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Disclosing large scale adverse events in the US Veterans Health Administration: lessons from media responses[☆]



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ABSTRACT

Objectives: We examined print, broadcast and social media reports about health care systems' disclosures of large scale adverse events to develop future effective messaging.

Study design: Directed content analysis.

Methods: We systematically searched four communication databases, YouTube and Really Simple Syndication (RSS) feeds relating to six disclosures of lapses in infection control practices in the Department of Veterans Affairs occurring between 2009 and 2012. We assessed these with a coding frame derived from effective crisis and risk communication models.

Results: We identified 148 unique media reports. Some components of effective communication (discussion of cause, reassurance, self-efficacy) were more present than others (apology, lessons learned). Media about 'promoting secrecy' and 'slow response' appeared in reports when time from event discovery to patient notification was over 75 days. Elected officials' quotes (n = 115) were often negative (83%). Hospital officials' comments (n = 165) were predominantly neutral (92%), and focused on information sharing.

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Conclusions: Health care systems should work to ensure that they develop clear messages focused on what is not well covered by the media, including authentic apologies, remedial actions taken, and shorten the timeframe between event identification and disclosure to patients.

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Introduction

On February 26, 2014, officials from the Department of Veterans' Affairs (VA) health care system faced congressional members of the House Veterans Affairs Committee to address questions regarding several large scale adverse events recently disclosed to patients at several medical facilities.¹ One of those facilities disclosed to approximately 700 patients that they may have a small yet possible risk of contracting human immunodeficiency virus (HIV) or hepatitis B or C as a result of improper insulin pen reuse on inpatient wards.² These actions prompted a neighbouring, private hospital to review their own insulin pen procedures. Finding similar problems, that hospital notified approximately 1900 patients of their potential risks.³ Both facilities offered remediation to potentially affected patients and attempted to restore trust, both individually and through the media. Media coverage of such disclosures reveals both the perceived actions of the health care systems and the responses of the media and the public to the manner of disclosure. Yet, it is not clear whether messages from the media reflect evidence-based, effective crisis and risk communication strategies. Many other health care organisation will face similar communication challenges in the future. This research on lessons from media responses to large scale adverse event disclosures in health care provides some direction for these communication challenges.

The unique challenges of large scale adverse event disclosures

Health care systems' disclosures of large scale adverse events are unique in that many patients are potentially exposed but few are truly at risk of injury or illness.⁴ Although much is known about disclosing clinical adverse events,⁵ very little research has been done to inform large scale adverse event disclosures to many patients.⁶ Large scale adverse events are often but not always infection control breaches, which present challenges for health care systems and public health officials alike because of the absence of known disease transmission.^{7,8} Contacting patients to inform them of these unknown yet significant infectious disease risks and requesting that they seek testing to rule out these risks is resource and labour intensive.⁹ The uncertainty of the disclosure may lead to distress and anxiety among patients and family members.⁴ Disclosures cannot happen overnight; records must be searched to determine who may have been impacted by the event,

contact information must be obtained and checked for accuracy, and communication plans need to be drafted and approved.

Examining media reports may help health care systems develop messages

In several cases, while health care systems were working to achieve disclosure, information on the large scale adverse events was leaked to the media, and thus, the disclosures of the event came from the media instead of the health care systems. The media is a potential information source for patients¹⁰ and other stakeholders of health care systems,¹¹ but it may also serve as a conduit for emotional reactions such as fear, worry, distress and anger.^{11,12} Information on how messages about these large scale adverse events are constructed and delivered by the media will assist organisation in developing their own messages to counter or confirm reported risk perceptions. For example, in 1982, Johnson & Johnson successfully used the media to deliver clear, personal response information to consumers quickly, such as throwing out bottles of Tylenol in their homes.¹³ In a recent Legionnaire's related incident, one hospital's leadership was not able to clearly communicate the level of risk, the number of people impacted or the facility's follow-up actions. As a result, the media reported on the lack of information about the event from officials, which often led to significant concerns for patients and families.¹⁴

Methods

VA mandates incident reporting and disclosure of clinical and large scale adverse events to patients who have been harmed, including cases where the harm may not be obvious or severe, or where the harm may only be evident in the future.¹⁵ We chose VA large scale events for our directed content analysis because of VA's commitment to full disclosure and the opportunity to track multiple events across the health care system on both a local and a national level. Below we carefully outline our approach to this study in accordance with established guidelines.¹⁶

Theoretical framework and analytic approach

We used a directed content analytic approach in order to ascertain the extent to which media reflect aspects of the crisis and risk communication.

Crisis and risk communication as an analytic framework

A health care organisation's communications during a crisis are aimed at communicating with stakeholders. This communication often occurs directly through outreach to affected individuals, but is also often performed through the media as a way to reach large groups of stakeholders.¹⁷ Four communication models and theories specific to communicating crisis and risk to individuals were used to develop a 14 item coding framework for a directed content analysis of the identified media reports.¹⁸ This framework is further described in [Table 2](#); italicized items here represent the 14 items in the framework.

The **Crisis and Emergency Risk Communication Model** assumes that perceptions of risk arising from public health adverse events are the result of low familiarity with the hazards and high levels of uncertainty of the exposures.¹⁹ *Responding adequately in a credible way, discussing the cause, providing reassurance and a consensus about lessons across multiple stages of communication in the disclosure process may alleviate these risks by reducing uncertainty and increasing self-efficacy for action (e.g., personal response activities) by those potentially affected, thus improving outcomes.* The **Situational Crisis Communication Theory** examines the *consistency and distinctiveness* of the event.²⁰ Consistency describes whether or not an organisation has faced the same or similar crisis in the past, and distinctiveness addresses how well or how poorly the organisation has addressed stakeholders in the past, in contexts other than crises. High consistency or low distinctiveness will intensify attributions of crisis responsibility and affect the organisation's reputation.²⁰ The **Stealing Thunder** model involves a *timing* strategy and a proactive approach involving admission of a weakness before that weakness is announced by another party.²¹ When timing is slow, perceptions of organisational secrecy abound; if timing is perceived as quick, more perceptions of organisational transparency exist. **Apology**, characterized by accepting responsibility for a crisis and asking forgiveness, has been shown to be a favourable strategy when compared with less accommodative strategies such as denial, excuse-making or justification.²² We used four criteria for authentic apologies in our coding frame: *accept responsibility, acknowledge what happened, express sympathy and offer compensation.*^{23–25} These theories describe risk and crisis communication strategies to use with both stakeholders and the media. Our analysis sought to analyse whether these messages were present in

media reports and which messages were present most often, to inform future messaging by health care organisation. We note that as VA researchers, our interest was specifically in understanding and improving the ways in which the VA's management of LSAE's are depicted in the media.

The six large scale adverse events

[Table 1](#) provides information on each of the six events which took place at six different facilities. Names of the facilities have been removed in order to protect their identities. With each facility, letters describing the adverse event and offering infectious disease testing at the facility as a follow-up were mailed to patients, but in three cases information on the adverse event was leaked to the media, and many patients and family members first learned of the issue through media reporting.

Data collection

We used key words and combinations of key words such as 'Veteran', 'Veteran hospital', 'VA', 'endoscope', 'colonoscopy', 'dental', 'dentist', 'ENT', 'adverse event', 'HIV', 'hepatitis', 'diseases' and 'disorders' in several databases to identify local and national media reports focused on six large scale adverse event disclosures that took place between 2009 and 2012 (see [Supplementary material](#)). The databases were 1) Lexis Nexis (national newswire/press releases and broadcast journalism), 2) Communication and Mass Media Complete (broadcast journalism), 3) ProQuest Newspapers (national and regional print media), and 4) ABI/Inform Newspapers (business/trade news). After initial examination, we noted low levels of local news reports resulting from the database searches. Using the same keywords, we searched YouTube and local media websites to identify these local broadcast reports and transcripts. Televisions reports were transcribed for analysis. Really Simple Syndication (RSS) feeds were established with these same keywords to identify past and ongoing blog posts about the six events.

Data processing and analysis

All articles were screened for relevance. Any reports pertaining to at least one of the six specific events were included; articles that did not mention any of the events were excluded. All reports were in English and were published in the US.

Table 1 – Description of Large Scale Adverse Events in Media Content Analysis.

Facility	Exposure description	Number of patients included in disclosure	Days in the media
Site 1	Improperly reprocessed ENT endoscopes	1104	835
Site 2	Improperly reprocessed ENT endoscopes	297	151
Site 3	Improper disinfection of auxiliary water tubing system used during colonoscopy reprocessing	6805	880
Site 4	Improper disinfection of auxiliary water tubing system used during colonoscopy reprocessing	2531	970
Site 5	Improper reprocessing of dental equipment	1812	652
Site 6	Improper infection control practices and techniques performed by a particular dentist over the course of several years	535	303

Table 2 – Communications Models and Theories.**Crisis and emergency risk communication model**

Model component	Example from media
Adequacy of response (N = 54)	‘Instead, some on the committee suggested the hospital’s director, XX, should be dismissed, and said they expected more progress in the aftermath of revelations in 2009 that nearly 2500 veterans might have been exposed to HIV and other illness during colonoscopies performed with improperly cleaned equipment.’ –National newspaper ‘That same month, the VA said it would offer free screening to 535 patients who received invasive dental work from X. The Y task force recommended going further, as more than 3200 patients were seen by X in the past 20 years.’ –Local newspaper
Consensus about lessons (N = 14)	‘The review noted the dental clinic, which sees more than 3000 patients annually, should have had more dental assistants. The lack of additional assistants may have increased the likelihood approved infection control practices were not followed, the report concluded.’ –Local newspaper ‘The inspector general’s office recommends that hospital superiors address inadequate staffing issues and ensure policies are followed. It says an acceptable plan has been submitted by medical center directors.’ –Blog
Discussion of cause (N = 112)	‘The problem began in March 2009 when the VA revealed that more than 2400 X-area veterans were given colonoscopies with improperly cleaned equipment and might have been infected with diseases. One or more X VA staffers had been rinsing colonoscopy equipment between uses instead of sterilizing it.’ –National newspaper ‘In X, a tube that was supposed to be cleaned after each colonoscopy was instead cleaned at the end of each day, Y said. And in Z, the ENT scopes used for looking into the nose and throat weren’t properly cleaned. Everyone who may have been exposed because of those problems was notified. All the problems were human error, he said.’ –National newspaper
Reassurance (N = 114)	Investigation: The center is taking an ‘ongoing in-depth look at a lot of aspects surrounding the allegations,’ X said. ‘When someone brings those things to your attention, you need to review what practices are happening.’ –National newspaper Prevention: In February of this year, the VA instituted an education program to implement what they called ‘stronger procedures and better accountability at VA health care facilities.’ –National newspaper
Personal response activities (N = 58)	‘X said the hospital has set up a special clinic for the dental patients who may be at risk. An education center at the hospital has been turned into the clinic. There, a call hotline has been set up to answer questions, and upon visiting, the patients get orientation about the problem, blood tests if they want, and even counselling. X is urging all of those patients to get the blood tests.’ –National blog ‘Well, if you’re a vet and you think you may be infected, call the X health care VA system. You can actually speak with a staff member or set up an appointment for screening. Here’s the phone number toll free 877-575-XXXX.’ –Local television report
Uncertainty Reduction (N = 5)	‘The risk of cross-contamination was low, “in the range of 1 in 1.8 million,” said Dr. X chief of gastroenterology and hepatology at Y Hospital.’ –National newspaper ‘National experts advised the hospital that patients’ risk of infection was remote. As a result, the hospital is notifying affected patients but isn’t asking them to receive follow-up tests or treatments.’ –Local newspaper

Situational crisis communication theory

Model component	Example from media
Evidence of consistency (N = 33)	‘The X VA has had a number of problems in the last two years with sterilizing equipment.’ –Local newspaper ‘This is not the first incident in which veterans may have been exposed to infection during colonoscopies. Last month, the Department of Veterans Affairs alerted about 6400 patients in Y that they might have been exposed to infectious body fluids during colonoscopies from 2003 to 2008. Another 1800 veterans treated in X., received a similar notification.’ –National newspaper

Table 2 – (continued)

Situational crisis communication theory	
Model component	Example from media
Evidence of distinctiveness (N = 2)	‘X’s procedures have come under scrutiny before. In 2003, an independent agency that evaluates and accredits most of the nation’s hospitals took the rare step of placing the X Medical Center on ‘conditional accreditation’ after a surprise inspection uncovered problems at X. The hospital regained full accreditation by the end of the year.’ –Local newspaper ‘The Veterans Affairs system that serves about 6 million vets a year in more than 1000 medical facilities has been praised by medical authorities for its successful efforts to reduce antibiotic-resistant staph infections from treatment, a common problem in U.S. hospitals. A study published last month in The New England Journal of Medicine reported VA hospitals reduced such infections by 60 percent in intensive care units around the country after three years of emphasizing hygiene education and sanitizer availability in its facilities.’ –National newspaper
Stealing thunder model	
Model component	Example from media
Response timing (Quick N = 6, Slow N = 57)	‘Mr. X, commander at an American Legion post in Y, said the lag between when the problems were discovered and when veterans were told was inexcusable.’ –National newspaper ‘The VA must work faster to identify the immediate and root causes of these recurring failures, fix them and get on with restoring confidence in the system.’ –Local newspaper
Transparent (N = 11)/Secretive (N = 50)	‘It’s outrageous, one, that this happens, but even worse is this secretive, almost cover-up mode that they go into when something like this happens,’ X told CNN. The Democrat didn’t call for Y’s ouster, but said ‘only way you can get accountability is if there is someone who actually pays a price for this.’ –National newspaper ‘X said keeping equipment sterile is a challenge for all health facilities and added that veterans should be provided with the best care possible. He also said the VA staff is ‘committed to that purpose,’ and has tried to make information about the situation available and transparent.’ –National newspaper
Authentic apology framework	
Type of Apology	Example from media
Accept Responsibility (N = 2)	X said the clinic is taking full accountability for those involved, whom he calls, ‘our nation’s heroes.’ –National newspaper
Acknowledge what happened (N = 2)	‘When something this serious happens, people who are responsible have to be held responsible,’ he said. In a prepared statement Friday, the X VA said, ‘failure to follow infection control procedures is not acceptable and we take the safety of our patients seriously.’ –Local newspaper
Express sympathy (N = 3)	‘We are deeply sorry for the concern this circumstance has caused veterans and their families,’ X said. –National newspaper
Offer compensation (n = 0)	n/a

Duplicate articles were removed which resulted in a total of 148 unique reports. Two authors compared coding results on a subset of 20 reports; after discussion and consensus a final coding framework was achieved (see Table 2). Each media report was entered into NVivo qualitative data analysis software for sorting and coding purposes.²⁶ Researchers coding the articles met biweekly to discuss application of the coding framework to ensure consistency.

Results

Media coverage from the six events resulted in 148 unique reports from national and local television broadcast, national and local newspapers and blog posts. There were more

nationally focused news and television reports (n = 77) than local (n = 49), excluding blog posts which are difficult to classify in terms of reach. We found evidence for 13 of the 14 coding categories based on our analytical framework (Table 2). Offering compensation as part of apology was the only code where we did not find any evidence in the media reports. Messages most often present in the media involved reassurance (n = 114, 77%) and discussions of cause (n = 112, 76%). Discussion of personal response activity, such as encouraging patients to return to the facility for infectious disease testing, was present in 58 (39%) messages.

Not all messages, however, were in the direction intended by the health care organisation. Adequacy of response and consensus about lesson findings indicated that media coverage often discussed the inadequacy of the health care

organisation's response, and that lessons were not learned. The media relayed messages of consistency, indicating that the organisation had been through these events in the past but that they had not corrected their procedures appropriately. Local and national newspapers called on the organisation to improve the timing of the disclosures, and national media focused on messages of secrecy instead of transparency. In four events where identification of the event to disclosure was less than 75 days, fewer messages of secrecy were mentioned, compared to two events where the disclosure took place more than 75 days from identification of the event. Few aspects of authentic apologies were present in reports ($n = 7$, 4.7%), but when they were, they echoed messages from the organisation's notification letters about the regret and sympathy they conveyed to patients and families.

Comments and sources

There were several sources for comments in media reports who presented conflicting messages. Hospital officials provided 165 comments in these 148 reports. Of these, 152 were neutral (92%), which corresponds to the organisation's role to provide clear, factual information and empathy to the audience. An example of an official's comment is:

*VA medical experts continue to believe that there is an extremely small risk to patients from the procedures followed at each site. To ensure best practices, the VA has initiated an administrative board investigation...We are taking corrective measures and ensuring Veterans have the information and care necessary to deal with this unacceptable development.*²⁷

Elected officials are key stakeholders for the VA and act in a manner that a board of directors might for another organisation. In the reports studied, elected officials provided 115 comments, and 95 of these were negative in tone (83%). One elected officials' comments related to a hospital's colonoscopy event: 'U.S. Rep. [name], said in a release that ... I have heard from local and national [organisation] officials over and over again that this horrible series of mistakes were flukes and that the health care that veterans receive is of the highest quality, but this latest fiasco puts those assurances in doubt.'²⁸

Consumers provided 47 comments, and most (41, 87%), were negative. Thirty-four of these consumers reported being patients who were directly notified about the event, while 13 reported that they had not been affected by the event. Interestingly, consumers who reported receiving a notification letter and commented in media reports had more positive comments, compared to consumers who were not personally involved in the risk notification event. A patient who received a notification stated: 'Things happen,' she said. 'I don't fault the [organisation]. I have been treated here for several years, and my life has been saved on several occasions.'²⁹

In contrast, a consumer who was not impacted said: 'To be honest, I'd like to see them come out and be honest about how big this really is,' he said. 'It might be embarrassing, but in the long run it might be better for them.'³⁰ This presents possible pre-existing attitudes toward the health care organisation that are revealed through media opportunities that these large scale adverse events produce. The first commentator reflected on

positive past experiences with the organisation, while the second commentator may have already had negative experiences with the organisation and expects that the health care system is not revealing the true scope of the issue. Additional comments were provided by Veteran Service Organisations (VSO) ($n = 17$) which serve as consumer advocate groups. VSO comments varied in tone with nine negative, five positive, and three neutral comments.

Discussion

This directed content analysis from media coverage of six large scale adverse events in health care provides lessons for planning ideal communications at a time of crisis or risk. Analysis of media messages, whether positive, neutral or negative, provides lessons on what types of messages media covers. Understanding the media response can help organisations determine what additional communications messages must be delivered in order to make sure key messages reach patients. Organisations must find alternate ways to deliver these messages and address the negative media coverage. Our analysis offers four lessons for health care systems on managing their external communications:

Deliver messages not covered by the media

The media most often focuses on one or two key pieces of information, or messages, about the event. Public health officials typically provide technical, fact-based messages without the story characteristics and human elements attractive to the media.³¹ Our analysis reveals that media most often delivers messages of reassurance (investigation and prevention) and discussion of cause. Crisis and risk communication theory stresses the need for many essential messages to be delivered to patients.¹⁹ Health care systems need to make sure that messages of personal response, understanding of the organisation's response, and authentic apology reach patients. Possible strategies, beyond sending letters, include establishing a public source for information and regular updates, secure messaging to patients, and patient-provider conversations. Clear messages addressing the topics not readily available from the media can be provided through these channels.

Build trust with the public

We found messages of slow response and secrecy in many media reports. To counter this, health care systems should provide as much information as possible in a timely fashion, even if all facts are not yet known. Consistent, clear and open communication can promote trust and effectiveness of messaging.³² The speed and aptitude with which organisations address crisis and risk communication are important. Transparency is the goal of disclosures, but the media and patients do not always view this as transparent communication because not all information about the event may be available, and patients' potential health risks are difficult to interpret. If public trust for an organisation is questioned, the organisation must find a partner organisation with higher

public trust to assist in delivering messages of risk.¹² Partnerships are a key strategy that can help health care systems provide clear messages during crisis and risk communication and promote trust in those messages.

Work with stakeholders

If information on large scale adverse events is not provided adequately, the media may increasingly focus on stakeholders for alternative sources of information. Our analyses showed that elected officials, service organisations, and patients who were not part of the adverse event are often sources for comment in media reports. Health care organisations can work directly with these stakeholders to prevent misinformation in the media. Bringing stakeholders into organisational briefings early and often may be one way to shape their public messages. Elected officials may be helpful in providing messages about personal response activities to their constituents and reassurance that the cause of the event is being addressed. Stakeholders may not always be willing to work with the organisation; however, providing them with clear factual information may improve the quality of information being delivered.

Improve timing of notifications and preparedness

We found that the time it takes from discovery to patient notification may have an impact on the types of messages in media reports, including the response time and the transparency of the organisation. Shortening the timing between large scale adverse event identification and disclosures to patients and families, to the extent possible, may minimize the volume of negative messages in the media. The number of reports in that time will vary depending on the type of event and any number of additional factors, such as who is at fault and contextual factors surrounding the event. The Stealing Thunder model emphasizes the importance of the organisation proactively sharing information so as to not be 'scooped' by reporters.²¹ However, accuracy is also important in disclosures. Moving forward quickly, once the organisation is prepared to disclose, is important in promoting transparency. Transparency can influence the amount of public trust received.⁴ If there is a long delay in notifying patients, the reasons for the delay should be communicated clearly.

One limitation of this analysis is that it focused only on large scale adverse events that took place in VA facilities. The VA faces unique levels of media scrutiny due to its congressional stakeholders. Other health care systems may not face these same challenges in communicating with the media and the public. However, we feel many of the lessons learned from these analyses are important for all health care organisations in thinking through media coverage of these events. Although we were unable to explore the perceptions of patients and employees to determine the impact of media coverage and other communications about the event, subsequent research has examined these perspectives in relation to other aspects of large-scale disclosures.³³

Bad news does not age well. Even when health care organisations deliver messages covering the elements of crisis and

risk communication necessary when disclosing large scale adverse events, the media will not convey all of those messages to patients and the public. To address the gaps in information covered by the media, organisations must be proactive in reaching out to patients and the public, working strategically with stakeholders, seeking out partnerships to increase trust in the organisation, developing clear messages regarding patients' personal responses and authentic apologies, and shortening the timeframe between event identification and disclosure to patients.

Author statements

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Appendix A. Supplementary data

Supplementary data related to this article can be found at <http://dx.doi.org/10.1016/j.puhe.2015.10.016>