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Patients' Experiences With Communication-and-Resolution Programs After Medical Injury

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IMPORTANCE Dissatisfaction with medical malpractice litigation has stimulated interest by health care organizations in developing alternatives to meet patients' needs after medical injury. In communication-and-resolution programs (CRPs), hospitals and liability insurers communicate with patients about adverse events, use investigation findings to improve patient safety, and offer compensation when substandard care caused harm. Despite increasing interest in this approach, little is known about patients' and family members' experiences with CRPs.

OBJECTIVE To explore the experiences of patients and family members with medical injuries and CRPs to understand different aspects of institutional responses to injury that promoted and impeded reconciliation.

DESIGN, SETTING, AND PARTICIPANTS From January 6 through June 30, 2016, semistructured interviews were conducted with patients (n = 27), family members (n = 3), and staff (n = 10) at 3 US hospitals that operate CRPs. Patients and families were eligible for participation if they experienced a CRP, spoke English, and could no longer file a malpractice claim because they had accepted a settlement or the statute of limitations had expired. The CRP administrators identified hospital and insurer staff who had been involved in a CRP event and had a close relationship with the injured patient and/or family. They identified patients and families by applying the inclusion criteria to their CRP databases. Of 66 possible participants, 40 interviews (61%) were completed, including 30 of 50 invited patients and families (60%) and 10 of 16 invited staff (63%).

MAIN OUTCOMES AND MEASURES Patients' reported satisfaction with disclosure and reconciliation efforts made by hospitals.

RESULTS A total of 40 participants completed interviews (15 men and 25 women; mean [range] age, 46 [18-67] years). Among the 30 patients and family members interviewed, 27 patients experienced injuries attributed to error and received compensation. The CRP experience was positive overall for 18 of the 30 patients and family members, and 18 patients continued to receive care at the hospital. Satisfaction was highest when communications were empathetic and nonadversarial, including compensation negotiations. Patients and families expressed a strong need to be heard and expected the attending physician to listen without interrupting during conversations about the event. Thirty-five of the 40 respondents believed that including plaintiffs' attorneys in these discussions was helpful. Sixteen of the 30 patients and family members deemed their compensation to be adequate but 17 reported that the offer was not sufficiently proactive. Patients and families strongly desired to know what the hospital did to prevent recurrences of the event, but 24 of 30 reported receiving no information about safety improvement efforts.

CONCLUSIONS AND RELEVANCE As hospitals strive to provide more patient-centered care, opportunities exist to improve institutional responses to injuries and promote reconciliation.

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Invited Commentary
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The misery of medical malpractice litigation for all involved[1-3] has made hospitals keenly interested in resolving medical injuries with patients before claims are filed. Among the strategies receiving attention are communication-and-resolution programs (CRPs), in which hospitals disclose adverse events, investigate, apologize, explain what happened, and when appropriate, proactively offer compensation.[4-6] Several reports suggest that CRPs can improve patient safety and reduce liability costs[7-9]; however, some commentators question whether they treat patients fairly.[10,11]

The literature about the needs of injured patients highlights that poor responses from health care providers can exacerbate the psychological, physical, and financial effects of adverse events.[12,13] Researchers have occasionally described patients' experiences of medical injuries, highlighting that institutions' responses frequently fail to meet expectations.[14,15] Applying these findings to CRPs is challenging, however, because the results "lack the granularity necessary to identify specific improvements" to serve the needs of the patients.[16(p2)]

Despite investment by the Agency for Healthcare Research and Quality in disseminating the CRP model,[17,18] patients' experiences with CRPs have not been investigated. Such research presents challenges[19]; hospitals worry that asking patients about their experiences could provoke distress or lawsuits. The resulting knowledge gap impedes development of patient-centered responses to medical injury.

Through interviews with patients and others, we explored what hospitals need to do to promote reconciliation after injury, what existing CRPs are doing well, and what hospitals could do better. We define *reconciliation* as engaging with patients and families about an unexpected outcome of care and offering remediation, with the goals of acknowledging and redressing emotional, physical, and financial harm; expressing an ethic of continuing care for the patient; and restoring trust.[16]

Key Points

Question Do patients' and families' experiences with communication-and-resolution programs suggest aspects of institutional responses to injury that could better promote reconciliation after medical injuries?

Findings This interview study of 40 patients, family members, and hospital staff found that patients have a strong need to be heard after medical injury that is often unmet. Although 18 of 30 patient and family participants (60%) reported positive experiences with communication-and-resolution programs overall and continued to receive care at the hospital, they reported that hospitals rarely communicated information about efforts to prevent recurrences.

Meaning Opportunities are available to provide institutional responses to medical injuries that are more patient centered.

Methods

Sites

We conducted interviews at Stanford University Medical Center, Stanford, California; Baystate Medical Center, Springfield, Massachusetts; and Beth Israel Deaconess Medical Center (BIDMC), Boston, Massachusetts (**Table 1**). These academic medical centers were selected because they operate CRPs that maintain patient contact information. Baystate Medical Center and BIDMC collaboratively implemented similar CRPs[20] and were treated as a single unit of analysis. The study was approved by the institutional review boards of Stanford University, Baystate Medical Center, and BIDMC, and all participants gave written informed consent.

Key Informants

We recruited injured patients or their family members for key informant interviews, along with administrators and clinicians involved with the CRPs. Patients and families were eligible for participation if they had experienced a CRP, spoke English, and could no longer file a malpractice claim because they had accepted a settlement or the statute of limitations had expired. The last criterion addressed hospitals' concerns about prompting lawsuits. The focus of this study was the experiences of patients and families with CRPs. Therefore, we primarily recruited patients and families rather than administrators and clinicians.

The CRP administrators identified hospital and insurer staff who had been involved in a CRP event and had a close relationship with the injured patient and/or family. The administrators identified patients and families by applying the inclusion criteria to their CRP databases. Family members were invited if the patient was deceased or a minor. Hospitals sent the study invitations, which stated that external researchers were conducting the study and allowed key informants to choose whether to share interview transcripts with CRP staff.

Interviews

Interviews were semistructured and used an interview guide informed by a prior study of injured patients from New Zealand (NZ).[16] Questions focused on the patient's injury experience, the hospital's response, and relationships between patients and individual clinicians as well as hospitals after the injury.

One of us (J.M.) conducted the interviews from January 6 through June 31, 2016. Interviews with staff and insurers lasted 45 to 90 minutes. Interviews with patients and families lasted 60 to 180 minutes, at the key informant's discretion. Eleven key informants chose telephone interviews and 29 chose face-to-face interviews at their home or workplace. Interviews were audio recorded and transcribed.

Data Analysis

Data were analyzed following the principles of grounded theory using NVivo (version11; QSR International).[21] Using transcripts from the first 6 interviews, 2 of us (J.M. and M.B.) used thematic content analysis[21] to independently identify the main themes, which formed the basis of a coding scheme. The 2 coding trees were discussed in detail, and any differences were resolved by negotiated agreement. One of us (J.M.) then coded the remaining transcripts, generating initial theories and continually comparing them against newly coded data.[22] For some questions, frequencies of responses were tabulated.

Table 1. Study Site Characteristics

Characteristic	Stanford University Medical Center	BIDMC	Baystate Medical Center
Hospital type	Teaching hospital and level I trauma center	Teaching hospital and level I trauma center	Teaching hospital and level I trauma center
No. of beds	613	672	716
Liability insurance arrangement	Self-insured	Risk retention group	Self-insured
CRP name	Process for Early Assessment and Resolution of Loss	Communication, Apology, and Resolution	Communication, Apology, and Resolution
Years since CRP implemented	9	3.5	3.5

Abbreviations: BIDMC, Beth Israel Deaconess Medical Center; CRP, communication-and-resolution program.

Results

We completed interviews with 40 of 66 identified informants (61%) (15 men and 25 women; mean [range] age, 46 [18-67] years). These participants included 30 of 50 invited patients or family members (60%) and 10 of 16 staff (63%).

Participant Characteristics

Distribution of the key informants across hospitals was fairly even (**Table 2**). Nearly all were working-aged adults, and 3 were parents of injured children. Staff respondents included 4 physicians and 6 CRP staff. Risk managers judged 27 of 30 patient injuries to have been attributable to error. Of the 30 patients and family members, 26 had received settlements, 1 had medical bills waived, and 3 had received no compensation.

Aspects of Hospitals' Responses to Injuries That Promote Reconciliation

Initial Approach

Of the several features of CRPs that promote reconciliation revealed by the interviews (**Table 3**), 29 patients or family members reported that the hospital's initial approach after the injury set a tone that heavily influenced further interactions. When the approach was mishandled, hospital staff struggled to remediate the strain that ensued. Four elements were particularly important for making a successful approach.

First, 22 of 30 patients and families wanted the hospital's first contact after the initial disclosure conversation to be by letter or email rather than telephone. Written contact felt less intrusive, provided space to process the information, and allowed patients and families to contact staff when they believed they were ready.

Second, 19 of 30 patients and families highlighted the importance of physical privacy in the aftermath of injury, which was scarce for hospitalized patients. One patient reported the following interaction:

The risk management people came to see me....There was a patient in the bed opposite me who was trying to pull his tubes out, so there was a swarm of nurses around that bed....It was just noisy chaos....It's not a conversation about the weather, you know; it's...very upsetting.

Private space was important for the sensitive discussions and for the emotional response. Respondents suggested that hospitals provide patients with a private room at no cost.

A third suggestion was to have someone with a role in patient services or safety and quality communicate with the patient or the family after the initial disclosure. Nineteen of 30 patients and family members commented that outreach from risk management made them suspicious about the hospital's intentions. They questioned whether CRP staff "were really there to help the patient or just limit their liability."

Fourth, all respondents (patients, family members, and staff) stressed the importance of having the right people present for the early disclosure conversation(s), including the attending physician. Patients were unsympathetic to excuses, such as "he is not a people person" or "he is too traumatized to talk to you." Seven of 10 staff respondents also recollected that the conversations that went poorly were those in which the involved clinician was absent. One reported, "I hear things like 'I almost wanted to come and bring the money back...because to this day, I still have not heard from that doctor.'" Eleven patients and family members mentioned that social workers should not be part of initial conversations because they cannot answer medical questions, and their presence triggered fears that the patient had died.

Communication Practices

Participants mentioned several communication practices that facilitated reconciliation. First, patients and families needed to be heard during disclosure discussions—not just receive information. They wanted clinicians and CRP staffers to listen attentively without taking notes, interrupting, or asking that patients confine themselves to clinically relevant information.

Second, 35 of 40 participants said that plaintiff's attorneys can be useful during the CRP process, to provide support and help ensure that patients are treated fairly. Eight patients and family members received attorney advice or representation, and 18 of the 22 who did not wished they had. The CRP staff and physicians were less uniformly enthusiastic about plaintiff attorneys than patients and families; one stated that attorneys may be a "blessing or a curse," and others distinguished between good attorneys who understood CRPs and others who were less knowledgeable. However, most staff endorsed plaintiff attorney involvement. As one noted, CRPs are sometimes criticized for trying to "cheat the patient out of his legal right or entitlement," and that having compensation offers evaluated by attorneys reassures everyone. It "makes us feel better," she continued, and "We've had attorneys say to the

Table 2. Interview Respondent Characteristics

Characteristic	Patients and Family Members (n = 30)	Healthcare Institution Staff and Insurers (n = 10)
CRP		
PEARL	11	5
CARe	19	5
Classification		
Error	27	NA
Nonerror	3	NA
Severity rating		
Death	3	NA
Permanent physical harm	8	NA
Temporary physical harm	19	NA
Clinical area		
Surgery	14	NA
Obstetrics	1	NA
Gynecology	1	NA
Hematology and oncology	3	NA
Pediatrics	3	NA
Radiology	3	NA
Emergency medicine	5	NA
Age group, y		
18-20	1	0
21-39	1	0
40-64	26	9
≥65	2	1
Sex		
Female	21	4
Male	9	6
Race/ethnicity		
European	27	8
Hispanic	2	0
Asian	1	0
Other	0	2
Educational level		
High school	1	0
Trade school	6	1
College	16	1
Graduate school	7	8
Time since initial injury, y		
2-3	20	NA
4-6	10	NA
Professional role		
CRP leader	NA	1
CRP staff member[a]	NA	4
CRP patient liaison	NA	1
Physician	NA	4

Abbreviations: BIDMC, Beth Israel Deaconess Medical Center; CARe, Communication, Apology, and Resolution (Beth Israel Deaconess Medical Center); CRP, communication-and-resolution program; NA, not applicable; PEARL, Process for Early Assessment and Resolution of Loss (Stanford University Medical Center).

[a] Includes risk managers and claims handlers.

patients, 'No, that's fair, what you are being offered.' And it makes them feel better."

Participants described the following specific attorney practices that facilitated reconciliation: (1) allowing patients to tell their story, which had therapeutic value; (2) avoiding an adversarial posture during discussions with the hospital; and (3) asking patients about the outcomes that they hoped for, including the relationship that they wanted with the clinician going forward. One patient credited these practices with enabling him to regain trust in clinicians who he had previously viewed as "evil."

Third, 28 of 30 patients and family members reported that they "hate that word, resolution," and 23 of 30 preferred an alternative such as "reconciliation." A patient explained, "It's not resolved, because I've lost a loved one." Participants in the prior study of injured patients in NZ[16] also disliked references to "resolution."

Relaying Safety Information

Although all 10 hospital and insurer staff said they told patients and families about efforts undertaken to prevent recurrences of the event, 24 of 30 patients and family members complained that this had not occurred. One family member recalled, "The hospital administrator risk guy…said, 'We're doing a full report on this. We'll give it to you before you leave the hospital'….We never got anything. That was very disappointing." For many patients and families, omitting safety information impeded reconciliation: "It's not resolved because I don't know if there was change." To ensure that this loop is closed every time, hospitals should document follow-up items promised to patients and review the list when the incident file is closed.

Compensation

Of 27 patients and family members who reported that they received compensation, 16 felt satisfied with it. Those who found it to be inadequate also described dissatisfaction with the overall communication process.

Participants identified the following 2 elements of the compensation process that contributed to successful reconciliation: proactive payment and a personal touch. Twenty-two of 30 patients and families experienced financial stress after the injury; thus, rapid compensation was critical. Patients wanted hospitals to inquire about looming bills, especially for low-income families, and offer help with them.

A gap occurred in perceptions about how proactive hospitals' offers of compensation were. The CRP staff said their philosophy was, "Don't wait for the demand, present the offer." However, 17 patients and families wished that the offer had come sooner without their having to specifically ask for compensation. When the offer was proactive, patients expressed appreciation; for instance, "They said, 'I know you are out of vacation time, you're losing your pay…we are going to buy you back [vacation] time.'"

Twenty-six patients and families discussed the need for a personal touch to ensure a humanized compensation process. One recommended practice was conducting face-to-face meetings or home visits, rather than using letters or email, after the initial written communication. Another was keeping communications nonadversarial. Some CRP staff gar-

Table 3. Aspects of CRPs That Promoted Reconciliation

Aspect Cited	Illustrative Interview Quotations (Informant)
The initial approach	
Emotional space	"I call the patient or family. I'm introducing myself to them. I'm explaining that we want to understand what happened [and] ask them if they have any specific questions or concerns. I follow up with a letter." (CRP staff member) "I think they should start with an email or a letter, instead of the phone call, because everybody has different things they're dealing with." (patient)
Physical space	"I think everybody that they injure should get a private room…because when you're that upset and confused, and things didn't go right, the last thing you need is to deal with other people in the room." (family member)
Right office	"The first letter I got I was pretty cynical about because the letterhead was [the risk management office]….They want to be really nice to me—yeah, sure….Even a different letterhead that doesn't say [Risk Management] would be good." (patient)
Right people	"A patient said to me, 'The physician has not come back and said anything to me. So this isn't ever going to end for me'." (CRP staff member) "I would have liked to only have the surgeon come in when he first met with us and maybe a resident…, but no hospital administrator and definitely no social worker …. I assumed my child was dead, because otherwise what do you need a social worker for?" (family member)
Patient liaison	"When I finally hit [the patient liaison], it did feel like a kindred spirit. It felt safe. I felt at least it would be looked at….There is a relationship there where you are part of a club that you don't want to be a part of." (family member)
Communication practices	
Clinicians	"What meant something to us was people, like the resident, who actually cared….He wrote [my daughter] a letter and came to visit her….He wasn't afraid to actually reach out….That meant something to us, more than an apology." (family member) "The doctor listened and let me talk and talk and talk. I almost cried because it was the first time anyone had heard how I felt. He talked when I was done. It changed how I felt about the hospital." (patient) "The attending should be in the room, no matter how upset he is. I'm not half as upset as the patient or the family. This isn't about me….The attending is the person the patient has a relationship with. That is the person to whom you have given your trust….That's the person who needs to sit in front of you and look you in the eye and say, 'I'm sorry, this is what happened.'" (physician)
Attorneys	"[My lawyer] spent lots of time hearing what I'd been through….He helped me through it all and gave me good advice. He's wonderful, very kind….And he's an expert on this subject. I was so pleased he was in the meeting with me." (patient) "I saw the hospital as my enemy and the doctor as evil. My attorney asked how I'd like the outcome to look and how I saw the relationship with the hospital as part of that. It made me realize that they didn't go into work that day to hurt me and it was the mistake that needed fixing, because they weren't evil people. I was able to trust them again and get more treatment there. I don't know if I'd have got to that point without my attorney, or it'd probably take a lot more time." (patient)
CRP staff	"[The patient liaison] was very good at…helping you feel like you were really heard." (patient) "It only takes one emotionally unintelligent comment and the entire process is derailed." (patient)
Relaying safety improvement efforts	"We tell patients what remedial action has been taken. Ideally, that is done before we meet." (CRP staff member) "I shouldn't have to keep putting my hand up to discover what patient safety policies and practices were put in place." (patient) "They're all about 'Hospital of the Future,' but it's like, 'Don't forget about your hospital of the past'….I just want to know how they've learned from it and if they've put any measures in place…or if they have forgotten." (patient) "They never gave us the report about improvements. It made me feel like only talking to them again through my attorney." (family member)
Compensation	
Proactive payment	"It was stressful. The hospital didn't want to give us money right away, even though they admitted they'd made an error." (patient)
Personal touch	"The claims agent came to my house. She was sensitive and personally felt bad about it and that helped humanize the whole experience." (patient) "[The insurer representative] and I ended up going back and forth for a long time….From my perspective, I also wanted to make sure I understood the full range of whatever the consequences were going to be….[W]e wanted to keep things kind of open until we figured out the overall impact….It was…probably a year or more [until] we finally settled on what the compensation would be." (male patient in his 40s)
Emotional needs of affected children	"I was 14 (a few days from 15) at the time….I never got the apology….I've never seen the collection of those doctors and nurses ever again and that upsets me….There has just been little to no closure." (patient) "My son is…having a hard time. He watched [his sister] go through [the operation]….He said, 'Why am I not invited to talk? I was affected by all this.' I mean, he's 11." (family member)
Feedback	"I've always wanted to give feedback to the hospital, not just about their mistake, but also how they were with me after the fact." (patient) "I would like to see [the providers] now….It's almost like a reminder to say, 'I'm still a real person that walks around, too.' (patient) "I always leave it open….Occasionally I hear back from families months or a year later….They just wish to go over the same territory again and again and again because it allows them some type of connection." (physician)

Abbreviation: CRP, communication-and-resolution program.

nered more positive reviews than others. For example, 1 patient described her compensation negotiations as "breaking the illusion that we're in this cooperative, collaborative process together" because when communication turned to money matters, "the iron fist came out of the velvet glove." A parent reported that they "did not even make an offer….they were so frugal and so aggressive with their mediation." Such experiences compounded patients' sense of victimization. Finally, participants emphasized that compensation discussions must be emotionally intelligent and compassionate.

Table 4. Recommendations for CRPs Emerging From Key Informant Interviews

Question	Recommendation
How should CRPs conduct the initial approach to the patient and family?	Ask patients what form of communication (telephone, letter, or face to face) they prefer after the initial disclosure conversation. Ensure that hospitalized injured patients and their families are immediately given a private room, if possible. Consider having the quality/patient safety office, not risk management or claims, make the initial, written approach to the patient or the family. Strongly encourage the attending physician to lead the initial disclosure conversation and participate in other discussions with the patient aside from compensation discussions. Avoid sending social workers to participate in the initial disclosure conversation with the patient and family. Encourage attorneys and other hospital representatives to adopt a nonadversarial style at all times. Recruit CRP staff with emotional intelligence, an ability to project authenticity, high empathy, and deep belief in the CRP's mission to advance patient-centered care and patient safety. Involve a patient liaison or similar person to help the patient and family navigate the process and provide continuity of communication.
How can CRPs meet patients' and families' emotional needs during the communication process and restore trust?	Create an opportunity for the patient and family to be heard, and be prepared to listen at length. Allow the patient's priorities to lead the discussion. Ensure that patient safety efforts are communicated to patients and family members. If learning takes place over a long timeframe, actively keep in touch with patients and families to share new steps taken. Use the term *reconciliation* instead of *resolution*.
How can institutions best conduct compensation discussions?	Where compensation is merited, offer it without waiting for the patient or family to ask for it. Notify patients that they may consult an attorney. Use face-to-face meetings and telephone calls to conduct compensation communications. Maintain a nonadversarial style. Anticipate the family's immediate financial needs and stressors, such as unpaid bills, and offer proactive assistance. Do not wait to receive a final tally of expenses long after the event occurs.
What ongoing contact, if any, should CRPs have with patients and families?	Routinely invite patients and families to provide feedback on their CRP experience a few months after CRP completion. Talk with parents about whether and how to involve children and siblings in discussions about the injury. Reach out to patients on the anniversary of the event to update them on what the hospital is doing to improve safety and assure them that they have not been forgotten.

Abbreviation: CRP, communication-and-resolution program.

Emotional Needs of Affected Children

Although few of the injuries in our sample involved minors, comments from parents of injured children and from 1 young woman injured at 14 years of age revealed frustration at the inattentiveness of the CRP process to children's needs. For example, the adolescent believed that she should have received an apology and been given a chance to express her feelings; the brother of an injured patient had wanted to share how the injury had affected him.

Patients' Overall Experiences

Based on an overall review of the transcripts, the CRP experience was positive overall for 18 of 30 patients and family members. For those who were dissatisfied, the wider process aggrieved them, not just the compensation aspect. Only 2 respondents characterized the programs as unfair.

Preserving the Therapeutic Relationship

One marker of the success of CRPs is patients' reported satisfaction with the process; another is whether they are willing to receive care at the hospital afterward. Eighteen patients and family members said they did (or would) receive ongoing care there. Some reasoned that errors can occur anywhere; others credited the CRP with restoring their confidence. One explained, "I had trusted [the hospital]....But I could tell that the doctor felt really, really bad. They treated me real nice.... I continued on with [the hospital]." All 8 patients and family members with attorneys chose to receive ongoing care at the hospital, and some specifically credited their attorney for facilitating the reconciliation. Among the 12 patients and family members who discontinued the therapeutic relationship, the main reason was that the hospital had not communicated any patient safety efforts.

Discussion

This exploratory project is the first, to our knowledge, to investigate patients' and families' experiences of CRPs. The key informants' accounts revealed several recommendations for hospitals' responses to patients and family members affected by medical injuries (**Table 4**). Our findings suggest some practices that serve patients' needs.

Consistently Communicate Patient Safety Efforts

Patients and families should be told at the conclusion of the investigation what, if anything, the hospital will do to prevent recurrences. Our findings, along with other research,[23-26] establish that safety improvement is a central concern for injured patients and that failure to communicate safety efforts exacerbates the harm. Therefore, the recommendation to consistently communicate patient safety efforts is well established and essential to undertake.

Although staff in our study claimed that they communicated safety efforts, accounts from patients and families suggest that this communication is sometimes overlooked. Hospitals may be concerned that acknowledgment of systemic weaknesses could expose them to legal action. However, our study and others[27-30] suggest that failing to communicate efforts to prevent recurrences may motivate patients to sue. Other barriers to communicating safety efforts are that the event may not have been preventable[31] or no remedial actions could be identified. Effective CRPs should help patients and family members understand these realities. They need to hear that hospitals have taken their experience seriously and made diligent efforts to determine whether care can be made safer. Hos-

pital representatives can also talk about "what we have learned" from the event, because some type of learning can always be identified from a patient's adverse experience.

Get the Right People in the Room

Consistent with the recent study of the needs of injured patients in NZ[16] and other prior research,[19] all patients and family members in our sample reported a strong need to hear directly from the person responsible for their care. Therefore, the recommendation to strongly encourage the attending clinician to lead the initial disclosure conversation should be considered as essential practice.

Patients and family members had negative reactions to assertions that the clinician was not good at difficult conversations or too upset to talk, and they did not believe that the presence of a division chief or an offer of compensation was an acceptable substitute. Although patients and family members occasionally mentioned other clinicians, such as social workers, their primary concern was that the attending physicians should be involved in the reconciliation process.

Two measures may assist when tension exists between the patients' desire to talk to the responsible clinician and their desire to talk with persons with high emotional intelligence. First, prior research and expert recommendations suggest that providing disclosure training or "just-in-time" coaching can improve the prospects for successful dialogue.[32,33] Second, hospitals can remind clinicians that their most important role in these conversations is to listen. The recent report about injured patients in NZ[16] revealed the patients' strong desire to be heard.[34] In addition, the literature on narrative and restorative competency confirms that listening to patients' stories without interrupting plays a critical role in fostering understanding and restoring trust.[35-38] Therefore, creating space for injured patients and families to be heard should be considered as an essential practice.

Patients' and families' accounts also reveal a desire to have a skilled support person, such as a patient advocate or attorney, present during conversations about the adverse event. Although only 8 patients and family members in our study had attorneys, they all reported positive experiences, and most of those without attorneys wished that they had obtained representation. The CRP leaders also increasingly recognize the value that the right kind of attorney can add to the process.[39] Such attorneys ensure that patients are treated fairly,[10,11] and they may facilitate restoration of the therapeutic relationship by asking the right questions when families are overwhelmed and provide another outlet for patients to be heard.

Connecting patients with attorneys who excel in these roles is challenging.[4,39] When an adverse event is not attributable to error, CRPs do not compensate the patient; thus, no pool of resources is available to pay the attorney. Hospital referrals to attorneys present a conflict of interest. However, CRPs can partner with attorney organizations to provide education on the CRP approach and develop a list of qualified, interested lawyers.

Anticipate Families' Immediate Financial Needs

Our findings, along with recent research,[4,23] illuminate the importance of institutions and insurers offering financial reparation to injured patients and families. In our study, 22 of 30 patients and family members reported financial stress in the aftermath of error. Bills that were due while the patient recuperated were a major concern, and patients expressed frustration that the hospital had not anticipated that they would need immediate relief while their case was evaluated. The CRP staff thought that they made proactive compensation offers, but to families, these offers did not come quickly enough.

In offering compensation, CRP representatives must keep the tenor of communications collaborative. Face-to-face communication during negotiations is desired by patients and may help preserve the right tone.

Ask About Involving Children

The small sample of cases (n = 3) in our study that involved injured children revealed some provocative findings. Children who experience medical errors or whose siblings or parents do may want to be included in communications about what happened. Hospitals should consider asking parents whether and how they think their children should be included. Models for family conferences can be found in the criminal justice domain, where family members of victims are invited to participate in reconciliation meetings with offenders.[40] More research is required before robust recommendations about children's involvement can be formulated.

The Value of Small Gestures

Other, small gestures can make a difference to families coping with medical injuries. The following 5 practices are supported by our interviews: (1) asking patients what form of communication (telephone, letter, or face to face) they prefer after the initial disclosure conversation, (2) giving injured patients a private room for the remainder of their stay, (3) using the term *reconciliation* instead of *resolution*, (4) asking patients a few months after the reconciliation process concludes whether they wish to provide feedback, and (5) reaching out to patients on the anniversary of the event to update them on what the hospital is doing to improve safety and assure them that they have not been forgotten.

Limitations

The primary limitation of our study relates to generalizability. Although well suited to yield insights about difficult CRP cases, our sample is not representative of all CRP events. Most of the patients and families that we interviewed experienced medical errors, but only a minority of all CRP events involved error. Furthermore, our hospitals restricted the sample to patients who could no longer bring a malpractice claim because they had already settled a claim or because the statute of limitations had expired. Patients who experienced adverse events not due to error or whose injuries occurred more recently might have answered interview questions differently. We also cannot rule out selection bias; hospitals may have selected patients who they thought were satisfied with how they had been treated. However, interview responses did not fit this profile. Finally, selective recall may have affected key informants' reports.

Conclusions

As hospitals strive to provide more patient-centered care, opportunities exist to improve the care that is provided after an adverse event. Even in hospitals with deep commitments to operating CRPs that serve patients' needs, only 18 of 30 patients and family members reported positive overall experiences. The CRP movement is young with much room to grow. Listening to patients illuminates the way forward.

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