Disclosure of Adverse Outcomes to Patients: Narratives and Beyond

Harvard Colloquium on Patient Safety

Rosemary Gibson

August 21, 2007

Cambridge, MA

Two Levels of Disclosure to Patients

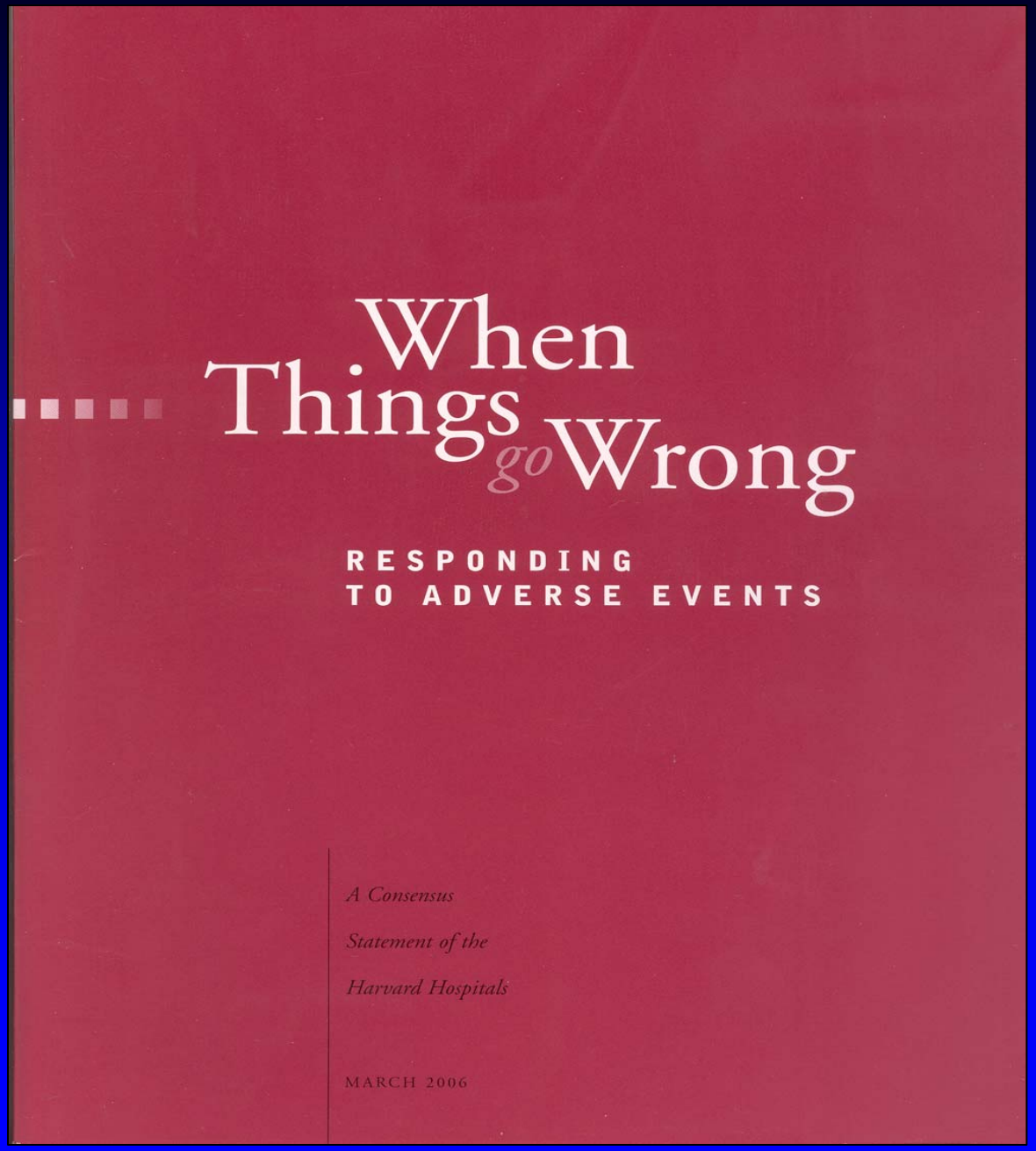
- **1. At the individual level – to patients and families**
- **2. At the organizational level: disclosure to the community for accountability for patient safety**

Disclosing to Patients & Families

- **Patient narrative…**

“If I can’t picture it, I can’t understand it.”

Albert Einstein


When Things go Wrong
RESPONDING TO ADVERSE EVENTS
A Consensus Statement of the Harvard Hospitals
MARCH 2006

What the Public is Hearing…

- **"The number of people needlessly killed by hospital infections is unbelievable. For years, we've just been quietly bundling the bodies of patients off to the morgue while infection rates get higher and higher."**

  Dr. Barry Farr
  Former President, Society for Health-care Epidemiologists of America
  Quoted in the Chicago Tribune

Data Show Scourge of Hospital Infections

Alarms raised on hospital infections

The Public Wants More than Disclosure to Patients and Families

- **They want to know that adverse outcomes won't happen to others**
- **They want disclosure of performance at the level of the organization for accountability**

The Public is Also Hearing How Good Health Care Can Be…

- **Public is becoming aware of IHI's work to reduce infections, and progress on MRSA in Sweden, Netherlands**
- **Pronovost's work with Michigan hospitals to reduce CLABs by 66% in 3 months**
- **Message: infections are not inevitable**

Motivation for the Public's Interest

- Experience of suffering and death
- 2 million people acquire infections in hospitals; 99,000 people die
- Data persuades, emotion motivates
- Every data point is a person

- **The other burdens of HAIs…**

Consumers Union Campaign: StopHospitalInfections.org

- **CU launched a campaign in 2003 to pass state laws requiring that hospitals publicly report infections**
- **To date, 19 states have passed laws requiring public disclosure of hospital infections**

Consumers Union

Publisher of Consumer Reports

End hospital secrecy and save lives.

Stop Hospital Infections .org

TAKE ACTION | NEWSROOM | LEARN MORE | SHARE YOUR STORY | DISCUSS THE ISSUES | LETTER TO THE EDITOR | DONATE

Your governor can help stop dangerous "super bug" in local hospitals!

A virulent "super bug" spreading in our hospitals poses **a deadly risk to patients** and drives up the c ost of hospital care. Most common antibiotics can't cure methicillin-resistant Staphylococcus aureus (MRSA) infections. People who develop them while in the hospital often suffer for years with additional hospitalizations and surgeries.

While some U.S. hospitals have implemented effective strategies to curb MRSA, most hospitals have not--**but they will if the public demands action**.

Directed by your governor, your state health department can assess each hospital's prevention program and then let the public know which hospitals are taking this deadly epidemic seriously. **Tell the Governor to make this a priority.** **41,202 letters sent so far!**

Just fill out the form below and send your email today! If you or a loved one have experienced MRSA, please tell the governor about your struggle in the "personalized" section of the letter below.

* Title:

* First Name:

Send This Message

Stop the spread of MRSA hospital infections

Dear *[Decision Maker]*,

A recent study found that hospital patients with increasingly

The Philadelphia Inquirer

Tuesday, November 14, 2006

Report: 19,000 Patients got Infections in Pa. Hospitals

By Josh Goldstein
INQUIRER STAFF WRITER

More than 19,000 patients in Pennsylvania contracted infections while being cared for at a hospital last year, driving up costs, hospital stays and death rates, a state agency reported today.

The report from the Pennsylvania Health Care Cost Containment Council marks the first time people anywhere in the country can examine how many patients became infected at a particular hospital. The independent state agency found 19,154 such cases in 2005.

Patients who got infections while at a hospital spent four times the number of days there as those who did not acquire infections. As a result, infected patients' bills were nearly 600 percent higher, the report said. More significant, patients with hospital-acquired infections had higher death rates. The death rate of patients with infections was 12.9 percent, amounting to 2,478 people, compared with 2.3 percent of other patients.

"Pennsylvania has taken a bold step toward transparency in health care," said Marc P. Volavka, executive director of the Cost Containment Council. "This is now a measure from which we can examine individual hospitals' improvement in this important area of patient safety."

Volavka cautioned that because of differences in how well hospitals tracked and reported infections, patients and their families should not use the report to compare institutions.

The report does, however, give patients a good place to begin asking questions of their doctors, hospitals and other care providers about infection rates and other preventable complications, he said.

Health care experts agree that the more the public asks about medical complications, the better providers will become at avoiding them.

"Certainly I believe this will improve how hospitals will perform," said John J. Kelly, chief medical officer at Abington Memorial Hospital.

Reporting of infections needs to be standardized across hospitals, Kelly said. He noted that a glitch at Abington resulted in a significant overreporting of urinary tract infections by the suburban hospital.

"Just as we overreported, I suspect there may also be some underreporting, Kelly said.

The report should be used by hospitals to make improvements, Volavka said.

The infection report comes after two years of work by the Cost Containment Council. During that time, hospital administrators and doctors have raised concerns about the epidemiological soundness of the agency's approach.

Transparency & Communication On Hospital/System Performance

“An object at rest tends to stay at rest and an object in motion tends to stay in motion with the same speed and in the same direction unless acted upon by an external and unbalanced source.”

Isaac Newton