

What happens after patient harm?

Why one family from Kansas is fighting to stop the secrecy and start conversations.

Melissa Clarkson

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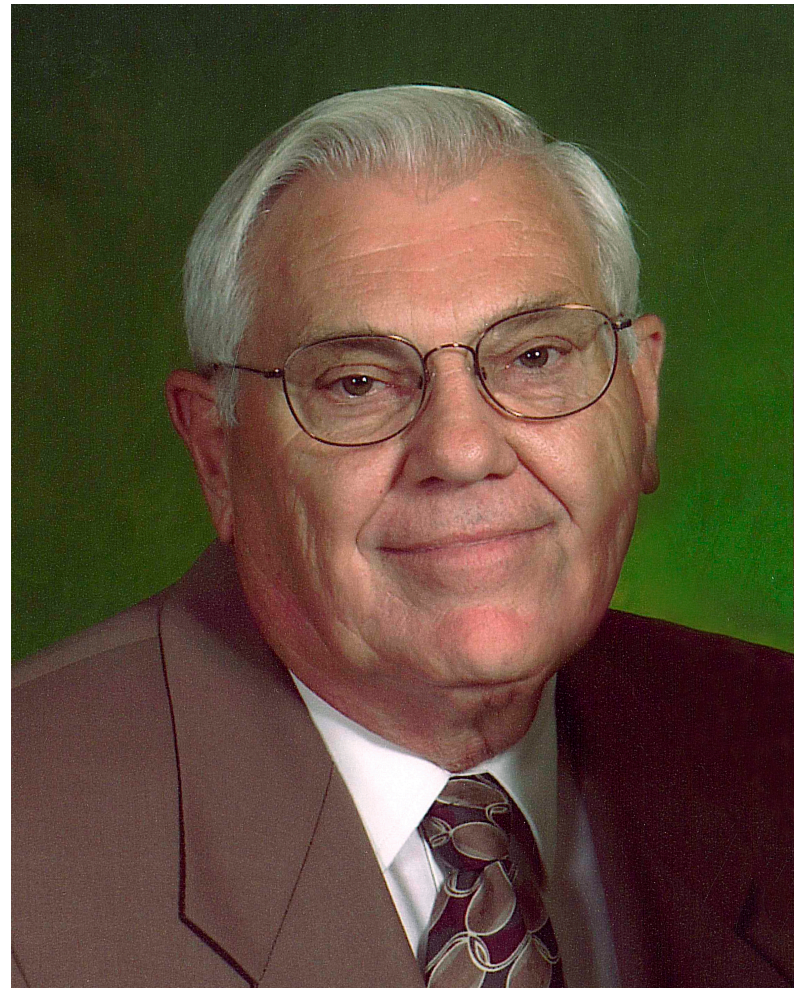
What happens after patient harm?

1. My family's story
2. Responding to patient harm
 - The tools of power and secrecy
 - A better way

My family's experience

2012

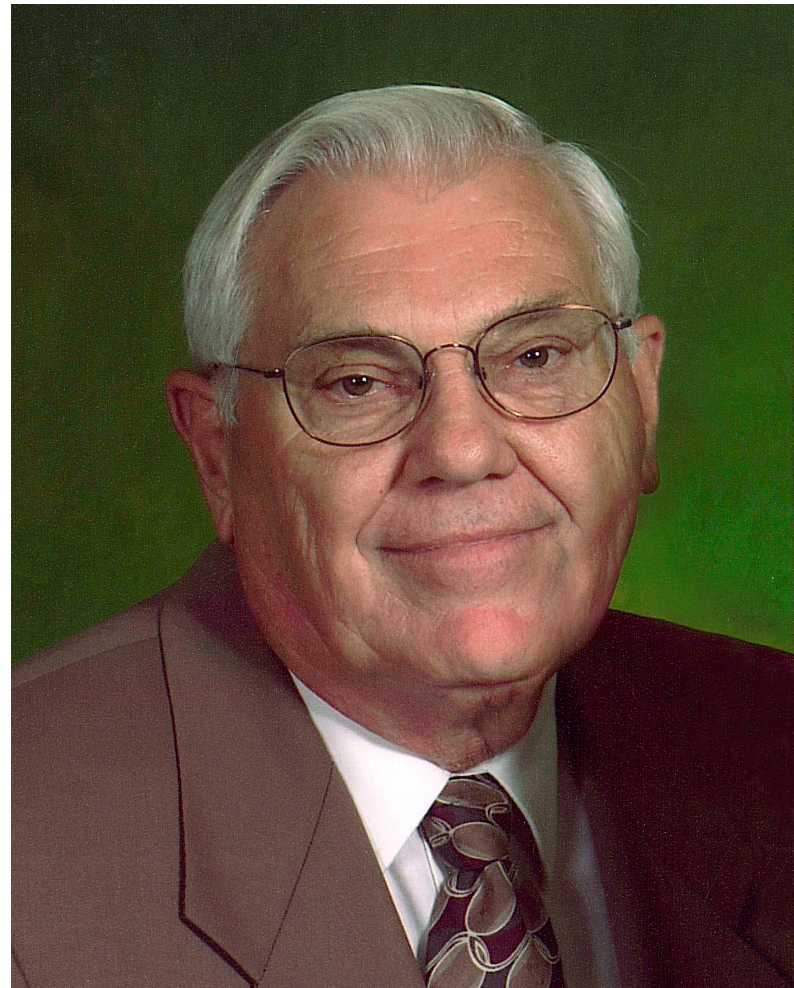
- My father was badly burned in Kansas
- Local hospital delayed transfer to burn center
- He died 11 days later



My family's experience

2012

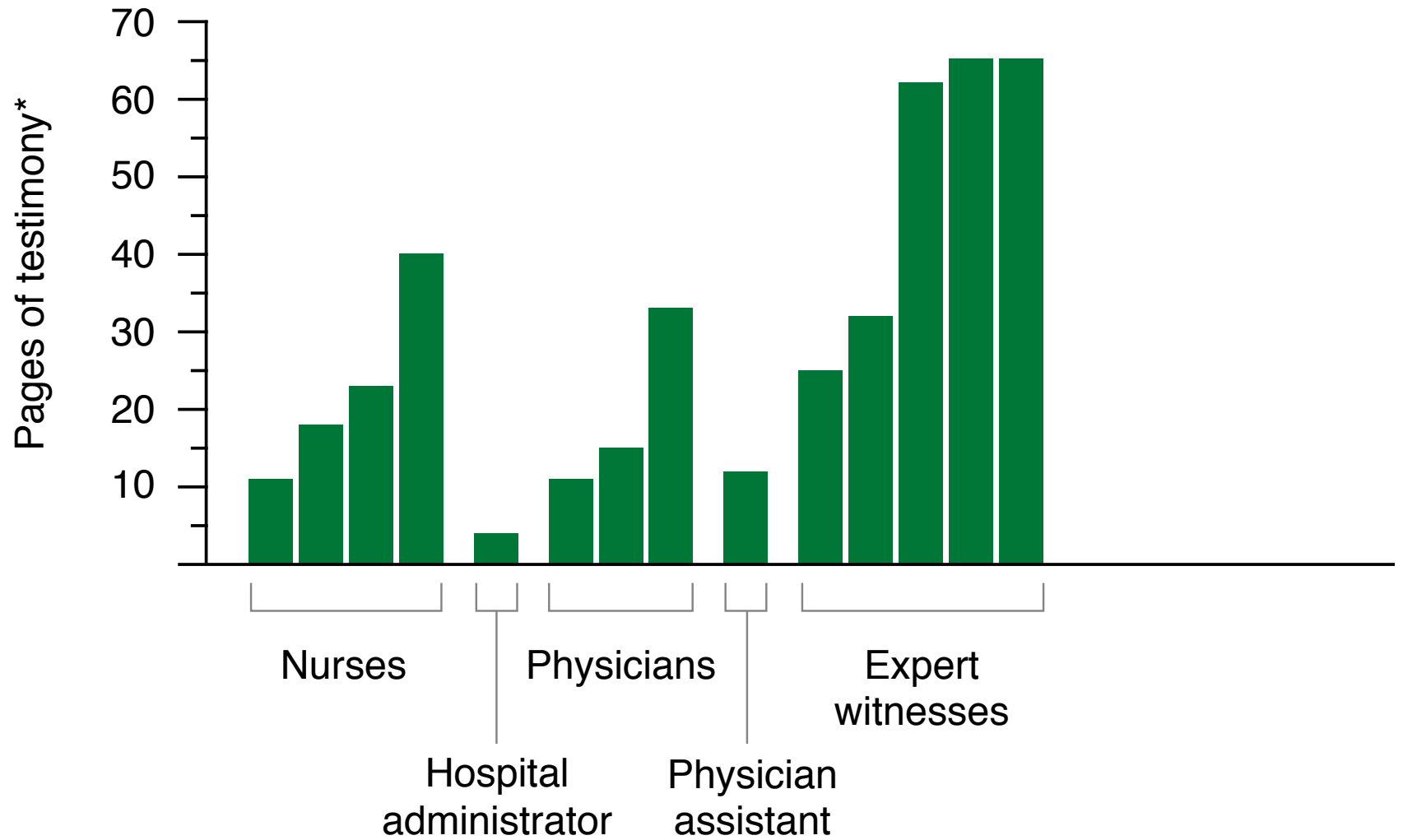
- My father was badly burned in Kansas
- Local hospital delayed transfer to burn center
- He died 11 days later
- Local hospital refused to talk to us about his care



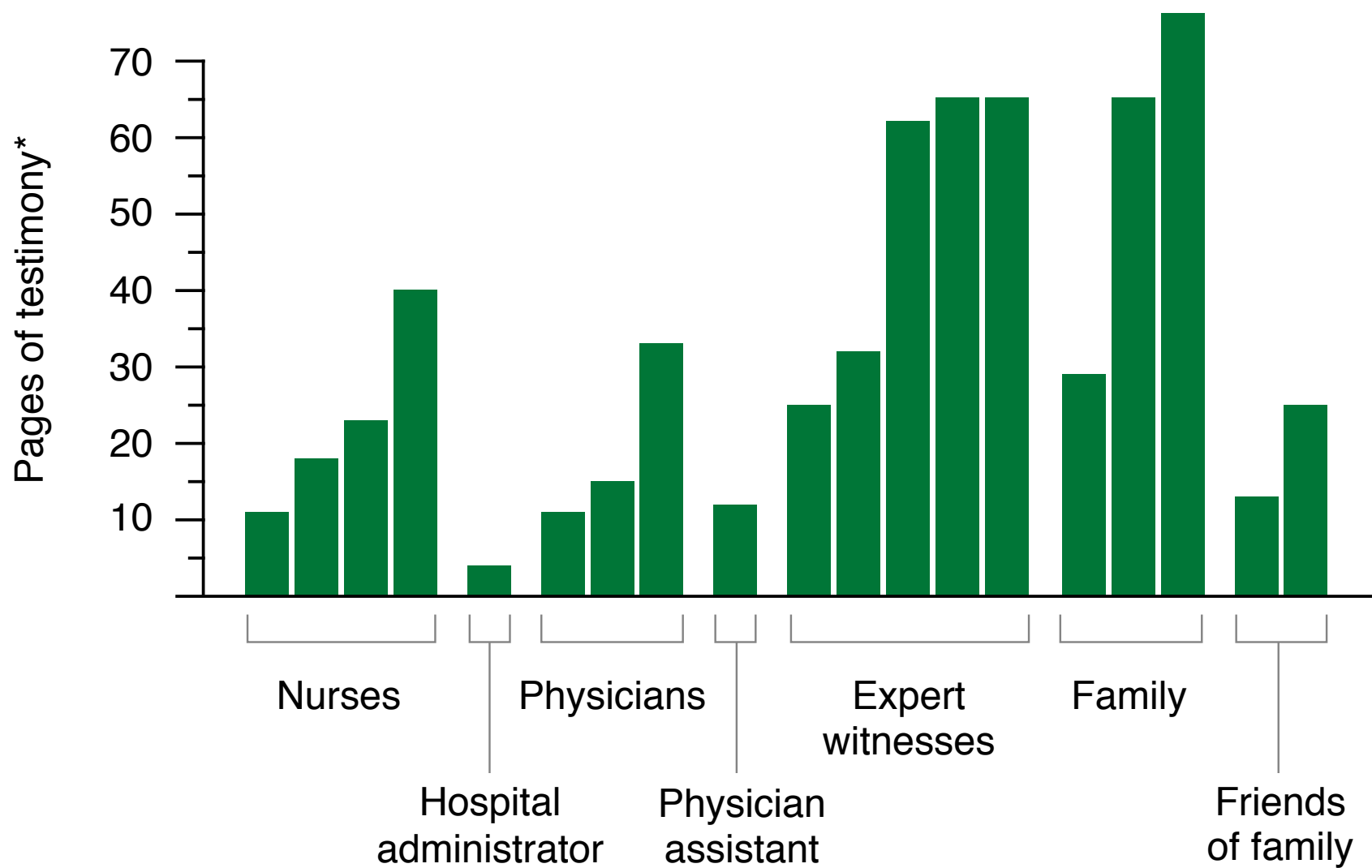
My family's experience

2014

- In January, decision to file lawsuit
- Depositions November 2014 – August 2015



* letter size pages (multiply by 4 for number of small deposition pages)



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My family's experience

2014

- In January, decision to file lawsuit
- Depositions November 2014 – August 2015

My family's experience

2014

- In January, decision to file lawsuit
- Depositions November 2014 – August 2015

2015

- In October, “The matter has been resolved”

My family's experience

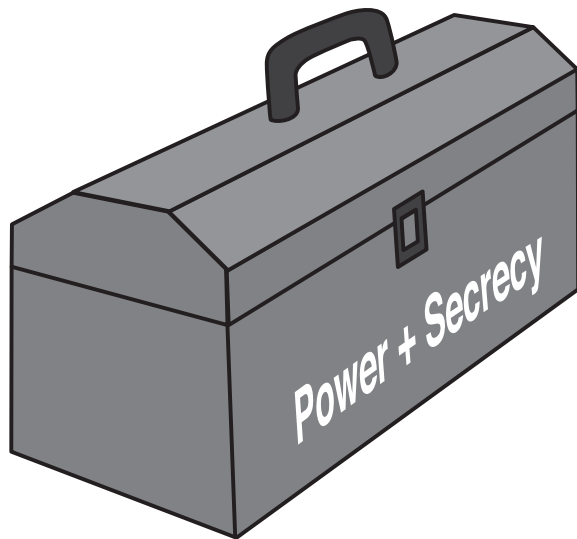
March 2012



3.5 years
financial cost
emotional cost
time and effort

October 2015

My family's experience



March 2012



3.5 years
financial cost
emotional cost
time and effort

October 2015

Tools of power and secrecy:

Nondisclosure agreements

A nondisclosure agreement limits what I say about my experience

5. Confidentiality

The undersigned agrees as part of the consideration for [REDACTED], that [REDACTED] shall be and will remain absolutely confidential and shall not be disclosed by the undersigned, the undersigned's family, the undersigned's attorney or any members or employees of the attorney's firm, to any person, firm, corporation, entity, media or the internet. If asked how the case was concluded, they shall respond by saying that the matter has been resolved. The undersigned further agrees that [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] This Agreement does not apply to preclude the Defendants from making any disclosure required by law or as part of any application for professional privileges, credentialing, participation in health insurance plans, or professional liability insurance, nor does it preclude the Fund from making disclosure as required by law.

Nondisclosure agreements are common: Data from Texas study

University of Texas System: Of 124 malpractice settlement agreements examined, 110 had NDAs

Patient/family was prohibited from...

100% disclosure of settlement terms and amount

56% disclosure that a settlement was reached

46% disclosure of the facts of claim

26% reporting to regulatory agencies

3% disparaging the physician / hospital

Tools of power and secrecy:

**Confidentiality of
investigations and reporting**

The hospital refused to share
information with us

The hospital refused to share information with us

“As it pertains to sharing information about our risk management activities, including reportable incidents, and [redacted], K.S.A. 65-4925 specifically precludes us from disclosing information with outside parties.”

The investigator for Medicare refused to share information

The investigator for Medicare refused to share information

“...we determined that some of the care your husband received did not meet professionally recognized standards of care.”

The Kansas Board of Healing Arts refused to share information

The Kansas Board of Healing Arts refused to share information

“Based upon the Disciplinary Panel’s review of evidence in the investigation and a thorough legal analysis, public disciplinary action was not authorized.”

Tools of power and secrecy:

**State statutes concerning
malpractice cases**

State statutes limit patients' access to the civil justice system

- Statutes of limitations
- Caps on damages that patient/family can collect
- Pretrial screening panels

State statutes tend to protect physicians, rather than patients

- Apology protection laws
common
- Mandatory disclosure laws
rare and weak

Patients **do not** have the right to know about unanticipated medical outcomes or harmful errors that occur in their care.

Our healthcare providers and administrators **do not** have the responsibility of providing accurate and complete information to patients about their care. This information includes, but is not limited to, information about any procedure performed (or not performed) upon a patient's body, and the outcome of any procedure performed upon a patient's body, any medication administered to a patient, instances in which the care provided has deviated significantly from the standard of care, and our knowledge of harmful errors that have occurred during patient care.

If a patient seeks this information, he or she must secure legal representation and file a lawsuit.

Tools of power and secrecy:

**Professional
healthcare societies**

Professional healthcare societies lobby the state for favorable laws

“The **Kansas Medical Political Action Committee (KaMPAC)** has a history of being active and influential in elections by wisely allocating its resources to help elect candidates dedicating to make Kansas the best state in the nation to practice medicine.”

Professional healthcare societies say they are advocates for patients

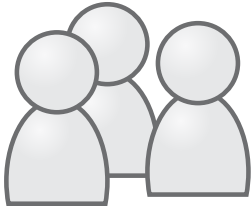
“The Board of Directors and staff are committed to achieving the KAMMCO mission through:

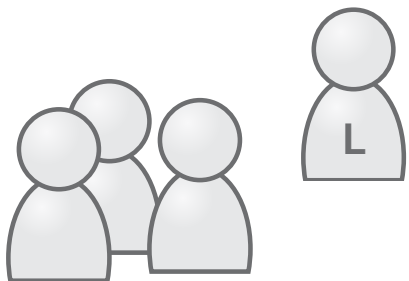
Integrity

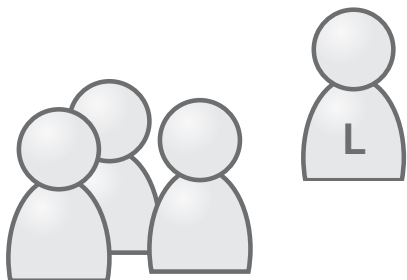
Reliable, ethical, and trustworthy. Demonstrating a high level of consistency between what we say and what we do. Paying strict attention to the fiscal responsibility necessary to promote long term financial stability.

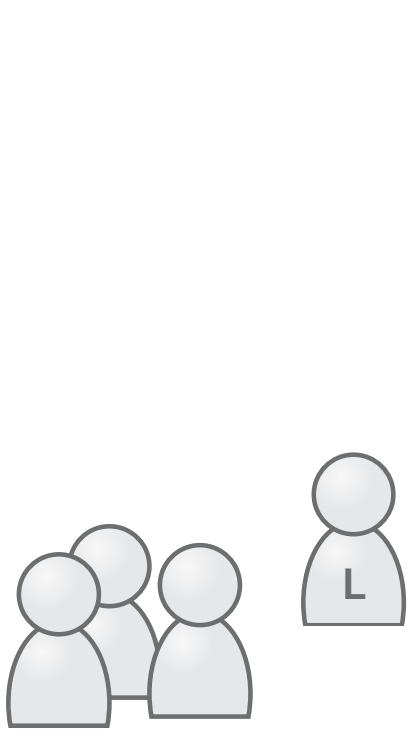
Advocacy

Unrelenting efforts to champion the cause of healthcare professionals and the patients they serve.”

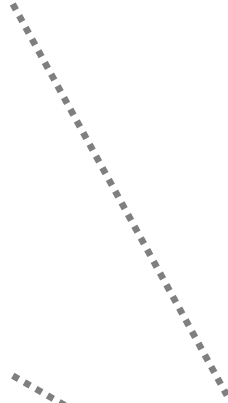


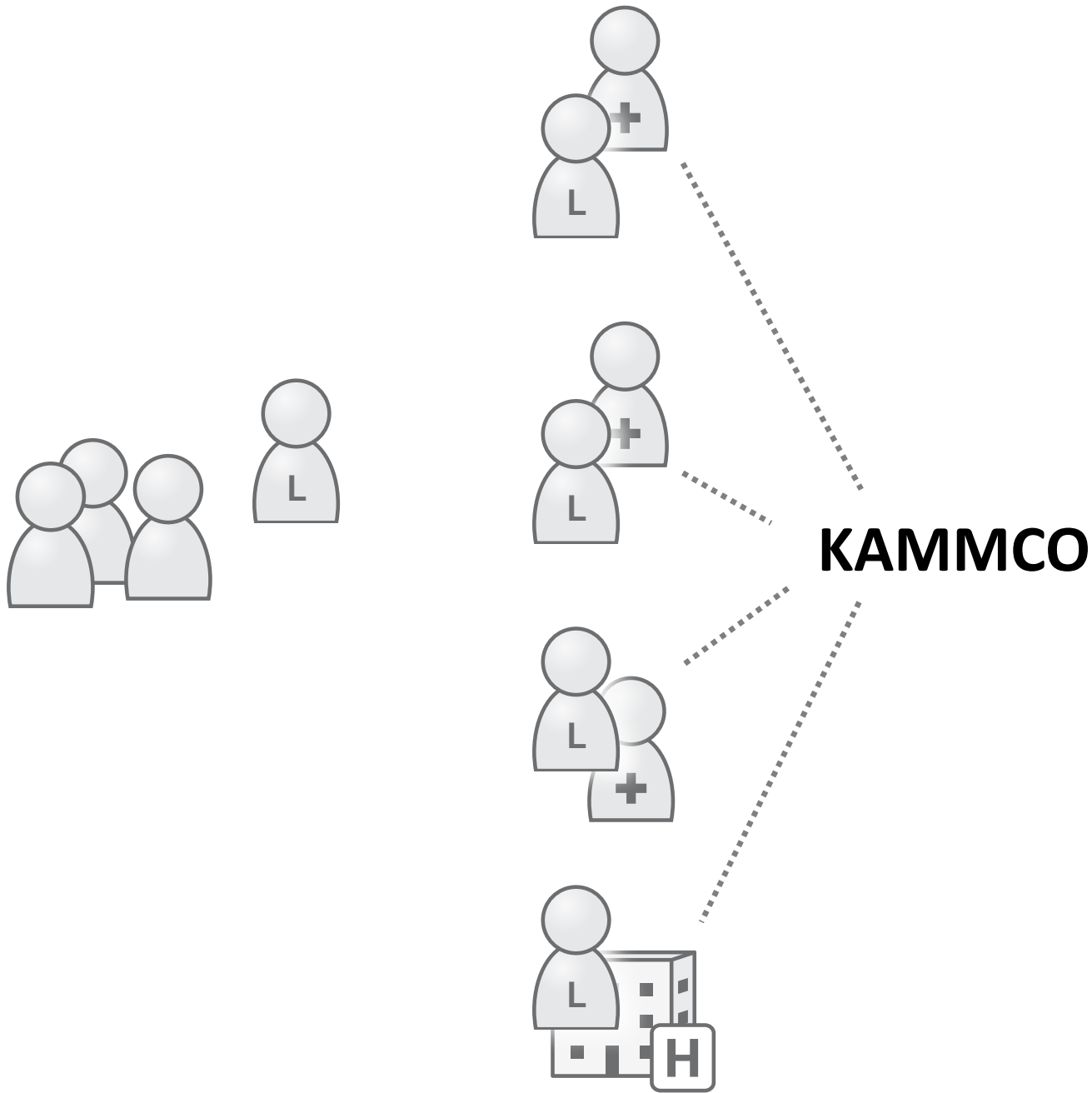


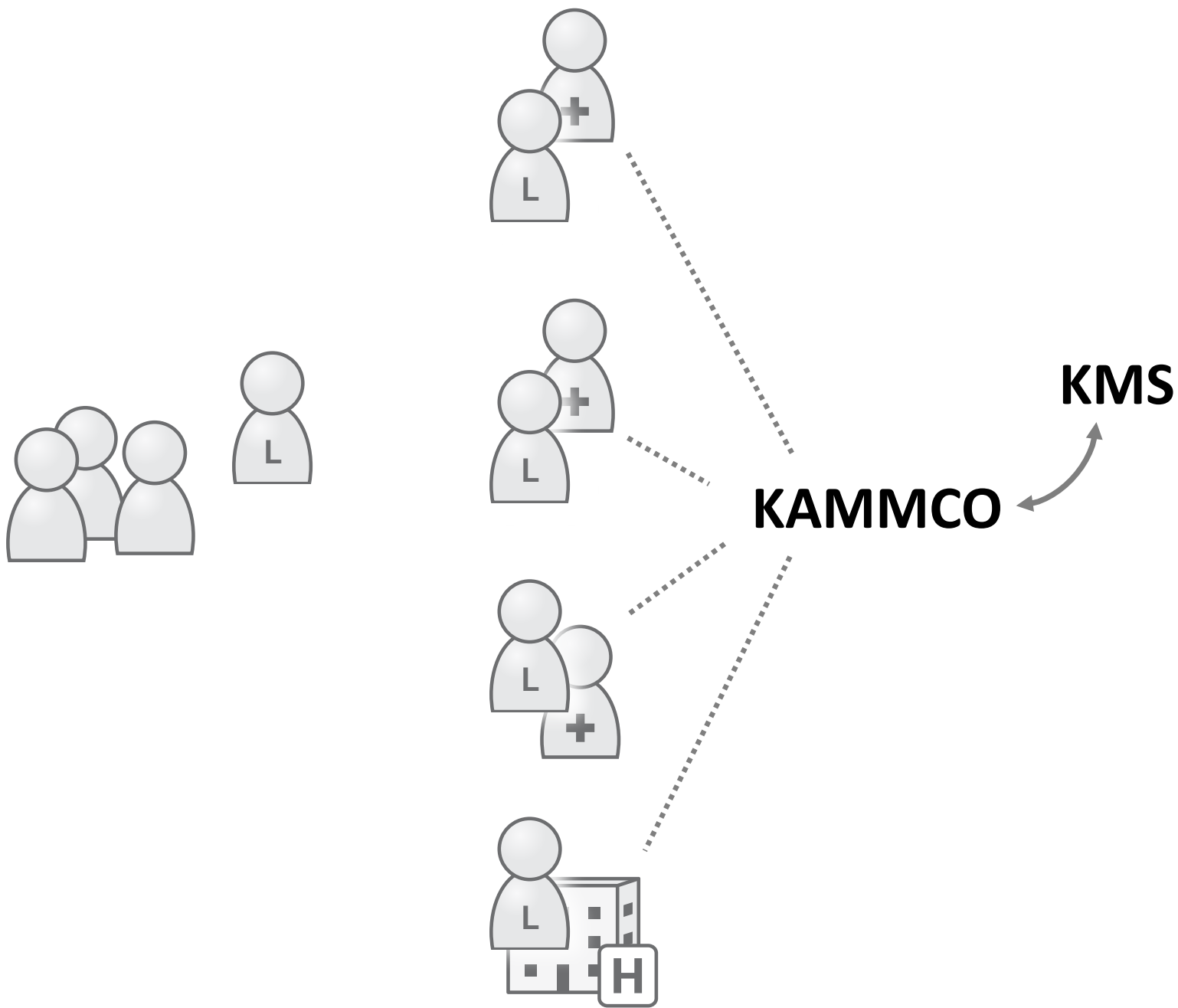


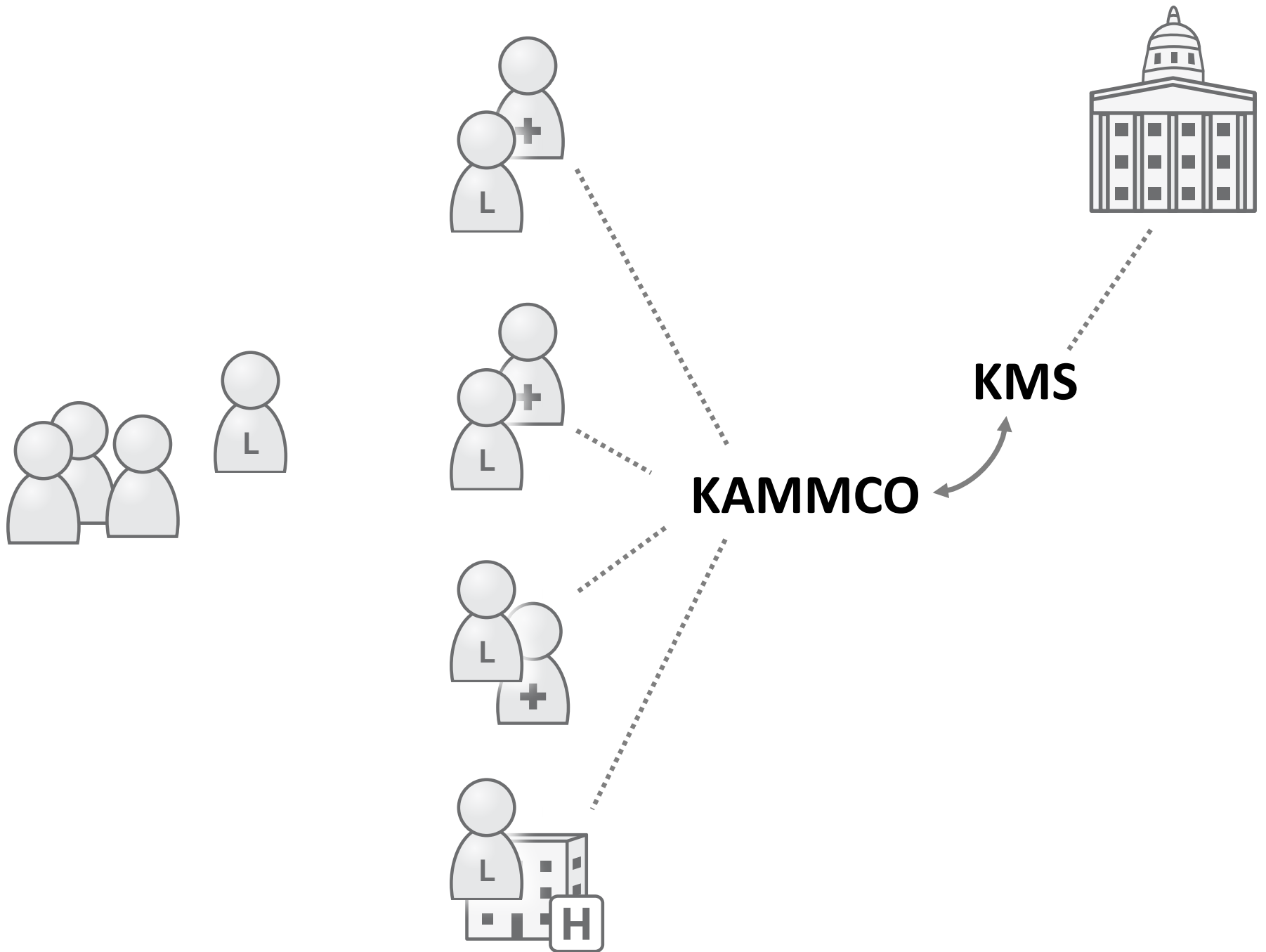


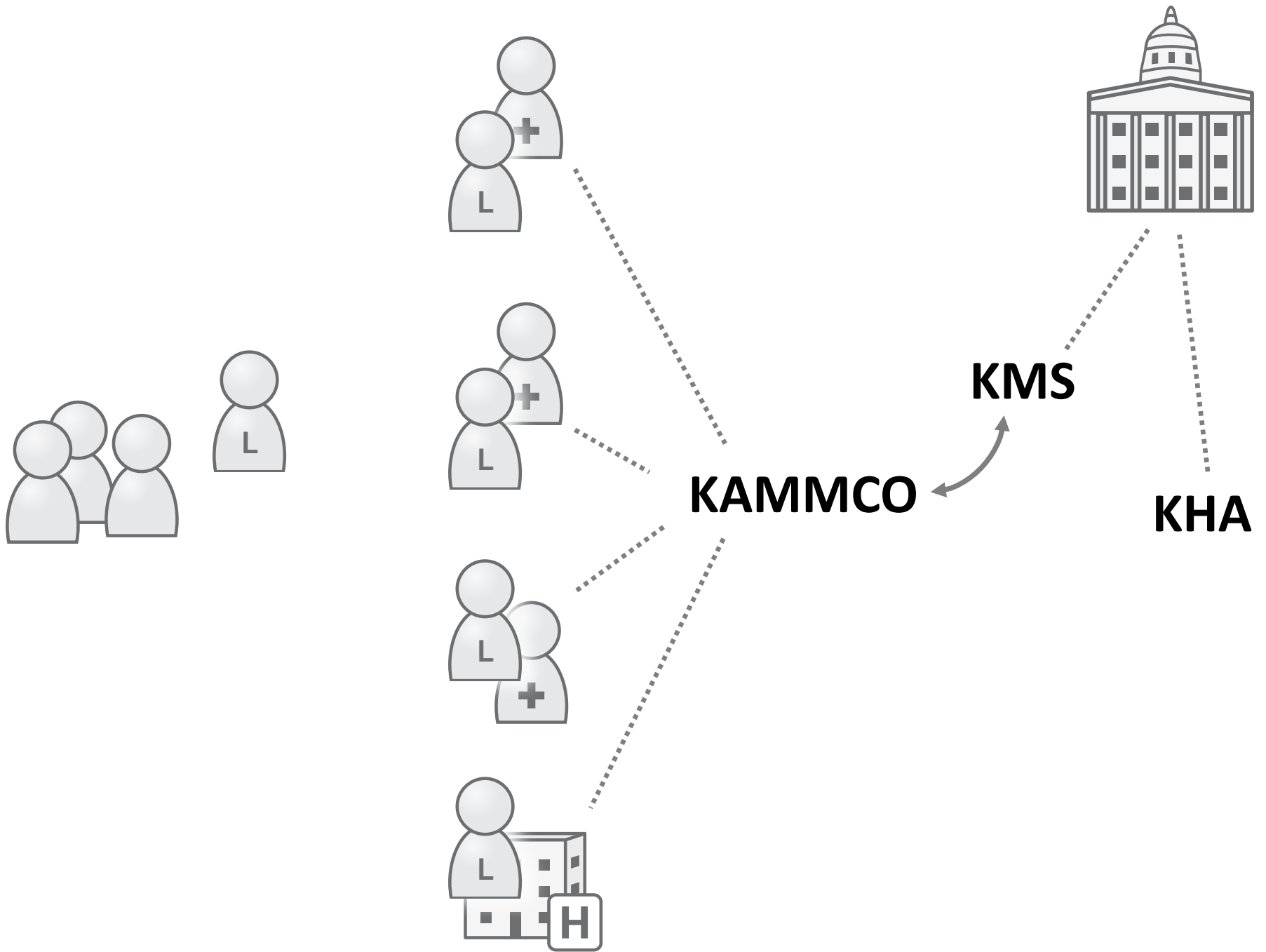
KAMMCO

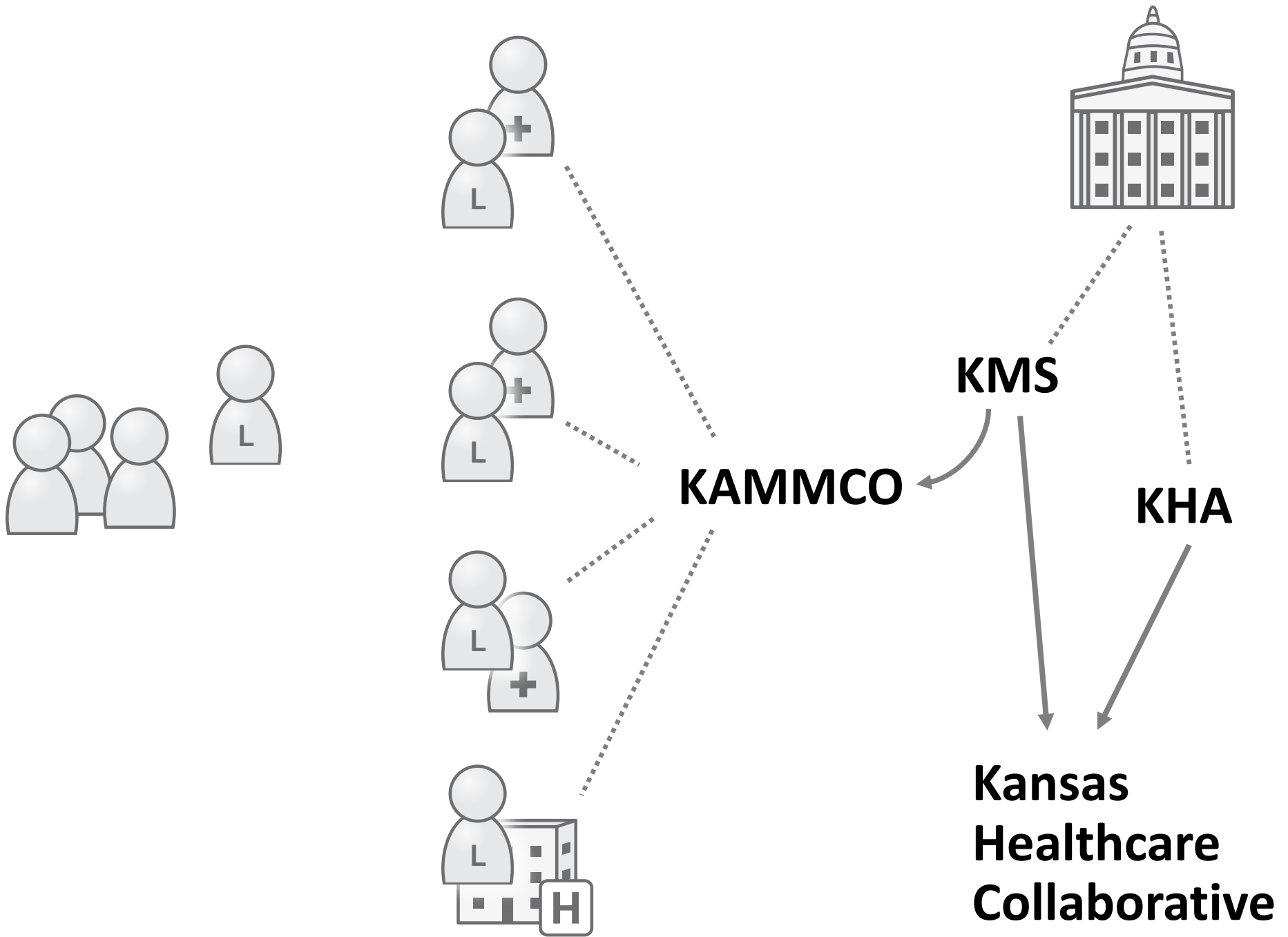






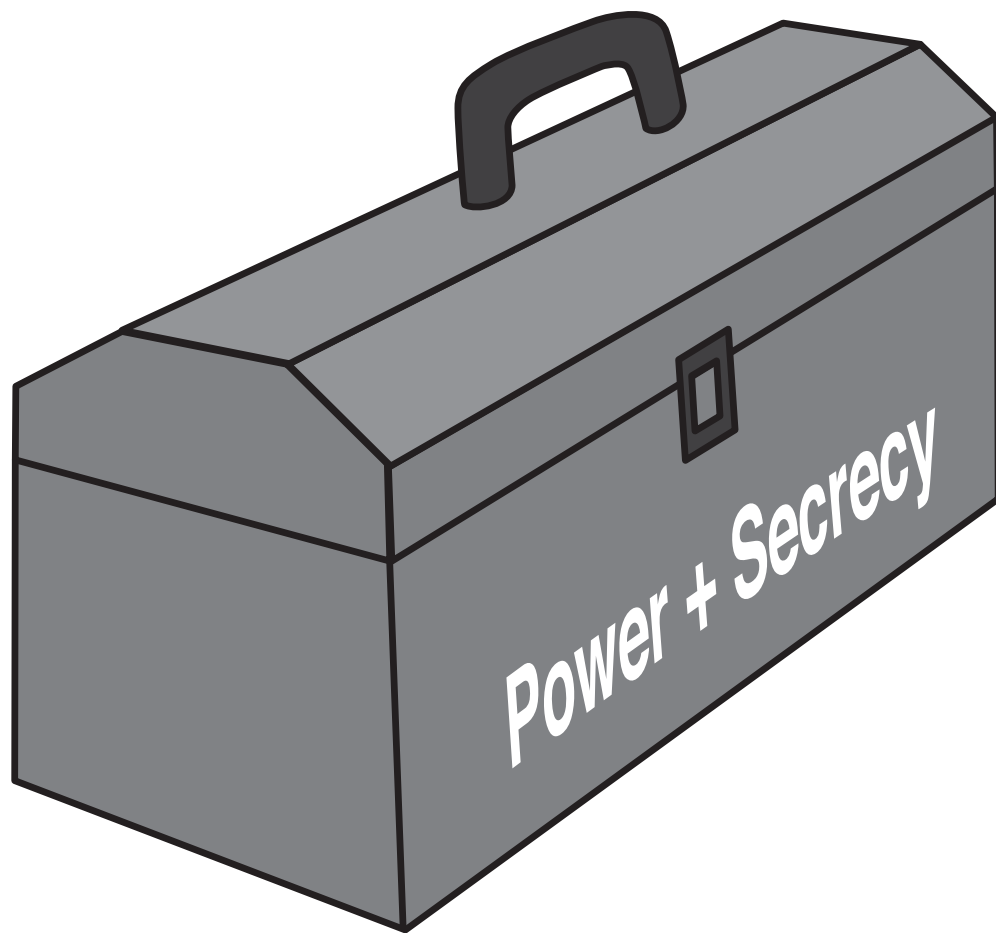






Tools of power and secrecy:

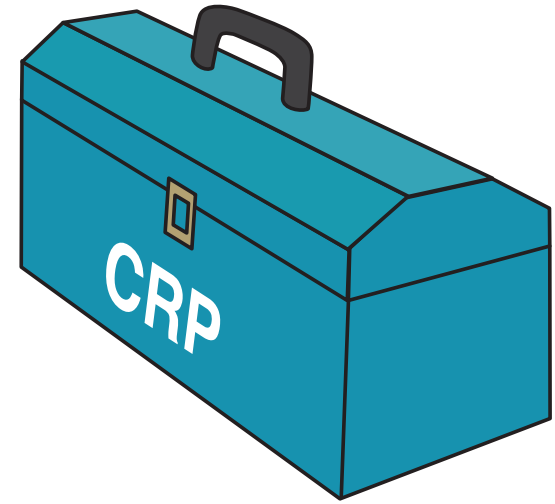
“Risk management”



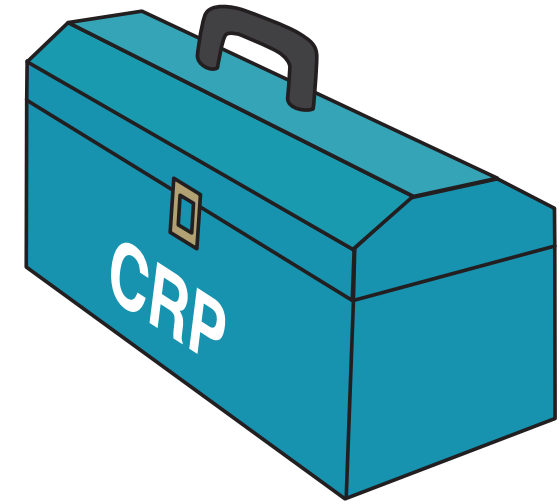
Patients and families have expectations after medical harm

- Timely explanation of what happened and why
- Mitigate consequences (“make it right”)
- Institutional changes to prevent from happening in future
- An apology

A better way:



Communication and Resolution Programs



A better way:

Communication and ~~Resolution~~ Programs Reconciliation

CRPs are based on a set of core commitments

1. Bring transparent with patients and families about what happened and why
2. Analyze adverse events and implement plans to prevent recurrences
3. Support emotional needs of patient, family, and care team
4. When care was unreasonable, proactively offer compensation

CRPs are based on a set of core commitments

5. Educate patient / family about right to seek legal representation at any time
6. When adverse events involve multiple parties, work collaboratively
7. Continuously assess the effectiveness of the CRP

communicationandresolution.org

**Collaborative**
FOR ACCOUNTABILITY
AND IMPROVEMENT
Reaching resolution after patient harm

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Healthcare organizations now have a compassionate and effective model for addressing patient harm

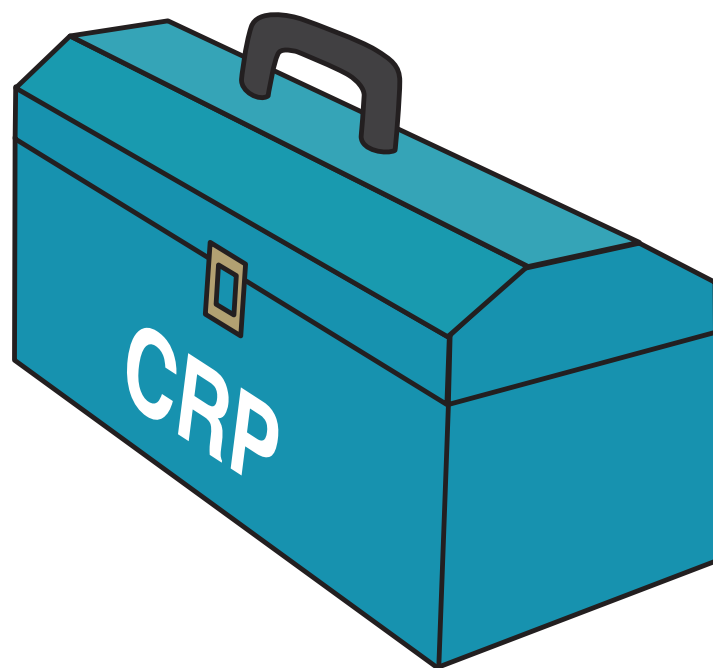
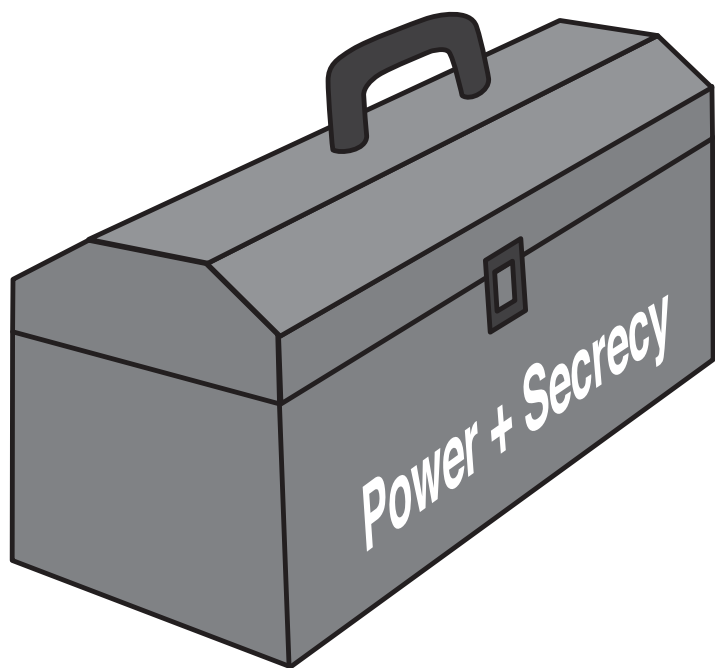
Communication and Resolution Programs (CRPs) are the emerging best practice for addressing patient harm.

When something goes wrong during healthcare, the best response is rapid and compassionate, and promotes healing for all involved. CRPs guide this response, leading to optimal resolution and improved patient safety. Empathetic communication, accountability, and application of learning to prevent similar incidents from recurring are at the heart of the process. Increasingly viewed as the future of healthcare, CRPs are adopted by some of the largest hospital systems across the country.

The Collaborative for Accountability and Improvement is dedicated to accelerating the spread of CRPs to healthcare institutions everywhere. The Collaborative brings together CRP innovators and respected experts in healthcare, law, and patient advocacy to support effective implementation and ongoing improvement of CRPs through training, shared learning, and advocacy.

Contact us to get started with a CRP at your institution.

Our education, training and hands-on support give healthcare leaders, providers, and risk managers a clear roadmap to establish and sustain a successful CRP.

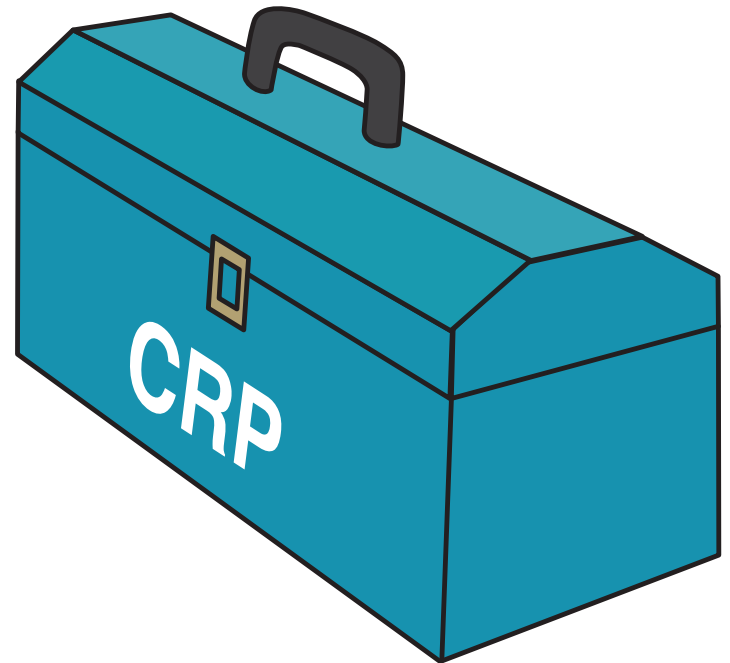


I believe that three groups are essential to making CRPs a reality

Insurance companies

Nurses

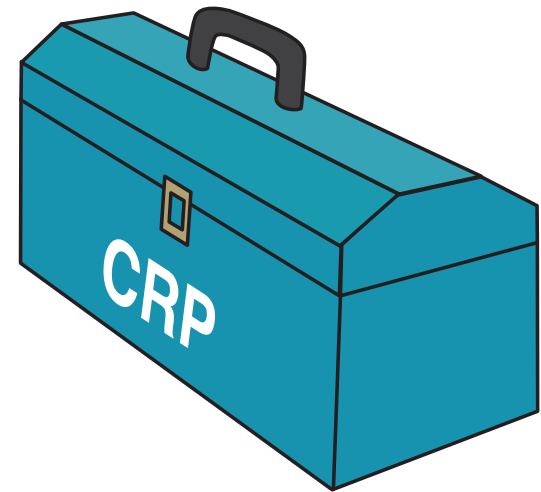
Students



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communicationandresolution.org