

## What Does *Accountability* Mean to a Patient?

*First in a series of point-of-view stories*

As the Commission gains visibility, more and more people want to tell us their patient safety stories. Perhaps a patient feels a provider has hurt instead of healed; perhaps a health care worker can't escape the memory of a mistake or make sense of what actually happened. The stories provide a human face to the numbers and reports we see.

Yet no one person's point of view offers the whole story. So, from time to time, we'll be reflecting on portions of stories that have been shared with us – without identifying patients or providers. We do this not to point fingers or stir up distress, but to encourage us all to listen, to ask questions, to search for answers to human concerns with the same diligence we apply to our search for safer techniques and processes.

### “Linda’s” Story:

Several years ago, “Linda” underwent back surgery to alleviate a painful condition. Although the surgery seemed to be successful, a post-surgical infection led to disabling after-effects and continuing pain.

Linda is both sad and angry about what's happened to her – her livelihood has been affected and she feels dismissed and blamed by providers and insurers alike.

Yet her words point to an even deeper distress: *“(I) have not had one single person ever take blame or even say that they were sorry for all the inconveniences I have had to suffer. . . . I just would have been a little more appeased if just one person would have owned up . . . I had been involved (as a health care worker) in this system for a good many years . . . I have always felt that the patient had all the rights that we could give them. Honesty, punctuality, respect, trustworthiness . . . but most of all honesty.”*

Even without knowing clinical details, the words jump off the page. This patient experienced a loss of trust because she felt her medical team was not being candid. And while some patients can be challenging to work with, the Patient Safety Commission believes that all patients have a right to know about serious adverse events that affect their lives. As such, the Commission requires reporting organizations to provide written notification to patients. The Board of Directors believes that this disclosure requirement supports and reinforces honest communication with patients. The Board of Directors also strongly encourages organizations to offer an apology in the wake of serious adverse events. Such words must be clearly considered and honestly stated.

Last October, participants from all around the state met to discuss the challenges and skills involved in making disclosure part of the healing process. To learn more please see the [“Disclosure Tool Kit”](#) on this site.

We welcome your contributions, stories, viewpoints, questions – and perhaps even answers. Please address comments to [jim.dameron@oregonpatientsafety.org](mailto:jim.dameron@oregonpatientsafety.org).