Thought paper

December 2015

Leading in a crisis: the power of transparency

Blair L Sadler and Kevin Stewart

The Health Foundation

About the authors
Blair L. Sadler is a Senior Fellow at the Institute for Health Improvement and is a Lecturer at the UCSD Rady School of Management where he teaches a course about crisis management and communications. He served as president and CEO of the Rady Children's Hospital in San Diego from 1980 to 2006. He is a graduate of the University of Pennsylvania Law School.

Kevin Stewart was a 2009/10 Health Foundation Quality Improvement Fellow at the Institute for Healthcare Improvement in Boston, USA. He is now Clinical Director of the Clinical Effectiveness & Evaluation Unit at the Royal College of Physicians in London where he leads the College's work on patient safety and quality improvement.

Acknowledgements
Jim Conway, Senior Fellow at the Institute for Healthcare Improvement (IHI), developed and led IHI's work in this area for many years and continues to promote the cause of transparency across health care; he has inspired us both to continue this work. We are also grateful to friends and colleagues for support and encouragement, including Jana Deen and Frank Federico from IHI and Linda Kenny from MITSS.

Leading in a crisis: the power of transparency
is published by the Health Foundation,
90 Long Acre, London WC2E 9RA

Background

Every health care leader dreads the call. Two new mothers have died within 24 hours of each other in the maternity unit; a senior staff member in the paediatric unit is found in possession of indecent images of children; reporting errors in mammography have left hundreds of women at risk of being given the wrong diagnosis. Health care organisations usually plan for power cuts, floods and epidemics, but we frequently don't plan for serious clinical crises like these.

Yet all organisations, even the best, will experience such crises. How they respond will provide clear and compelling insights into their culture. Failure to respond promptly with empathy and transparency can have a lasting impact on the organisation and the people who work there. It can make a bad situation much worse. On the other hand, organisations that embrace a crisis as an opportunity to act transparently, to learn and improve can enhance their reputations and contribute to their journey of becoming truly high performing.[1,2,3,4]

In our roles as chief executive of a children's hospital for 26 years in San Diego, California and as chief medical officer of a medium-sized general hospital trust in the south of England for five years, we have experienced at first hand the pressures of being a leader in crises where patients were harmed – as briefly described in the boxes on the following pages.

We have felt the anxiety and fear, endured the sleepless nights of second guessing ourselves wondering whether we had done the right thing, shared tears with those harmed, and the despair and worry that are part of it all when things go wrong. These are, after all, intensely personal experiences and ones that are life-changing and stay with us forever.

Blair L Sadler

I vividly remember, as a 39-year-old chief executive who had been on the job just two weeks, dealing with the shock that three babies had died in our neonatal intensive care unit (NICU) for reasons we could not understand. I remember our experienced medical director, David Chadwick, asking experts at the Centers for Disease Control and Protection (CDC) and the California Department of Health to get on the next plane and help us figure it out. I remember talking to every family who had a child in our hospital, explaining what we knew and didn't know and offering to transfer their child to another hospital in San Diego if they preferred (only one said yes). I remember going public with a news conference the next day, and for the next five days, explaining what we knew and what we didn't know. I remember the discovery that we were dealing with an adenovirus that was transmitted in the air handling systems of our NICU (the first time this had happened in the US). I remember feeling the relief that no other patients were harmed and, subsequently, to our surprise, receiving awards from the media for our honesty and transparency.

I remember 20 years later dealing with a surgical error that caused harm, taking the same approach to apology and disclosure, and inviting the parents to a board of trustees' meeting where we made a promise to them that the systems failures that occurred would be corrected and that they would receive periodic reports of the changes we had made. We promised that they would be invited to a future board meeting each year until they were convinced that we had fulfilled our promise.

We also made an 11-minute video about our experience and showed it to all 3,000 employees, 700 physicians and all our volunteers. We continued to show it to all new employees and physicians. I remember asking everyone to voluntarily sign a pledge that, if they thought of anything that could help make our care safer and better, that they would let us know. I remember how our culture strengthened as a result, the remarkable employee engagement, and the several media awards that followed.

Six years later, I remember when the police informed us that we had an employee who was trafficking in massive amounts of child pornography and may have taken inappropriate photos of some of our patients without their knowledge. I remember the press conference we had with the chief of police explaining what had happened, expressing the pain we were feeling, and seeing over half of the assembled media in tears as they shared our pain with us. I remember the relief when the former employee was sentenced to a very long time in jail and the community and media recognition that followed.

Kevin Stewart

I was the chief medical officer of a medium-sized general hospital in the south of England for five years. During Christmas 2007, two new mothers died within 24 hours of each other in our maternity unit from Group A streptococcus infection. There had not been a maternal death in the unit for 11 years. The organisation was in transition, with a new CEO, new board chair and several executive director vacancies. I found myself starting with a blank sheet of paper and a skeleton team that was depleted further through vacancies and holidays. I vividly remember the devastation that affected the whole organisation, the vilification by the media and the trauma of an 18-month coroner's investigation and subsequent inquests. But a decision from the outset to say sorry, acknowledge failures, and be completely transparent with the families and with the public served us well. Despite the terrible tragedy, the organisation emerged with its reputation enhanced and a determination to learn from events.

Since these events, we have had the opportunity to work with leaders in numerous health care organisations in the US, the UK and elsewhere. Despite their differences, it is striking to observe and experience how similar the core issues are – the fears, the shock, the sadness, the extraordinary time pressures, and the need to act from the heart as well as the head.

In this paper, we review the management of serious clinical crises in the United States, lessons learned from other industries, the experience of the Mid-Staffordshire crisis in the NHS and the subsequent reports by Robert Francis and Don Berwick. We discuss legal and media barriers to effective action, review lessons learned from the 'second victim' literature and provide our recommendations for action.[1,5,6] These recommendations are heavily influenced by our previous roles and the experiences we have briefly described above.

The power of transparency emerges as a recurrent theme from all this work. Leaders who promote and model transparent behaviours and instil a transparent culture in their organisations can use crises as learning and improvement opportunities. Those that don't may be destined to recurrent failure.

Introduction

There are three types of victims of any serious clinical crisis.

- The first victims are patients and their families, including those directly harmed and those put at risk.
- The second victims are front-line clinical staff and those who support them, in whom there are well-recognised psychological effects of involvement in an adverse patient safety incident. These effects can extend to managers, leaders and all those with a direct relationship with the organisation.
- The third victim is the organisation itself, whose reputation can be significantly harmed in the eyes of its patients, stakeholders and the general public.

Organisations need to be clear about their priorities among these three and all of their behaviour needs to flow from these. There is a moral and ethical imperative to prioritise the needs of patients and families above all others, followed by addressing the needs of those working at the front line and others who may have been second victims. The welfare of the organisation can be best assured by taking this approach, which will help minimise damage to its reputation and may even enhance it.

Despite several individual examples of courageous and transparent behaviour, too often organisations are not prepared to act transparently and rapidly when a crisis occurs. Often the result is denial that a problem exists, disagreements about assigning blame, lack of clarity about priorities among the three victims and how to proceed. This can lead to confusion, mixed messages and an erosion of trust.

Lessons from the United States

Over the years, senior leaders at the Institute for Healthcare Improvement (IHI) have received calls from executives in hospitals throughout the United States seeking urgent help with serious clinical crises. Although they described very different clinical situations, the similarities in the calls are striking. Leaders were devastated by what had happened, desperate to do the right thing, yet usually starting with a blank sheet of paper. They worried about how much or how little to say publicly, how to deal with the media, how to engage with their legal advisers and how to deal with staff. Too often they had already compounded the situation with a clumsy initial response.[2]

Drawing on its experience in helping these organisations, and on lessons from the business literature,[7,8,9,10] IHI developed a suite of materials to help others, summarised in the white paper *Respectful management of serious clinical adverse events*.[1]

The IHI white paper has proposed a leadership approach to addressing crises based on transparency, and on a model which makes the needs of patients and families the first priority, followed by those of staff, then those of the wider organisation. It describes a culture that organisational leaders can model and promote to facilitate maximum engagement.

In recent years, several health care systems in the US have shown courage and compassion during a crisis. However, too many organisations still have not made a clear and explicit

commitment to hold themselves accountable in a world of increasing transparency. Too often there seems to be a significant gap – indeed a chasm – between what organisations acknowledge they should do and what they actually do. The end result is that, while they may survive the initial crisis, they fail to learn from it, fail to develop systems to detect, prevent or mitigate the next crisis and, ultimately, when that does occur, they may be starting with a blank sheet of paper again.

The IHI approach is founded on an open, learning organisational culture based on transparency at every level. It fosters an environment where open disclosure to patients after adverse events is supported, as well as an organisational level transparency dealing with patients, the wider public and other stakeholders in times of crisis. Such an approach has also been proposed by Berwick[6] and is implicit in Bohmer's[3] description of the components of high performing health care organisations. However, this type of culture in health care is often the exception rather than the rule.

What can we learn from other industries?

Common themes emerge from the business literature that have a remarkable resonance for us in health care.[7,8,9,10,11] An organisation's response to a crisis often has as much potential to cause harm as the crisis itself, but in the early days and weeks, organisations frequently fail to recognise a problem at all; if and when they do, they fail to understand its gravity and its potential adverse effects on the business and its customers. Decisive, respectful, transparent leadership in the face of a serious crisis can begin to repair damage, rebuild public confidence and ultimately enhance the reputation of the organisation. A delayed, defensive, inadequate response will have the opposite effect and will be what defines the organisation in the face of the public. The events leading to the crisis may be beyond the control of the leadership, but how they react is not.

Serious crises are rarely unique and, in retrospect, are rarely found to have come completely out of the blue. When the Deepwater Horizon oil rig spilled 4.9m barrels of oil into the Gulf of Mexico in 2010, it was assumed that it was a 'one-off' event. The subsequent investigation revealed that most oil workers didn't want to work on the rig because they knew that safety incidents regularly occurred but weren't addressed. They called it the 'well from hell'.[11]

When businesses do acknowledge crises, they may address them as one-off catastrophic events to be dealt with and forgotten before moving on. This fails to recognise what crises really are and makes the organisation susceptible to further catastrophic failures. Crises are often an extreme manifestation, precipitated by force of circumstance or misfortune at the time, of underlying problems within an organisation that create the latent conditions in which a crisis can arise. As in the 'well from hell', safety monitoring systems are either inadequate to detect 'weak signals' of problems or are repeatedly ignored or rationalised as insignificant.[9,11,12] Viewed in this light, crises also provide real opportunities for organisations to reflect, learn, develop and grow.[6]

As humans, we work against well recognised cognitive and cultural biases which prevent us from recognising warning signals, acknowledging crises when they do arise and then accepting and learning from failures.[8] Human factors science teaches us that individual clinicians will often rationalise their patient's falling blood pressure or reducing oxygen saturations as due to faulty equipment rather than an obvious sign of a clinical problem.[13] In clinical practice we have developed forcing functions and other processes to mitigate such biases (eg checklists, alarms, override functions). The same biases affect organisational leaders faced with what in retrospect seem to have been obvious signs of trouble.[8] The Harvard Business Review devoted an entire issue (April 2011) to exploring and understanding the cultural and other factors that prevent organisations from learning from failures.[14] Leaders who have emerged from a serious crisis may be naturally less inclined to explore and re-examine the painful episode. Most pressures

within the organisation will be to achieve closure and move on. What's more, a leadership culture that celebrates and promotes success may be less likely to encourage leaders to examine their organisation's mistakes. No CEO wants to be remembered for their failures.

The failures of automobile manufacturers to respond to their safety defects that killed and harmed many people are powerful examples of a lack of transparency.[15] As the US government hearings unfolded, testimony revealed numerous examples of cover-ups, lack of accountability, and refusal to treat the victims harmed with empathy, transparency and support. When viewing harm caused by any organisation, Ben Heineman says it well: 'It's our problem the moment we hear about it.'[16]

Lessons from the UK

Most UK readers will be familiar with the details of the multiple, repeated failures between 2005 and 2009 when hundreds of patients died or were harmed as a result of substandard care at the Mid Staffordshire NHS Foundation Trust. The subsequent public inquiry and the recommendations of the Francis report will dominate the NHS quality and safety agenda for many years.[17] Mid Staffordshire was not an isolated example, although it was an extreme one.[18,19]

Much of the subsequent analysis has uncovered familiar themes.[5,6]

- A repressive, opaque leadership culture contributed to the failings in the first place, exacerbated the situation when problems did emerge and compounded the harm with repeated denial and defence during the investigation. The lack of transparency extended beyond failure to listen to concerns about individual incidents to a failure to respond to regulators, politicians, patient groups and the media when faced with evidence of system-wide failure. This happened despite the fact that the NHS has promoted policies supporting transparency for many years[20] and the existence of a much more benign approach to medical litigation in the UK than in the US.
- Clinical staff and others who did raise concerns about quality of care were ignored, marginalised or even victimised.

- The predominant focus for the leadership was financial and operational performance, which took priority over all other issues including quality of care.
- Systems for measuring and monitoring quality and safety were inadequate to deal with repeated early warnings and 'weak signals' of safety risks; they were ignored, disregarded or dismissed. Macrae has called on health care to learn from other safety critical industries that develop monitoring systems to amplify and proactively investigate such 'weak signals'.[12]
- Initial public and media reaction questioned the motivation of staff, especially nurses, some of whom were blamed for an 'uncaring' or 'unprofessional' attitude and most of whom were characterised as having come to accept substandard care as the norm. While a small number of staff have faced regulatory or legal sanction because of unprofessional behaviour, it has emerged that many did attempt to raise concerns but these were ignored or dismissed. While there had been a perception that the hospital's staff had been silent, in retrospect it transpired that the organisation had been deaf.[21]

Don Berwick, former president and co-founder of the Institute for Healthcare Improvement led a team of patient safety experts to help the NHS develop a system-level response to the Francis report. He recommended a complete refocusing of the health care system so that quality of care, and patient safety in particular, became the clear priority above all others. To achieve this, he stressed the need for widespread culture change to one that embraced transparency, with patients involved at every

level from the front line to the board.[6] He promoted the concept of a learning organisation founded on 'trust in the good will and good intentions of staff', supported by opportunities for training and experience in quality improvement skills.[22]

Since the publication of the Francis and Berwick reports, the NHS in England has introduced a statutory duty of candour, obliging organisations to disclose details of moderate and severe harm to patients, along with an apology.[23] Criminal sanctions can be applied to those failing to do this. The NHS inspection regime has been redesigned and now involves more front-line clinicians. A new independent body is to be established, organised in a similar way to that which exists for airlines, to investigate serious failings in care and to promote a learning approach.

A further review led by Sir Robert Francis found numerous examples throughout the NHS of staff who spoke out about poor care (so called 'whistleblowers') being ignored, marginalised or even victimised. This led to the *Freedom to speak up* report,[24] which recommended that independent advocates be appointed in NHS organisations to support staff and prevent victimisation.

Professional bodies representing clinicians have been strongly supportive of the need to improve transparency and to promote a learning culture but recognise that top-down initiatives can only have a limited impact.[25]

What inhibits transparency and open disclosure?

Five specific factors seem to inhibit transparency in health care: actual or perceived litigation risk, inadequate training in disclosure, fear of negative media coverage, lack of effective and transparent leadership, and unresolved 'second victim' effects.

Fear of litigation

In the US, the challenges of achieving alignment and consensus with an organisation's legal counsel and insurer continue to be a barrier to offering prompt apologies and disclosure to patients. Fear of litigation often causes clinicians to say less rather than more when something goes wrong. A traditional, conservative approach from their legal counsel often supports this. Initially, the evidence of whether open disclosure of harm following adverse events affects the risk of litigation has been mixed: some health care systems have reported reduced litigation costs, while others found a neutral effect. However, there are compelling moral arguments in favour of open disclosure and most clinicians and patients support it.[26,27,28,29]

In recent years, there have been several promising innovations including the Disclosure, Apology and Offer (DA&O) programme at the University of Michigan, which has shown impressive results.[30] The COPIC insurance programme in

Colorado[31] and a recent Hospital-Based Communication and Resolution programme in New York City involving five hospitals also show promise.[32] A study of communication and resolution programmes in six different health systems has shown positive effects but their experience reinforces the importance of strong champions for change and devoting significant resources and time to the effort.[33] When weighing and balancing key decisions in a crisis, legal counsel should get a vote, but not the only vote. The traditional 'deny and defend' legal mantra seems outmoded and even dangerous.[30,31]

Although litigation concerns by individual clinicians and by organisations are frequent in the US, there are clearly other factors inhibiting transparency that are common to all health care systems. In the NHS, litigation risks are low by comparison and the service is indemnified by a government agency. Policies and procedures promoting transparency and backed by various regulations have existed for a decade,[20] yet a lack of transparency was still a prominent feature of the Mid Staffordshire failure.

Insufficient training

While at an individual level most clinicians and managers support the concept of an open dialogue with patients who have been harmed, many have not been trained in the delicate communication skills required to have these difficult conversations. In addition, the leadership culture in many organisations, does not support such transparency. Without appropriate training, preparation and support, it is not surprising that organisations can be paralysed with fear during a crisis, and incapable of prompt, effective action.

Negative media coverage

Negative media coverage can also be highly damaging. Some organisations try and avoid the media rather than learn how to deal with it promptly, honestly and transparently. The unmistakable reality is that in today's era of the internet, social media and 24/7 news coverage, coupled with increasing public expectations, the old rules no longer apply. Protectionist legal and media advice has become bad advice. Communicating with the media is a learned skill, and organisations should provide media training to key leaders and those who will be speaking publicly on their behalf. Developing positive, collaborative relationships with the media over time can actually build mutual trust and respect that provides a solid platform for communication when a crisis occurs. The words 'no comment' should be avoided – they are disrespectful and encourage cynicism and criticism. Proactive approaches to external communications over time can set the stage for mutually respectful interaction in many cases.[34,35,36]

Lack of effective and transparent leadership

When a serious crisis occurs, effective and courageous leadership is essential. But too often organisations have not been explicit about what they expect from their leaders. Do they have leaders who are skilled and experienced in effective communication internally and externally in times of crisis? Do they have the ability to act knowing that, if they do, they will receive the support of the board? If not, it is likely that fear and undue caution will prevail over courage and transparency.

Unrecognised 'second victim' effects

When patients suffer adverse events, the clinicians who have been caring for them are themselves susceptible to psychological trauma. This can have symptoms ranging from sleep disturbance and anxiety to clinical depression and a condition resembling post-traumatic stress disorder. In 2000, Albert Wu coined the term 'second victims' to describe this phenomenon,[37] and the term has since expanded with the work of Susan Scott and colleagues from the University of Missouri.[38,39,40] Their definition of second victims is:

> *Healthcare providers who are involved in an unanticipated adverse patient event, in a medical error and/or a patient related injury and become victimized in the sense that the provider is traumatized by the event.*

These effects are common in clinicians from all disciplines and their gravity is proportionate to the severity of the harm caused to patients. Effects can be mitigated by a supportive, collaborative work environment and exacerbated by the investigation of the incident or legal proceedings, especially if a punitive approach is taken. In the immediate aftermath of an incident, such effects in clinicians will tend to suppress transparency. In the longer term, if unaddressed, they erode a safety culture by fostering a defensive approach to clinical practice.[36]

Conclusion and recommendations – the power of transparency

Serious clinical crises should force health care organisations to look in the mirror. When they do, what will they see? If they see an organisation with a culture that encourages prompt disclosure, apology, transparency, and collaborative resolution, then they are likely to learn, grow and develop. If they do not, and the culture seems to be to deny and defend, it could erode efforts to become a highly reliable and optimally safe organisation.

We are often asked, 'Based on your experiences and what you have learned from others, what would you advise a health care leader?' In response, we have developed two sets of recommendations: one for organisations and the one for individual leaders at all levels.

Recommendations for organisations

- **Embrace an organisational culture of transparency.** The board and leadership espouse and support core values of transparency, compassion and respect at every level of the organisation. Leaders promote and model a truly open culture where patient care is prioritised above all else and harm is seen as a failure of systems, not people. Conversations are encouraged in an open and just culture, with supporting policies and practices in place.

- **Actively support compassionate patient, family and employee communication.** Ensure that this policy is well known throughout the organisation and includes appropriate apology and disclosure when harm occurs. Legal advisers share the organisation's commitment to rapid disclosure and support.
- **Design, disseminate and regularly test a crisis management plan.** There is a written crisis management plan that is regularly tested, modified and reviewed by executive leadership, clinicians and the board. It includes the core principles of internal and external transparency and support for second victims.
- **Develop and implement adequate training.** Training programmes are in place about communication with patients, families and other carers when harm occurs. Programmes include coaching and training for making disclosures and apologies. There is adequate media training for key personnel.
- **Commit to learning from serious clinical crises.** The organisation conducts a thorough assessment of all clinical crises to understand and learn from failings and help reduce risk of future events. Outside advisers are welcomed and provide their perspective. The organisation is continually learning and improving, and shares lessons learned.
- **Recruit, develop, and support leaders who act with courage and transparency.** The organisation recognises that, in times of crisis, prepared and effective leadership is essential. It provides support for leaders to ensure that they can communicate and act effectively on its behalf.

Recommendations for leaders

During your time as a leader, it is likely that something will unexpectedly go seriously wrong, resulting in a patient or patients in your care being harmed. A crisis will result. In today's age of 24/7 media coverage, there will be intense and immediate pressure to provide answers that you may not have, and before you are fully prepared. Should this happen, we provide the following ten suggestions, based on our experience:

1. Throw away your calendar, act with intense urgency, own the problem and form a crisis management team.
2. Never worry alone. Leading in a crisis is both an individual and a team exercise. Don't be afraid to ask for help.
3. Notify all key stakeholders quickly.
4. Apologise to those harmed and offer to help in any way possible.
5. Lead with your genuine feelings – empathy, outrage, sadness and disappointment. Lead from your heart, as well as your head.
6. Get media training. Communicating with the media is a learned skill. There is no excuse not to develop it.
7. Promise to correct any error and do so.
8. Lead with courage and compassion for the victims.
9. Acknowledge when you are scared, confront your fears and embrace uncertainty.
10. Commit to a culture of transparency. It is the platform on which everything rests.

We believe that these two sets of recommendations, if widely adopted and embedded in the culture of health care organisations, could make significant positive impacts on patients, families, staff and the organisations themselves. We believe they are vitally important components of the larger goal of becoming transparent, constantly learning, high reliability enterprises. At its core, this approach places priority on the people directly harmed (the first victims), includes care and compassion for carers and staff (the second victims), and understands that the reputation of the organisation itself (the third victim) can be less damaged, even enhanced, through transparency.

Don Berwick's advice to the British health care system could probably equally apply to health care leaders in every system in the world.

> *Place the quality of patient care, especially patient safety, above all other aims. Engage, empower, and hear patients and carers at all times. Foster whole-heartedly the growth and development of all staff, including their ability and support to improve the processes in which they work. Embrace transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge.*[6]

References

1. Conway J, Federico F, Stewart K, Campbell M. *Respectful Management of Serious Clinical Adverse Events.* IHI Innovation Series white paper (second edition). Cambridge, Massachusetts: Institute for Healthcare Improvement, 2011. (Available on www.IHI.org)
2. Conway JB, Sadler BL, Stewart K. Planning for a clinical crisis. *Healthcare Executive*. 2010;25(6):78–81.
3. Bohmer R. The four habits of high value healthcare organisations. *NEJM.* 2011;365(22)2045–7.
4. Senge PM. The leader's new work: Building learning organisations. *MIT Sloan Management Review*. 1990;32(1):7–23.
5. Francis R. *Report of the mid Staffordshire NHS Foundation Trust public inquiry.* London: The Stationery Office, 2013.
6. National Advisory Group on the Safety of Patients in England. *A promise to learn – a commitment to act.* London: Department of Health, 2013. (Berwick Report)
7. Augustine N. Managing the crisis you tried to prevent. *Harvard Business Review*. 1995;73(6):147–158.
8. *Harvard business review on crisis management*. Boston: Harvard Business Press, 2000.
9. George B. *Seven lessons for leading in a crisis*. San Francisco: Jossey-Bass, 2009.
10. *Leading through a crisis*. Boston: Harvard Business Press, 2009.
11. Edmonson A. Strategies for learning from failure. *Harvard Business Review*. April 2011:49–56.
12. Macrae C. Early warnings, weak signals and learning from healthcare disasters. *BMJ Qual Saf*. 2014;0:1–6.
13. NHS Institute for Improvement and Innovation. *Implementing human factors in healthcare*. www.institute.nhs.uk/safer_care/general/human_factors.html (accessed 10 December 2015)
14. The Failure Issue. *Harvard business review*. April 2011. https://hbr.org/archive-toc/BR1104
15. Levin D. Here are some of the worst scandals in history. *Fortune*, September 26, 2015, 8 am EST, Fortune.com/2015/09/26/auto-scandal/11:31 am PST, December 13, 2015.
16. Heineman B. The crisis management lessons from Toyota and GM. *HBR blogs* 2014. https://hbr.org/2014/03/the-crisis-management-lesson-from-toyota-and-gm-its-our-problem-the-moment-we-hear-about-it/ (accessed 10 December 2015)
17. Martin GP, Dixon-Woods M. After Mid Staffordshire; from acknowledgement, through learning, to improvement. *BMJ Qual Saf*. 2014;23:706–708.

18. Keogh B. *Review into the quality of care and treatment provided by 14 hospital trusts in England*. London: Department of Health, 2013.
19. Dixon-Woods M, Baker R, Charles K, et al. Culture and behaviour in the English National Health Service. *BMJ Qual Saf.* 2014;23:106–115.
20. National Patient Safety Agency (UK), National Reporting and Learning Service. *Being open: communicating patient safety incidents with patients, their families, and carers.* www.nrls.npsa.nhs.uk/resources/?entryid45=65077
21. Jones A, Kelly D. Deafening silence? Time to reconsider whether organisations are silent or deaf when things go wrong. *BMJ Qual Saf*. 2014;23:709–713.
22. Vincent C, Burnett S, Carthey J. *The measuring and monitoring of safety*. London: The Health Foundation, 2013.
23. Regulation 20; *Duty of Candour.* London: Care Quality Commission, 2015.
24. *Freedom to speak up; a review of NHS whistleblowing*. February 2015. www.gov.uk
25. *Learning from serious failings in care*. Academy of Medical Royal Colleges and faculties in Scotland, May 2015.
26. Kachalia A, Shojania K, Hofer TP, Piotrowski M, Saint S. Does full disclosure of medical error affect malpractice liability? The jury is still out. *Joint Commission Journal on Quality and Patient Safety.* 2003;29(10):503-511(9).
27. Kachalia A, Kaufman S, Boothman R et al. Liability claims and costs before and after implementation of a medical disclosure program. *Ann Int Med.* 2010;153(4):213–221.
28. Wojcieszak D, Saxton JW, Finkelstein MM. *Sorry works! Disclosure, apology, and relationships prevent medical malpractice claims*. Bloomington, IN: Author House, 2010.
29. O'Toole J, Bennis W. What's needed next: A culture of candor. *Harvard Business Review.* 2009;87(6):54–61,113.
30. Boothman R, Imhoff SJ, Campbell, Jr A. Nurturing a culture of patient safety and achieving lower malpractice risk through disclosure: lessons learned and future directions. *Frontiers of Health Service Management.* 2012;28(3):13–28.
31. Quinn RE, Eichler, MC. The 3 Rs Program: The Colorado Experience. *Clinical Obstetrics and Gynecology.* 2008;51(4):709–718.
32. Mello MM, Boothman RC, McDonald T, Driver J, Lembitz A, Bouwmeester D, et al. Communication-and-resolution programs: the challenges and lessons learned from six early adopters. *Health Affairs.* 2014;33(1):20–29.
33. Mello MM, Senecal SK, Kuznetsor Y, Cohn JS. Implementing hospital-based communication-and-resolution programs: lessons learned in New York City. *Health Affairs.* 2014;33(1):30–38.
34. Jenny C. Preventing the exploitation and abuse of children (Letter). *Health Affairs.* 2012;31(4):883.
35. Sadler B. How a children's hospital discovered child pornographers in its midst. *Health Affairs*. 2011;30(9):1795–1798.

36. Sadler B. Preventing child abuse (the author replies). *Health Affairs.* 2012;31(4):883.

37. Wu A. Medical error: The second victim. The doctor who makes the mistake needs help too. *British Medical Journal*. 2000;320(7237):726–727.

38. Scott SD, Hirschinger LE, Cox KR, McCoig M, Brandt J, Hall LW. The natural history of recovery for the healthcare provider 'second victim' after adverse patient events. *Quality and Safety in Health Care*. 2009;18(5):325–330.

39. Scott, SD, et al. Caring for our own: deployment of a second victim rapid response system. *The Joint Commission Journal on Quality and Patient Safety.* 2010;36(5):233–240.

40. Pratt S, et al. How to develop a second victim program: a toolkit for health care organisations. *The Joint Commission Journal on Quality and Patient Safety*. 2012;38(5):235–240.

The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen.

We make links between the knowledge we gain from working with those delivering health and health care and our research and analysis. Our aspiration is to create a virtuous circle, using what we know works on the ground to inform effective policymaking and vice versa.

We believe good health and health care are key to a flourishing society. Through sharing what we learn, collaborating with others and building people's skills and knowledge, we aim to make a difference and contribute to a healthier population.

The Health Foundation
90 Long Acre, London WC2E 9RA
T +44 (0)20 7257 8000
E info@health.org.uk
@HealthFdn
health.org.uk

Registered charity number: 286967
Registered company number: 1714937