. But other members of the leadership team (chief nursing officer, chief medical officers, chief quality and safety officer, chief risk officer) can gather the growing evidence to make the case for greater transparency.

Leaders are also responsible for the culture of their organizations, and a strong culture of safety is needed to support and sustain transparency. In the definition adopted by the Agency for Healthcare Research and Quality (AHRQ), safety culture is "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management." A culture of safety is one in which clinicians are encouraged to report safety lapses and near misses, where everyone knows how to report such incidents, and where the organization commits to learning from them by sharing the results of the investigations into their causation.

Assuming that the commitment by leadership is in place, an organization that wants to begin to increase transparency should have a good idea of how their patient safety culture stacks up, for example, by implementing the AHRQ Hospital Survey of Patient Safety Culture and assessing their most recent results.

### Transparency about errors and adverse events

When they hear the word "transparency" applied to healthcare, most people likely think of the disclosure of medical errors, and there are valid reasons why health professionals and their organizations should

embrace transparency in regard to errors, including what was done to resolve them fairly.

The University of Michigan Health System began a program of disclosure and apology 14 years ago. The framework for the approach is simple, as Rick Boothman, JD, chief risk officer, explains it, "Reach out to those harmed, be honest, explain where appropriate, disclose our mistakes, and learn from our experiences."

Transparency is essential if professionals and organizations are to learn from mistakes and implement practices to keep them from recurring. Honesty also preserves the healing relationship and provides closure to both clinicians and patients. Boothman said that healthcare organizations "have largely underestimated the degree to which patients and their families who have been injured because of medical mistakes feel responsible that it not happen again."

One study of the Michigan Model reveals that, even as the demand for clinical services has increased, medical professional liability (MPL) claims and liability costs have decreased.<sup>2</sup> Boothman has said that incident reporting has increased, and noted that greater openness has led to more robust quality and safety efforts.

Boothman also made the point, however, that transparency is not a one-size-fits-all solution. Different organizations in different states with different legal concerns need to adapt it so that it works for them. He is confident, however, that years of experience have convincingly shown that traditional fears that honesty will lead to litigation catastrophe have been overblown and should not trump the essential importance transparency holds for improving quality and safety.

In Massachusetts, the Massachusetts Alliance for Communication and Resolution Following Medical Injury (MACRMI) ([www.macrmi.org](http://www.macrmi.org))<sup>3</sup> provides resources for healthcare organizations looking to embrace transparency between clinicians and patients about errors or adverse events. Currently, six hospitals in Massachusetts are pilot sites in the alliance. In addition, Mello et al. have written about the lessons learned by the some of the early adapters of communication and resolutions programs.<sup>4</sup>

Kenneth Sands, MD, chief quality officer, Beth Israel Deaconess Medical Center (Boston), and one of the founders of MACRMI, recently described one reason for transparency about adverse outcomes. "In a

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large majority of these cases, we're talking to people who had something unexpected happen to them that probably couldn't have been prevented, but for which they have not gotten a good explanation," he said. "Absent [a good explanation], they generate hypotheses that the organization is hiding something and that they were harmed unnecessarily."

In addition to having strong leadership support and a strong safety culture, Sands recommends that organizations instituting a communication and resolution program consider the following:

- Have a commitment from the risk management and patient safety departments to move forward, with a staff person (sometimes reassigned from one of those areas) to manage the program.
- Put the necessary support in place, including patient resources and peer support for clinicians.
- Consider a similar collaborative approach with peer organizations. The support of the larger community of like-minded institutions can be helpful in both implementation and reinforcement of the approach.
- Secure a commitment from your medical professional liability insurer to partner with your institution in implementation of a communication and resolution program.

## Making patients and families part of the team

Transparency in the domain of direct clinical care can be framed as "extreme honesty with patients and their families from start to finish,"<sup>1</sup> which of course covers much more than what happens when something goes wrong. It includes, for example, practices such as true informed consent, which requires that patients be fully informed about the pros and cons of treatment decisions. Any such information needs to be available to patients in language that is accurate, easily intelligible to them, and free of jargon. Conveying this information may require communications training for clinical staff. Creating the means to ensure true informed consent is an example of a long-term strategy worth pursuing.

Here are some recommendations that leaders can put into place fairly quickly, and at relatively low cost:

- Inform patients of the role that trainees play in their care, and make sure that all clinical staff introduce themselves and explain their jobs.
- Disclose all conflicts of interest. Set the expectation that clinicians should reveal any real or perceived conflict of interest regarding treatment recommendations.
- Include patients and families in inter-professional and change-of-shift bedside rounds.<sup>5</sup> Although this may require staff training and buy-in, this is an example of a practice that could begin in a high-performing unit and then be implemented more broadly.
- Include patient representatives in organizational operations and governance. Most hospitals have at least one patient and family advisory

council (PFAC). Others have many PFACs working on operational, quality, and safety initiatives. Reach out to systems in your region and learn their best practices for expanding and deploying these valuable resources.

- Include patients and families in the event-reporting process. Put mechanisms in place that encourage patients and families to ask questions and speak up when they believe something has gone wrong with their care. Make sure all served by the organization know where to go with a complaint or a concern.

## Conclusion

Barriers to greater openness between clinicians and patients include the fear of litigation and concerns about damage to a provider's or organization's reputation when something goes wrong. Yet, organizations that are pursuing greater transparency have demonstrated that such fears are largely unfounded and, in fact, discovered that more openness can bring positive results, actually enhancing reputation, reducing medical liability costs, increasing quality and safety, and promoting robust and meaningful peer review.

While clinical care is an important focus for expanding openness, it is only one area of healthcare where greater transparency is needed. If we really want to lead through learning, we must move toward greater transparency among clinicians through peer review or other mechanisms; among organizations through regional or national collaboratives; and with the public, through reporting of useful quality and safety metrics. Only with progress in all four domains will we realize power of transparency to promote accountability, trust, and ethical behavior, and to drive improvements in quality and safety. 

For related information, see [www.npsf.org](http://www.npsf.org).



## References

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