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PATIENT SAFETY & MEDICAL LIABILITY

Editorial

CANDOR: The Antidote to Deny and Defend?

On September 9, 2009, President Barack Obama dispatched the Department of Health and Human Services on a mission to explore the related problems of health care's inadequate focus on patient safety and the proliferation of medical malpractice litigation. One approach to these sibling challenges is a principle-based, proactive, and transparent response to patients who have experienced injury due to an adverse event. Disclosure and resolution call for health care professionals and institutions to investigate adverse events and honestly explain what happened to patients and families, leveraging patients' experience quickly to improve patient safety and prevent the recurrence of such incidents, and, when appropriate, apologize and offer fair compensation.

This approach is now embodied in the recently released Agency for Healthcare Research and Quality's Communication and Optimal Resolution (CANDOR) toolkit (AHRQ 2016), which represents a synthesis of best practices from early adopters, such as the Michigan model first formulated in 2001, and identified by a number of the Patient Safety and Medical Liability Demonstration grantees whose experience from implementing this approach is reported in this Special Issue (Helmchen, Lambert, and McDonald 2016; Mello et al. 2016). An anecdote from one of those projects illustrates the most common challenge to adoption. After the basics of disclosure and resolution were outlined to the participants, a skeptical insurance executive exploded: "Why in hell would we do this? We're already paying out a king's ransom! You must be insane." Viewing disclosure and resolution entirely through the eyes of a claims manager, the executive missed the point. The critical bridge between his insured health systems' core mission and how they responded to injured patients escaped him. CANDOR's power and its potential can only be fully appreciated by grasping that link.

The connection between a health care organization's attitude toward injured patients and the organization's existential mission has been missed for decades. Medicine is inherently dangerous; the dangers cannot be fully controlled and health care is not likely to be completely safe anytime soon. Patients will continue to experience unintended outcomes that range from insignificant to catastrophic even under the best of care. We should control what we can control, however, and to quote Shakespeare's Hamlet, "aye, there's the rub."

Scholars have frequently observed, "For over a century, American physicians have regarded malpractice suits as *unjustified* affronts to medical professionalism, and have directed their ire at plaintiffs' lawyers... and the legal system in which they operate" (Sage 2005). "Physicians revile malpractice claims as *random* events that visit *unwarranted* expense and emotional pain on competent, hardworking practitioners..." (Studdert, Mello, and Brennan 2004). The simple truth is that because unintended outcomes *can* happen even with the best of care, health care has tarred them all with the same brush and, sadly, sidestepped accountability for those injuries that occur as a result of *avoidable medical mistakes.* Ironically, treating injured patients as financial threats leaves patients feeling abandoned without answers and induces hospitals myopically to expose other patients to the risk of the same bad outcome, precisely the factors that compel patients to seek legal advice (Hickson et al. 1992; Vincent, Young, and Phillips 1994; Marcus 2002). The way health care organizations chose to respond to injured patients paradoxically created the malpractice predicament and, sadly in the process, erected a sizeable barrier to clinical improvement.

What is the antidote? CANDOR is not merely a proactive claims management strategy designed to settle claims more quickly and more cheaply. Savvy claims professionals have performed that for decades. Moving cases in a more cost-effective manner may ameliorate some of the pain and expense of "deny and defend," but it is merely a Band-Aid™ and does nothing to help identify the quality and safety risks that can and should be controlled. Elementally, CANDOR is a deliberate strategy intent on *normalizing honesty, transparency, and accountability.* As such, health care leaders must see their organization's response to injured patients, not as an exclusive province of lawyers and risk managers,

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but first and foremost as integral to their clinical responsibility. They must insist on an honest and transparent response to patients harmed in their organization, not just because it is a moral and ethical imperative, but because honesty serves a true culture of safety that is indispensable to their organization's core mission.

Axiomatically, all safety and quality improvements must follow a simple path: (1) problems must be aggressively identified because logically one cannot fix a problem one does not know about; (2) problems must be analyzed and prioritized because attacking myriad issues haphazardly will create chaos; (3) fixes must be tried and tested for effectiveness and durability, and to detect unintended consequences, because health care is interconnected and the status quo resists change; and (4) good news must be communicated, to show staff that speaking up yields true improvement, which will, in turn, engender their trust and engagement and spur more reporting. Fulfilling all four steps fires the engine of improvement. Health care leaders must deeply care how their organizations respond to injured patients because "deny and defend" interferes with every step on the path to improvement (Boothman, Imhoff, and Campbell 2012).

The future of CANDOR hinges on understanding *why* it is indispensable to health care's core mission. Seen solely as the province of lawyers, risk managers, and insurance executives, at best, CANDOR will be used selectively to cherry-pick claims for resolution largely for business reasons. If the implementation of this approach is dependent entirely on converting lawyers, risk managers, and insurance executives to see injured patients differently, opportunities for improvement will be lost. What makes this response unique is that it lays the groundwork for clinical improvement and lights the path to patient centricity.

In those health organizations that have tried disclosure and resolution programs and failed, leadership did not absorb its connection to their core mission and did not actively and personally support adoption against the skeptics and doomsayers. As regulatory and accreditation organizations like the Centers for Medicare & Medicaid Services (CMS) and The Joint Commission recognize the bridge between an organization's honesty and transparency toward injured patients and the prioritization of safety within the organization's culture, those that embrace transparency and accountability will be rewarded with greater patient satisfaction, better clinical outcomes, and a competitive advantage. Health care leaders will instinctively understand the benefit to their organizations as well as to the individual patient. Instead of demanding, "Why in hell would we do this?" they will ask, "Why would anyone NOT do this?"

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